

# Young carers in Glasgow: health, wellbeing and future expectations

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## **Authors' note**

In November 2017 this report was updated, due to the regression analysis having been conducted on a more restricted sample than required. While the headline results are unchanged by these updates, some of the individual figures have changed slightly due to the larger number of cases that were able to be included. The following figures have been updated:

Figures 4, 5, 6, 7, 8, 9, 10 and 11.

Tables A1, A2, A3, A4.

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## **Executive summary**

### **Background**

- The Carers (Scotland) Act (2016) commences in April 2018 and is a central component of the Scottish Government's carer policy. Local authorities will have a duty to provide a range of support based on the identified needs of carers.
- In relation to young carers, the Act places a duty on health board areas and local authorities to offer a Young Carer Statement to identify support needs and personal outcomes, which are recognised as relevant to the young carer.
- Evidence shows that young carers tend to have poorer outcomes in terms of health, education, and employment. Young carers are also thought to be under-identified. Important factors that are associated with undertaking caring roles include higher levels of deprivation, adults with long-term health conditions and lone parent households, all of which exist disproportionately in Glasgow.

**This research used data from a health survey of more than 11,200 secondary school pupils in Glasgow to investigate the prevalence of young carers, and any differences in their health, wellbeing, and expectations after leaving school.**

### **Key findings**

- Almost one-in-eight pupils said they provided care for someone in the household with almost one-third of them stating that no one knew about it. Around three-fifths were female with just under one-fifth from a black and minority ethnic background.
- Young carers were more likely to be registered for free school meals and live in a lone parent household, with the highest proportion of carers within this age group found among those aged between 14 and 15.
- Over half of the young carers cared for someone with a disability, one-third for someone with a long-term condition, almost a quarter for someone with a

mental health problem, and around 1-in-10 for someone with a drug or alcohol problem.

- Young carers were twice as likely to report having a limiting illness or disability themselves when compared with non-carer pupils. Poorer physical and mental health outcomes were particularly evident among those caring for someone with mental health or addictions issues.
- Even taking background factors and the presence of household illness into account, young carers were less likely to see themselves entering further or higher education.
- Carers were also slightly more likely than non-carers to have taken part in activities such as work placements, careers guidance and job searches.

### **Conclusions**

- If the proportion of carers found in this survey existed across all secondary schools in Glasgow, then there could be around 3,000 young carers in the city. This figure does not include those in primary school, further education or in work, or those not engaged with education or employment.
- In sharp contrast, in Glasgow only 300 young carers were identified by social services in 2015. Possible explanations for under-identification include stigma, fears of unwanted intervention and forced separation, as well as not identifying with the role of 'carer'.
- The new duty for public services to identify and offer support could present future challenges for services in Glasgow and across Scotland – in particular, ensuring that young people feel comfortable enough to disclose their carer status, and that effective support measures contribute towards improving their health outcomes and future prospects.

# 1 Introduction

The Carers (Scotland) Act (2016) commences on 1st April 2018 and is a central component of the Scottish Government's carer policy. Under the Act, local authorities will have a duty to provide support based on the identified needs of carers. Each local authority will be required to have its own service for both adult and young carers, and must provide information and advice on, among other things, emergency and future care planning, advocacy, income maximisation and carers' rights. In relation to young carers, the Act will place a duty on health board areas and local authorities to offer a Young Carer Statement – a comprehensive view of the support needs of the young carer and how they will be met<sup>1</sup>.

In advance of the Act being implemented, and recognising that research on young carers continues to be a developing area, this research report aims to build on the existing evidence, based on the needs of young carers and how these might be addressed by utilising a large survey of young people in Glasgow. The report is structured to:

- summarise the background and wider context for young carers
- review the literature with a particular emphasis on demographics, poverty and disadvantage, health, education and employment
- describe findings on young carers from secondary analyses of the Health and Wellbeing 2014/15 survey of over 11,200 school pupils in Glasgow City
- discuss the implications of the findings within the context of the wider policy landscape and the forthcoming implementation of the Carers (Scotland) Act in 2018.

In the context of this report, carers refers to unpaid carers – those who provide support and care, most often to family members who are affected by a disability, physical or mental health issues, or issues with substance misuse<sup>2</sup>.

## **2 Background and context**

### **2.1 Carers in Scotland**

The prevalence of carers in Scotland can be difficult to accurately assess – carers are generally under-identified in surveys and censuses due to a variety of factors, including: participants not self-identifying as a carer; possible secrecy where someone in the family has a mental health, drug or alcohol problem; and in terms of young carers, surveys and censuses are most often filled out by an adult<sup>3,4</sup>. The 2011 Census identified 11% of the Scottish adult population as carers, with 1.4% aged under 16 having caring responsibilities, while the Scottish Health Survey (SHeS) in 2012/13 identified 17% of the adult population and 4% of those aged 4-15 as carers<sup>2</sup>. A Scottish Government estimate puts the figure at 7% of young people aged 4-24 in Scotland (93,000) as having caring responsibilities<sup>1</sup>. However, it is thought that the prevalence of young carers could be far higher, with two recent UK surveys finding 8%<sup>5</sup> and 12%<sup>6</sup> of young people sampled reporting that they had moderate or high caring responsibilities.

In terms of defining young carers, the Carers (Scotland) Act 2016 defines young carers as a person under the age of 18 who provides or who intends to provide care for an adult or child needing care, except where the child needs care solely due to its age<sup>7</sup>. For the purpose of this report ‘young carers’ is used to refer to those up to 18 years of age, and ‘young adult carers’ is used to describe those aged up to 25 years old. Young carers are most often defined as providing ‘substantial or regular care’ to those they care for<sup>8</sup>.

### **2.2 Supporting carers**

In terms of policy responses, the Scottish Government set out a five-year strategy, ‘Getting it Right for Young Carers’, in 2010 to improve the identification and support of young carers<sup>9</sup>. The strategy recognised that while young people can benefit from providing care, it can also adversely affect their health, wellbeing and educational attainment. Furthermore, there is recognition that inappropriate care undertaken by young people may infringe on children’s human rights. For example, caring responsibilities may prevent them from joining clubs, spending time with friends, limit opportunities to relax, play and participate in recreational activities, and potentially have a negative impact on their education<sup>10</sup>. These rights-based themes were explored in a GCPH seminar series lecture on the economics of dignity by Professor Marilyn Waring<sup>11</sup>.

More recently, the Carers (Scotland) Act (2016), which will commence in April 2018, aims to support adult and young carers’ health and wellbeing, and includes a specific



section outlining the Young Carers Statement. Health board areas and local authorities will be required to offer a Young Carer Statement to pre-school and school children, respectively. Salient issues that must be covered by the statement include: the nature and extent of care provided by the young carer; its impact on their wellbeing; their ability and willingness to provide care; and its appropriateness. The statement will also identify whether provisions are in place to respond to any emergency and future carer arrangements, the support the responsible authority provides or intends to provide, and if a break from caring is required. Once the young carer turns 18, the statement remains in place until an adult plan has been put in place<sup>12</sup>.

In terms of financial support, Carer's Allowance is a key welfare benefit that carers are entitled to claim. To qualify, the person must be 16 or over and caring for a severely disabled person for a minimum of 35 hours per week. Those in full time education or working and earning, after certain deductions, more than £110 a week (£116 as of 10th April 2017) are not eligible to claim. Universal Credit, which is currently being rolled out as a replacement for a number of benefits, also contains a carers component which can be paid from the age of 16 if the carer is caring for more than 35 hours a week, and it is for someone who is 'severely disabled'<sup>7</sup>. In 2013, Carers UK estimated that over 30,000 people across Scotland were entitled to Carer's Allowance but did not claim, with an estimated value of over £93 million per year<sup>13</sup>.

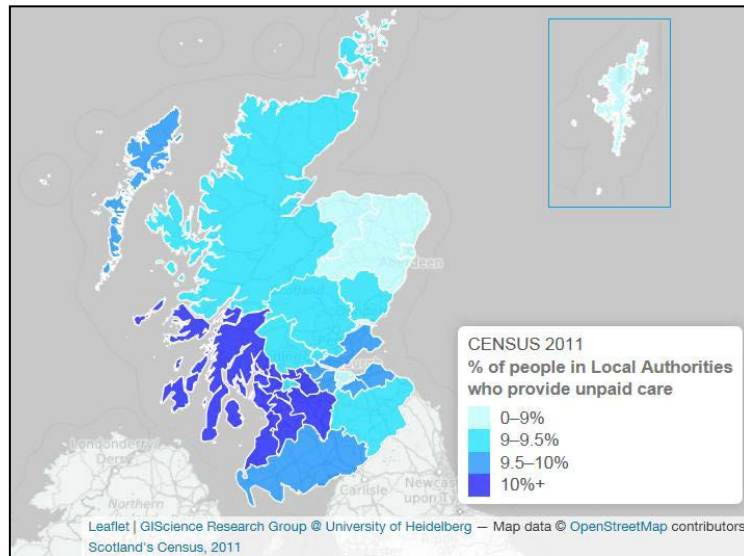
### **2.3 Carers' roles**

The care which carers provide can vary considerably. The type of care needed varies depending on the condition of the person receiving care, and care is not just provided for those with long-term conditions or disabilities – often care is given to those with mental health, drug or alcohol problems. It can range from undertaking household chores, physical care, such as moving or lifting a person, to intimate personal care, such as washing and going to the toilet, and providing emotional support and monitoring of a condition<sup>14</sup>.

### **2.4 Context: west coast of Scotland and Glasgow City**

The highest rates of caring across all age groups tends to be in local authority areas towards the west coast of Scotland with East Dunbartonshire and West Dunbartonshire showing the highest rates at nearly 11% of the population. In contrast, Aberdeen City has the lowest rate at 7% (see Figure 1).

**Figure 1: Distribution of unpaid carers across Scotland.**



Source: 2011 Census<sup>2</sup>.

Deprivation appears to be an important factor in the amount of caring undertaken. Data from the 2011 Census revealed that 47% of adult carers living in the most deprived areas care for 35 hours a week or more compared with 24% of carers living in the least deprived areas. Moreover, despite the overall rates of caring in Glasgow City being below the national rate (9.3%), compared with other local authorities, the city had a higher proportion caring for 35 hours a week or more (the rate at which Carer's Allowance can be claimed, and which is a significant amount of caring over the course of a week)<sup>2</sup>. A similar picture of high caring prevalence exists in other authorities across the west coast of Scotland that experience high deprivation levels, such as West Dunbartonshire and Inverclyde.

This picture is perhaps unsurprising due to the relatively high proportions of residents with long-term health conditions in the west of Scotland. For example, the percentage of those in Glasgow aged 16-74 who were long-term sick or disabled and economically inactive was 23.7%, compared with 16.6% across Scotland. Moreover, the proportion of children living in households with working-age adults, where at least one adult had a disability was 23% in Glasgow in 2014, higher than the 19% Scottish average<sup>15</sup>.

More specifically, in terms of problem drug and alcohol use, Glasgow is higher than the Scottish average. The percentage of adults with problem drug use in the city was estimated at 3.2% in 2012/13, higher than the national average of 1.7%<sup>16</sup>. In 2011, the rate of alcohol-related deaths in the city was approximately double that of Scotland as a whole<sup>17</sup>.

In terms of mental health and wellbeing, The General Health Questionnaire (GHQ-12) is used to identify individuals showing signs of the presence of a possible psychiatric disorder (as indicated by scores of 4 or higher). Between 2012 and 2016,

the proportion of adults with scores of 4 or more in Greater Glasgow and Clyde was 18%, higher than the Scottish score of 15%<sup>18</sup>.

Within a Scotland-wide context, the picture of adult caring across the west coast could be characterised as being one of higher prevalence and higher levels of time spent caring that juxtapose challenging health inequalities and the highest share of deprived areas across Scotland. To what extent this picture is applicable to young carers will be explored in a review of the literature with a particular focus on demographics, poverty and disadvantage, health, education and employment.

### **3 Literature review**

A brief review of the literature was undertaken to gain an understanding of the lives of young carers and the ways in which caring can impact on them, as well as to investigate previous research carried out with young carers. The review involved searches of academic databases, such as ASSIA and SocINDEX, alongside government and academic websites. This review was by no means exhaustive and intends to set the scene by exploring five specific areas: identifying young carers; demographics, poverty and disadvantage; physical health; mental health and wellbeing; and education and employment.

#### **3.1 Identification**

There are many reasons why young carers may be difficult to identify. Many of those who would be classified as young carers do not see themselves as such, and feel that they are just 'helping out' – this is linked to those that do not feel that there is anything unusual in their situation<sup>19,20</sup>. Some feel that their caring role will not be recognised or respected if it is revealed to adults in authority. There are those who have had a bad experiences of contact with services in the past, and therefore avoid them, and also those who are not aware of the types of support available<sup>21</sup>. Some young carers are afraid of the embarrassment that revealing their status may cause to themselves and their families – societal expectations that children are recipients rather than givers of care are strong – and that revealing a non-normative set-up could leave the family open to accusations of poor parenting<sup>19</sup>. Young carers can also fear their status being revealed to services, with fears of unwanted intervention and forced separation<sup>20</sup>.

#### **3.2 Demographics, poverty and disadvantage**

A longitudinal study of young carers in England found that the average income of a young carer's family was on average £5,000 less than a family with no young carer; young carers were more than four times as likely to be in families where no-one was working, and over one-and-a-half times more likely to have a mother with no educational qualifications<sup>22</sup>. Young carers are more likely than their non-caring counterparts to be in a lone parent family<sup>14,22</sup>. Looking at the Scottish census data from 2011, children living in a lone parent household were more likely to be a carer (6.6%) than those from a two-parent family (2.5%); and more likely to have more substantial caring responsibilities. Glasgow has the highest percentage of lone parent families in Scotland – the 2011 Census found that 40% of all households with children in the city were headed by a lone parent<sup>23</sup>. In the most deprived areas, 28% of young adult carers (those aged under 25) provided care for more than 35 hours per week, whereas in the least deprived areas this was 17%<sup>2</sup>. A recent Scottish survey of young carers found that 27% of the sample lived in the most deprived 15% of Scotland<sup>24</sup>.

A large-scale survey of young carers in 2004 found that almost one-third (29%) of those surveyed cared for a person with mental health problems, including those with drug- or alcohol-related problems. Half (50%) of the respondents cared for someone with a physical disability or illness<sup>14</sup>.

### **3.3 Physical health**

Although there is not a vast amount of research on the objective physical health of young carers, adults who provide unpaid care are more likely than their non-caring counterparts to have poorer health outcomes, in terms of both self-reported health outcomes<sup>25</sup> and objective health measures<sup>26</sup>. These differences can be seen to be caused by a number of different pathways, including: strain through physical exertion; changes in health due to health behaviours such as diet and exercise; and physiological effects of psychological distress<sup>25</sup>.

In terms of self-rated health, for those aged under 25 with no caring responsibilities, 97.6% rated their health as 'very good' or 'good', however this figure was 86% among those in the same age range who provided more than 35 hours of care per week. Over one-fifth of young adult carers (22%) have a long-term illness or disability, compared with 11% of non-carers<sup>2</sup>.

Young carers themselves have reported several physical health issues stemming directly from their caring responsibilities, including tiredness, exhaustion and backache, and project workers who work with young carers have reported that they have seen evidence of the impact of caring on both the diet and exercise of young carers<sup>28,29</sup>. A small study of 61 young carers in Edinburgh reported that 60% had trouble sleeping, and 30% reported issues around eating<sup>30</sup>.

### **3.4 Mental health and wellbeing**

Carers are more likely than non-carers to report negative mental health and wellbeing, with almost 1-in-20 (4%) of young adult carers in Scotland having a mental health condition, compared with 1-in-100 (1%) of non-carers<sup>2</sup>. In their study of young carers in the UK, Becker and Becker found that young carers reported worry, stress, anxiety, depression, anger, upset, resentment and resignation<sup>28</sup>. In comparison with their non-caring counterparts, young carers were significantly more depressed and had lower self-esteem<sup>31</sup> and reported being less happy<sup>32</sup>. In a study of former young carers, 70% reported that they had long-term psychological effects as a result of their caring responsibilities<sup>29</sup>. Although the numbers of young carers in the Scottish Health Survey are too small for much in-depth analysis, there are a number of salient findings referring to adult carers, for example that providing over 35 hours of care a week is associated with a lower WEMWBS<sup>a</sup> score, and carers

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<sup>a</sup> The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale for assessing mental wellbeing.

were also more likely than non-carers to exhibit signs of the presence of a possible psychiatric disorder (35% versus 15%)<sup>2</sup>. However the relationship between being a young carer and the impact on mental health and wellbeing is not a simple one – the type of illness or disability; the frequency and duration of care; and the type of tasks undertaken can all have a differing effect, as can the socioeconomic situation of the family and the type and frequency of social support received<sup>33</sup>.

The higher prevalence of physical and mental health issues among young carers can impact in a myriad of ways, however it should not be assumed that being a young carer is inherently negative: young carers have reported positive feelings that come from caring, such as closeness to family; a sense of responsibility; and a source of practical life skills<sup>34</sup>.

### **3.5 Education and employment**

It is not surprising that the combination of the physical and mental effects of caring would have an impact on a young person's participation and success in education. Coupled with the fact that young people from poorer backgrounds are more likely to have social, emotional and behavioural problems<sup>35</sup>; are less likely to do well in terms of educational attainment<sup>36,37</sup>, are less likely to apply for and attend higher education courses, even if they receive the same qualifications as their more affluent counterparts<sup>38</sup>, and tend to be from more disadvantaged backgrounds, there is likely to be a cumulative effect on the educational outcomes of young carers<sup>39</sup>. A report from the Joseph Rowntree Foundation on research carried out with young carers in England found that parental illness often had an indirect effect on young carers' outcomes. However, a lack of appropriate, affordable social care services, educational difficulties, poverty, and social exclusion and stress resulting from caring, all had more direct influences<sup>40</sup>.

Research illustrates that young carers' educational outcomes are indeed affected by their caring responsibilities. Over 70% of former young carers in a survey of 41 felt that their education had been affected by their caring responsibilities<sup>29</sup>. A longitudinal study of young carers found that 1-in-20 had missed school due to caring responsibilities, they had significantly lower achievement at GCSE (General Certificate of Secondary Education), and they were more likely to end up outside the education system and out of work or training<sup>22</sup>. Butler and Astbury found that young carers who provided emotional support for others had negative experiences with schooling, such as poor attendance and bullying, as well as with stigma and feelings of isolation<sup>41</sup>. In a separate study, when compared with non-carers, young carers were also more likely to report that they 'sometimes' or 'often' were afraid to go to school due to bullying<sup>31</sup>.

Structural factors, such as the labour market, as well as the geographical and psychological boundaries associated with caring, have been found to impact on the sense of future possibility reported by young carers, and decisions about future study

and employment are made within the constraints of caring responsibilities<sup>42</sup>. Some young carers have been found to display 'limited horizons' – their thinking about the future restricted by their caring responsibilities<sup>43</sup>. In terms of further and higher education, qualitative research with 60 young adults who had been young carers showed that decisions on *where* to study and to some extent *what* to study – depending on the timing of classes for example – was influenced by caring responsibilities. Some young carers have reported being unable to move away from home due to caring responsibilities<sup>3</sup>. Moreover, an Edinburgh study found that over half of young carers reported worrying about who will look after their parent(s) in the future<sup>30</sup>. This influence has been conceptualised using the phrase 'bounded agency' which in the case of young carers and their transition into adulthood looks at the *"way in which structural factors in their past and present shape their daily experience across major life domains, their sense of future possibility"*<sup>42</sup>.

The combination of educational disadvantage and the long-term nature of caring responsibilities means that young carers are often at a disadvantage in the labour market, and the move from school to employment can be much more complex for those with caring responsibilities<sup>3</sup>. Data from the Longitudinal Survey of Young People in England found that young carers in work at the ages of 20 and 21 were more likely to be in lower skilled occupations than their non-caring counterparts<sup>22</sup>. Unpaid care can be seen as labour, and labour that incurs costs to the carer, both direct costs such as those to physical and mental health, but also opportunity costs, such as disruption to education and impact on future employment<sup>44,45</sup>. Several studies have found that many young carers go on to work in caring jobs after leaving school, with some young adult carers identifying skills and dispositions that they had gained while caring for a family member<sup>42</sup>, and others feeling that these skills were the only thing they had to offer in the world of employment<sup>28</sup>.

These findings suggest that not only do young carers have poorer health and mental health outcomes than non-carers, but that those with the highest caring responsibilities are more likely to come from the most deprived areas and lone parent families, and that caring responsibilities also exacerbate factors such as educational and employment issues; social exclusion and poverty.

## **4 Methods and approach**

### **4.1 NHS GGC secondary schools health and wellbeing survey**

The NHS Greater Glasgow and Clyde (NHS GGC) secondary schools health and wellbeing cross-sectional survey has been undertaken across local authorities within the GGC health board area. The survey aims to provide information for policy-makers, health practitioners, and planners about the lives and health of secondary school age young people, and asks a wide variety of questions about their life, home circumstances, behaviours, health and emotional wellbeing, among other issues. There have been three waves of the survey in Glasgow City with the first survey undertaken in 2006/2007.

This report presents findings from the third wave of the Glasgow secondary schools survey which was carried out in 2014/2015. The survey data of 11,215 secondary school pupils was used to investigate the prevalence of young carers, the type of care provided, and any differences in terms of health, wellbeing and expectations after leaving school. Health was measured by the self-reported physical health conditions reported by the pupils, as well as by the emotional, behavioural or learning difficulties / disabilities reported. Mental health was measured using the Total Difficulties scale of the Strengths and Difficulties questionnaire. The Strengths and Difficulties Questionnaire (SDQ) is a behavioural screening questionnaire that can be filled in by parents, teachers, or self-completion. Participants are rated, or rate themselves, on five domains: emotional symptoms; conduct problems; hyperactivity-inactivity; peer problems; and pro-social behaviour. The total difficulties score is a sum of the first four subscales<sup>46</sup>. The score can be between 0-40, with a score of 13 or under being normal, 14-16 borderline, and 17 or above being a cause for concern, with pupils who had a borderline/cause for concern score being included in the medium/high score category. Expectations after leaving school were measured using pupil responses on their post-school expectations, for example further or higher education, work, or an apprenticeship.

### **4.2 Analysis**

Using the 2014/15 schools survey data, 'young carers' were identified by the following two-step process:

1. The pupil self-reported that someone in their family household had a disability, long-term illness, drug/alcohol problem or mental health problem.
2. The pupil self-reported that they looked after or cared for this person because of their disability, long-term illness, drug/alcohol problem or mental health problem.



The analysis was then carried out in two stages:

1. The prevalence of young carers in the data was explored along with the results for young carers versus non-young carers for a selection of responses.
2. Hierarchical multiple logistic regression analysis<sup>b</sup> to examine the effects of pupil background on: participants' mental health; post-school aspirations; emotional, behavioural or learning difficulties / disabilities; and physical health conditions. There were three steps to the modelling, controlling for:
  - I. the pupil's background – sex; age; deprivation (whether the pupil reported receiving free school meals); ethnicity; lone parent family
  - II. the pupil's carer status
  - III. the presence of illness in the family – disability; long-term illness; drug/alcohol problems; mental health issues.

Logistic regression is a statistical technique used to calculate the probability that a person will be in one of two groups – in this case, either having reported: one or more physical health conditions or not; a medium/high difficulties score or not; one or more emotional, behavioural or learning difficulties / disabilities or not; and the expectation of going on to further or higher education after school, or not.

### **4.3 Sampling**

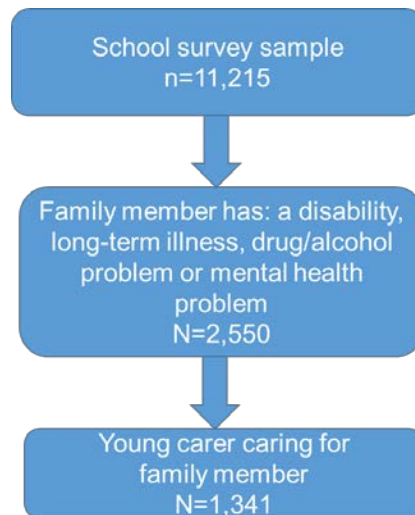
The Glasgow City survey involves the participation of first to sixth year pupils (age range 11-18) in all of the 30 secondary schools across the city – a population of around 26,000 pupils. In the 2014/2015 survey there was a response rate of 88%, resulting in 11,215 pupils taking part.

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<sup>b</sup> The full methodology and tables for the second part of the analysis can be found in the Appendix.

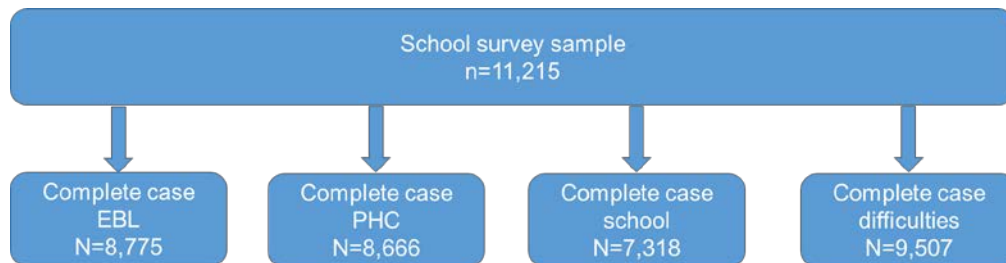
In Stage 1 of the analyses the full pupil sample (11,215) was used (see Figure 2).

**Figure 2: Stage 1 analysis flowchart.**



At Stage 2, a complete case analysis was conducted using a sample that excluded those pupils who were missing data in any of the variables used in the subsequent modelling of the four outcomes variables, leading to four different sample sizes<sup>47</sup> (see Figure 3).

**Figure 3: Stage 2 analysis.**



## 5 Stage 1: How do young carers differ from their non-carer classmates?

### 5.1 Prevalence of young carers

Overall, 12% (N=1,341) of the school pupils reported that they looked after or cared for a household family member. In terms of level of care, 41.7% looked after them 'every day' (4.9% of the overall sample); 29.1% 'a couple of times a week' (3.5% overall); and 29.2% looked after them 'once in a while' (3.5% overall).

Almost three quarters (73.1%) cared for a household or family member with one condition; while 16.6% cared for someone (or possibly more than one person – it is not possible to discern this from the data) with two conditions; while 4.2% had three conditions, and 1.3% four conditions.

**Table 1. Percentage of pupils caring for household member(s) with one or more conditions.**

One condition	Two conditions	Three conditions	Four conditions
73.1%	16.6%	4.2%	1.3%

Over half of these carers (54.5%) cared for someone with a disability; over one-third (34.8%) for someone with a long-term condition; almost a quarter (23.9%) for someone with a mental health problem; and just over one-tenth (10.7%) for someone with a drug or alcohol problem<sup>c</sup>.

The survey question did not ask the pupils to specify the way(s) in which they provided care, however from the literature this could be any of a wide range of types of care, including household chores, personal care and emotional support. Comparing young carers with the overall survey sample revealed gender and ethnicity differences. Just under three-fifths of the young carers were female (57.3%) compared with 51.5% overall. Just under one-fifth (18.7%) of young carers were identified as black and minority ethnic (BME), slightly lower than the overall BME percentage (19.7%) within the survey sample. A breakdown of the demographics of the carers and non-carers is shown in Table 2.

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<sup>c</sup> Please note these figures do not add up to 100% as more than one option could be chosen here, as illustrated in Table 1.

**Table 2. Demographic breakdown of pupils.**

Characteristic		Carer (N=1,341)	Overall (N=11,215)
Gender	Male	42.7%	48.5%
	Female	57.3%	51.5%
Ethnicity	BME	18.7%	19.7%
Free school meals	Registered	33.1%	22.1%
Lone parent family		35.1%	30.8%
Age	11	3.2%	3.8%
	12	15.6%	17.2%
	13	17.3%	17.8%
	14	19.9%	19.5%
	15	18.4%	17.6%
	16	14.6%	14.4%
	17	10.8%	9.5%
	18	0.3%	0.2%

As NHS GGC carries out similar schools surveys in other local authority areas operating across the health board area, the opportunity was provided to provisionally compare the prevalence of young carers. The surveys undertaken in East Dunbartonshire and Inverclyde have an identical question to those asked in Glasgow City. However, the Renfrewshire survey asks a slightly different question, and does not ask about frequency of care in the same way. Therefore, the results cannot be directly compared but are provided for information purposes only. Table 3 also shows the Scottish Index of Multiple Deprivation (SIMD) 2016 local share – the percentage of the area’s data zones that fall into Scotland’s 15% most deprived areas.

**Table 3. Carer figures from other local authorities across NHS GGC.**

Local authority	Pupils with any caring responsibilities	Sample size	Year	SIMD 15% local share 2016
Glasgow	12%	11,215	2014	42.9%
East Dunbartonshire	9%	2,907	2014	1.5%
Inverclyde	14%	3,606	2013	35.0%
Renfrewshire	19%	5,600	2013	20.9%

## **5.2 Demographics, poverty and disadvantage**

Overall, young carers were more likely to be overrepresented in a range of standard measures that looked at poverty and disadvantage.

Young carers were more likely than non-carers to receive free school meals (33.1% and 21.1% respectively). Free school meal registration is often used as a proxy for individual and school level deprivation, and while not an ideal indicator, does give an indication of the level of deprivation in a given area.

Young carers were also less likely than their non-carer counterparts to live with both parents (51.7% versus 58.3%), and slightly more likely to live with just one parent (35.1% versus 30.3%).

Over a quarter of young carers (28.6%) did not have their own bedroom, compared with just under a quarter (24.2%) of non-carers. Overcrowding of housing is often used as a proxy for deprivation.

Young carers were less likely than non-carers to have eaten breakfast on the morning of the survey (57.2% versus 64.3%). Eating breakfast is associated with being a healthy weight, and may benefit academic performance, whereas skipping breakfast is associated with those from poorer backgrounds<sup>48</sup>.

Although the pattern of family computer ownership is similar across carers and non-carers, it is worth noting that the percentage of carers who reported having no computers was almost double the percentage of non-carer pupils (3.7% and 2.1% respectively).

## **5.3 Physical health**

There were striking differences in the reporting of physical health between carers and non-carers.

Almost 16% of the young carers reported that they had a limiting illness or disability, almost double than the level of non-carers (15.7% versus 8.0%).

As would be expected with almost double the number of carers reporting that they had a limiting illness or disability than non-carers, self-reported health over the last year was lower among carers. Self-reported health over the last year was recorded as one of five faces, with the happiest face being coded as a 1 and the saddest face coded as a 5. In general, young carers felt slightly worse about their health over the last year than non-carers, with almost double the amount saying they felt their health over the last year was a 5 (5.8% versus 3.0%). The average score for a young carer was 2.44, and the average score for a non-carer was 2.24.

Again, consistent with the response to whether the pupils had a limiting illness or disability, in general young carers were more likely to report that they had any emotional, behavioural or learning difficulties/disabilities – more than double for dyslexia (9.9% versus 5.5%), ADHD (5.2% versus 2.2%), and mental health / emotional illness (10.6% versus 4.0%).

Young carers were also more likely than non-carers to report that they had certain physical health conditions, such as asthma (21.0% versus 15.3%), eczema or psoriasis (12.1% versus 7.5%), stomach or digestion problems (5.3% versus 2.7%), or urinary/bladder problems (3.3% versus 1.3%).

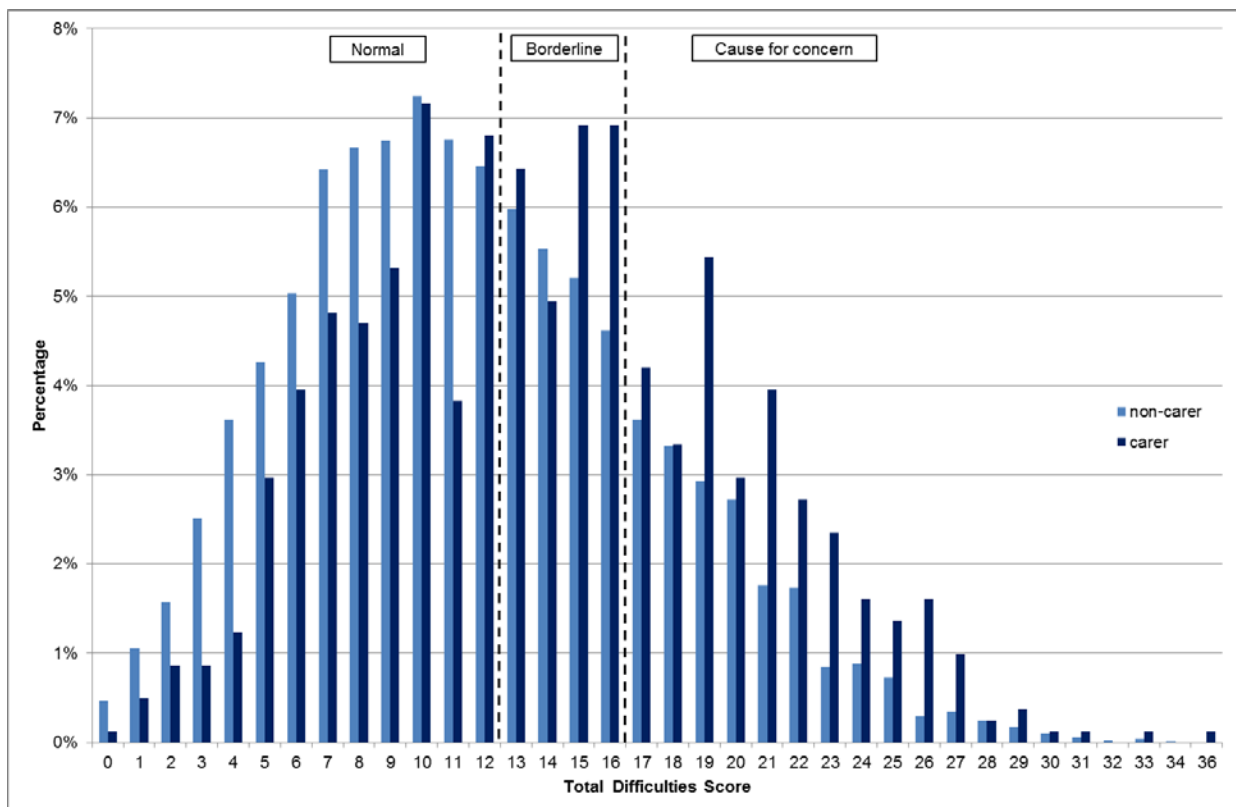
Carers were more likely to report that they had less than 3 hours sleep (5.4% versus 2.6%), or between 3 and 5 hours sleep (15.1% versus 10.5%) in the night before the survey than their non-caring counterparts.

### 5.4 Mental health and wellbeing

As with physical health, carers were overrepresented in outcomes that examined the mental health and wellbeing of the pupils.

As can be seen below in Figure 4, the distribution of total difficulties scores shows that carers are more likely to be borderline or cause for concern, again consistent with the literature on young carers and mental health<sup>2,29,31,49</sup>.

**Figure 4: Distribution of total difficulties scores.**



Young carers were more likely than non-carers to worry about things, including school (44.7% versus 36.0%); but also personal and family issues, such as the way they look (40.8% versus 30.3%); as well as the future (48.8% versus 39.8%). Unsurprisingly they were more likely to be worried about caring for a family member.

Young carers were more likely than non-carers to report that they had been bullied. This was the case for bullying at school (25.3% versus 15.2%), somewhere else (13.0% versus 6.3%), and online (14.3% versus 7.2%).

## **5.5 Cultural and social activities**

There were few differences between carers and non-carers in terms of the community services they had visited within the last year, with carers slightly more likely to have visited a library (61.0% versus 56.1%) or community centre (30.6% versus 25.2%).

Those who identified as carers were more likely than non-carers to have taken part in almost all of the social activities listed in the survey, including doing voluntary work (30.9% versus 26.0%), taking part in a charity event (33.0% versus 27.5%), drama/acting/singing/dancing groups (29.6% versus 24.6%), religious activity (19.6% versus 16.9%) and youth organisations (14.5% versus 12.4%).

## **5.6 Education and employment**

Carers were less likely than non-carers to think that they would be going on to university after leaving school (39.2% versus 46.9%), with carers thinking they were more likely to be working (25.4% versus 21.4%), or undertaking a trade or modern apprenticeship (6.5% versus 4.3%).

Young carers were also slightly more likely than non-carers to have taken part in school-based employment activities, such as work placements (25.1% versus 19.7%), careers guidance (19.0% versus 16.0%) and job searches (18.8% versus 15.9%).

## **5.7 Views on caring**

Those who identified as a carer were asked two follow-up questions on how their caring responsibilities had affected them.

Over half of the young carers said that 'it makes me feel good to be able to help' (51.9%), and over a third said that they had learned new skills through caring (34.0%). However over a quarter said that it makes them tired (26.8%) and just under a quarter reported that it meant they were sometimes unable to do homework (24.2%).

The young carers were also asked who knew about their caring responsibilities. Almost a third said that no one about their caring (30.9%). Over half (56.1%) said



their friends knew, just under a fifth said that a teacher knew (18.4%), and around a tenth said that carer support services knew (8.9%). Just over 1-in-20 reported that youth services were aware (5.7%).

## 6 Stage 2: Do differences between young carers and their counterparts persist?

### 6.1 Physical health conditions

As we saw in the first findings section, there were differences between carers and non-carers in terms of reporting a physical health condition<sup>d</sup>. A binary variable for physical health conditions was constructed with two categories – pupils either indicated that they had one or more of the conditions, or they did not.

In order to look at whether these differences persist when the pupil's background and the presence of family illness in the household were controlled for, a hierarchical logistic regression model was constructed. The results can be seen below. As this was a binary outcome, a logistic regression analysis was carried out. The output can be interpreted as the odds ratio for each variable – for example, if the output for 'male' was 1.5, we could say that male pupils were 1.5 times, or 50%, more likely to report they had one or more conditions as opposed to female pupils.

The graphs show the odds ratio on the vertical y-axis, with bars for each variable included. Bars with a score less than 1 indicate a negative association, and bars with a score more than 1 indicate a positive association.

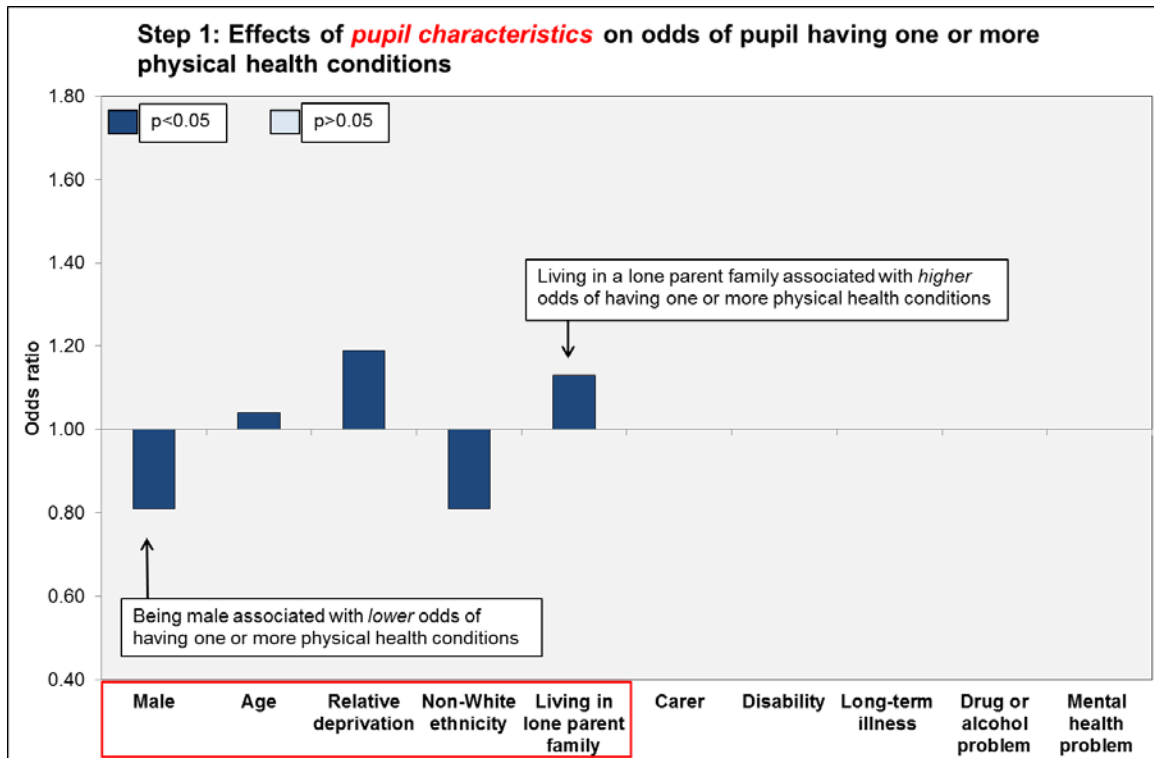
Significance was assessed by looking at *p* values – the level of confidence we can have that the finding is statistically different from zero. A value of greater than 0.05 ( $p > 0.05$ ) suggests we cannot have confidence that the finding is statistically significant; a *p* value of under 0.05 ( $p < 0.05$ ) suggests we can be 95% certain that the finding is statistically significant. In the graphs, pale blue indicates the result is not statistically significant ( $p > 0.05$ ), and dark blue that the result is significant ( $p < 0.05$ ). The full tables, including confidence intervals, can be found in the Appendix.

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<sup>d</sup> The conditions were: asthma; diabetes; eczema/psoriasis; epilepsy; arthritis/painful joints; cystic fibrosis; stomach/digestion, constipation or bowel problem; urinary/bladder problems (wetting); hearing impairment; visual impairment; or other physical illness or disability.

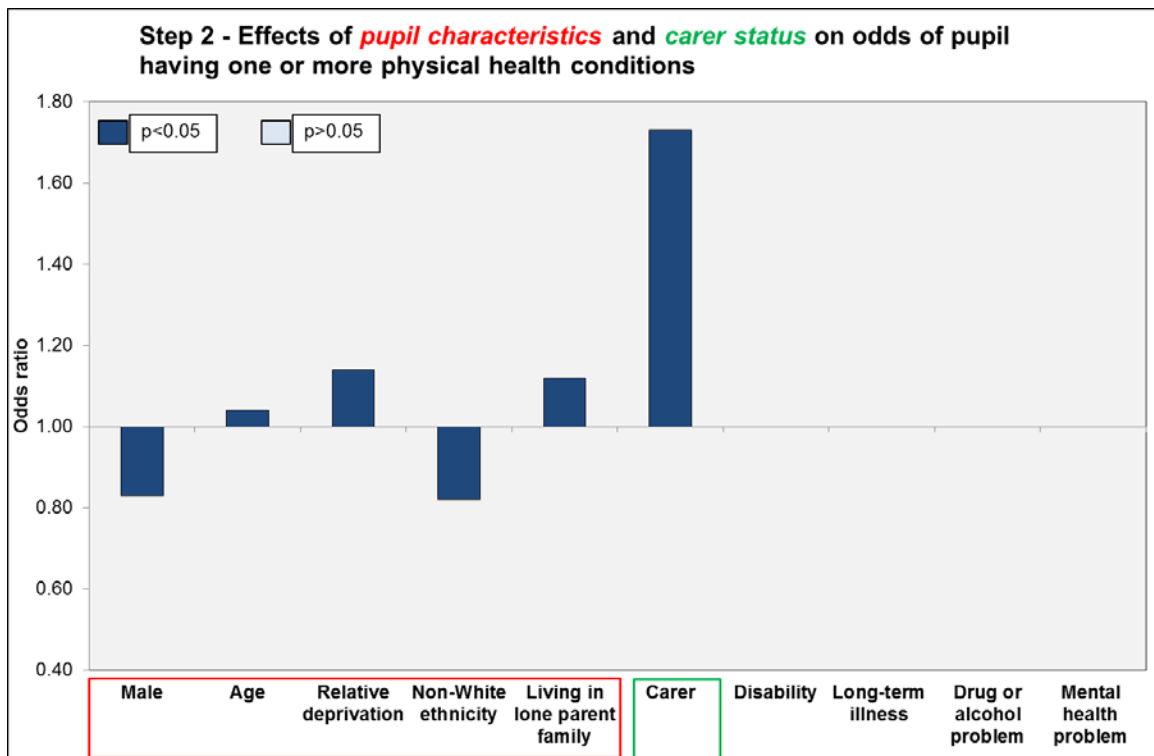
In step one, as can be seen in Figure 5, pupils' gender, age and living in a lone parent family were all significantly associated with the reporting of a physical health condition. Males were less likely to report a physical health condition, and older pupils, those receiving free school meals, and those in lone parent families were more likely to report a physical health condition.

**Figure 5: Step 1 – physical health conditions.**



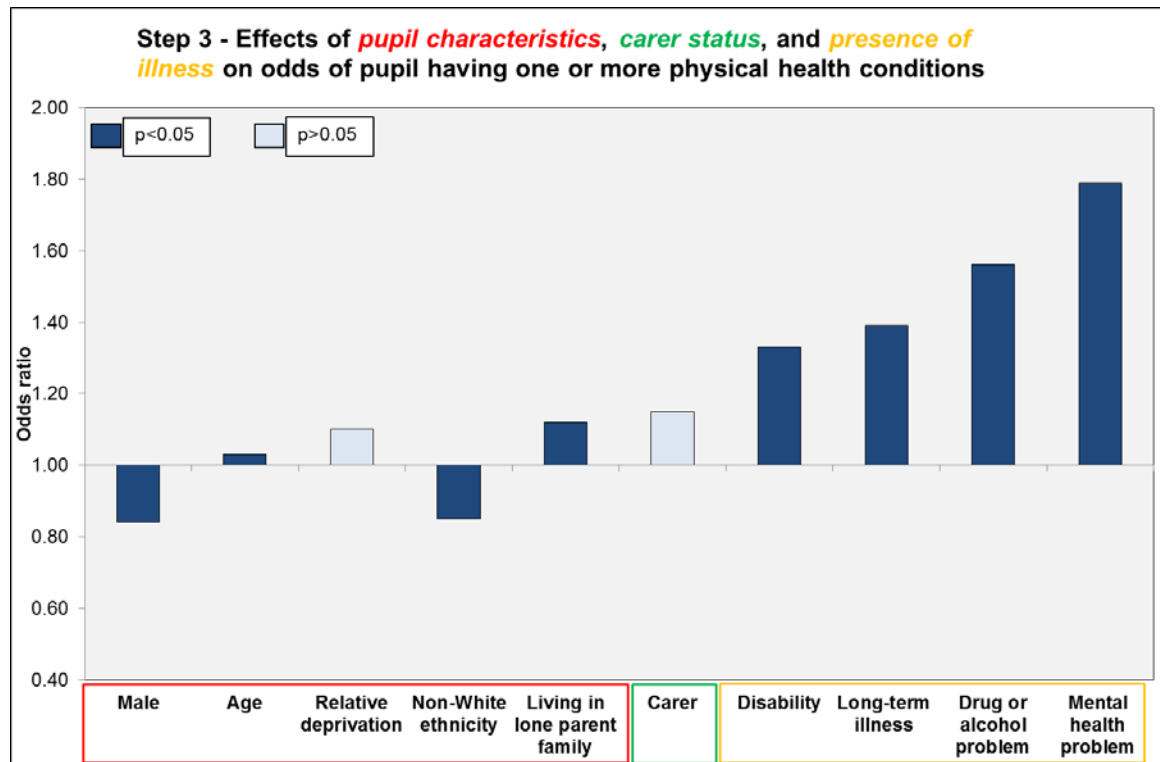
As can be seen in Figure 6, some of the pupils' background factors (gender, age, lone parent family) remained significant with the introduction of carer status in the second model. Being a carer had a strong and significant association with reporting one or more physical health conditions, with an odds ratio of 1.73 – carers were 73% more likely to report one or more physical health conditions than non-carers, even after accounting for background factors.

**Figure 6: Step 2 – physical health conditions.**



In the third step, the four variables covering the presence of illness in the family are introduced. As can be seen in Figure 7, when they are introduced, carer status has become insignificant. Of the presence of illness variables, all are significant. In other words, those living with a family member with a long-term illness, drug or alcohol problem, or mental health problem are all more likely to report physical health conditions, over and above background factors<sup>e</sup>.

**Figure 7: Step 3 – physical health conditions.**



These findings suggest that the reporting of one or more physical conditions is associated with the presence of illness in the household.

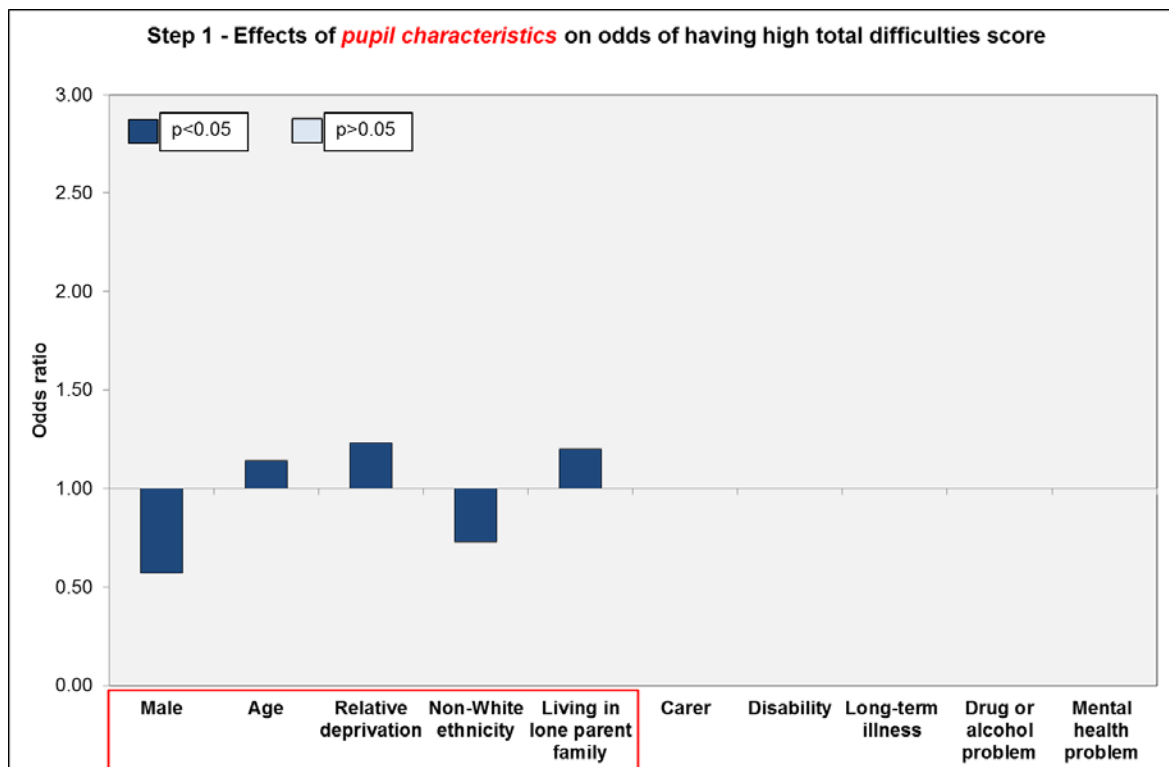
<sup>e</sup> A fourth step, adding interaction terms into the model, was undertaken with all outcome variables but no significant results found. The results can be found in the Appendix.

## 6.2 Mental health and wellbeing

In the first section of the findings we found that the total difficulties scores for carers and non-carers differed, with carers tending to have a higher score, suggesting that young carers have poorer mental health and wellbeing than non-carers.

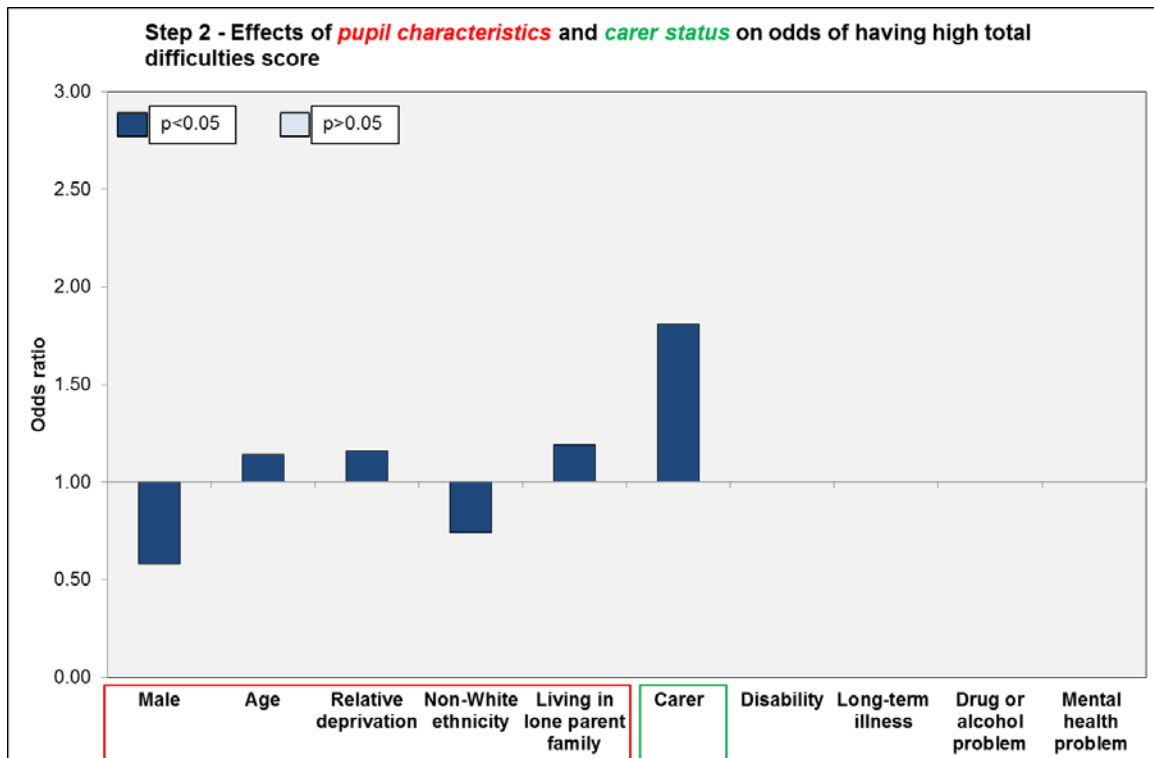
As can be seen in Figure 8, the first step of the model showed that gender, age, deprivation and ethnicity all had a significant impact on whether a pupil had a high difficulties score. Not having a medium/high difficulties score was associated with being male and being of a non-white ethnicity, while having a medium/high difficulties score was associated with age, being registered for free school meals, and living in a lone parent family.

**Figure 8: Step 1 – mental health and wellbeing.**



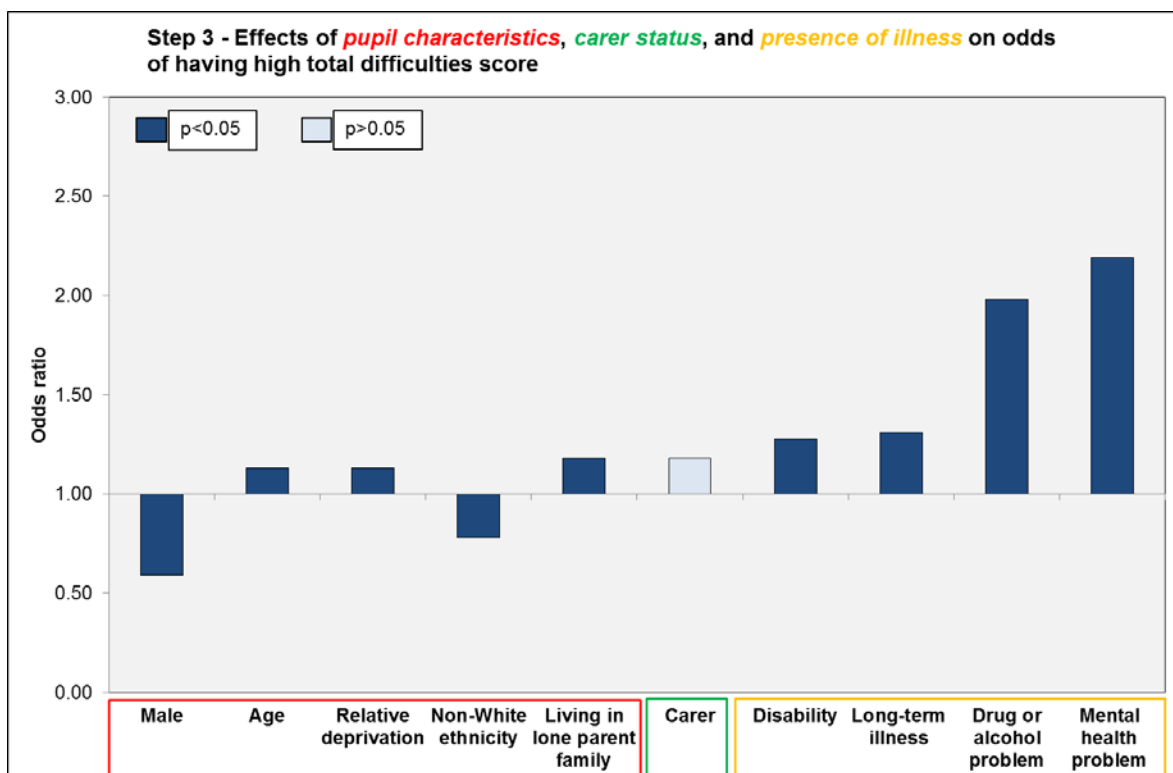
The next step was to add the young carer status into this model. As can be seen in Figure 9, this also had a significant association with whether a pupil had a medium/high difficulties score. It showed that those who were carers were more likely to have a medium/high difficulties score than those who were not carers, over and above background characteristics.

**Figure 9: Step 2 – mental health and wellbeing.**



The third step of the model introduced whether the pupil had a family member in the household with an illness or long-term condition. In the presence of the four illness variables, caring status becomes insignificant, as can be seen in Figure 10. However, all four of the types of illness/condition are significantly associated with a having a medium/high difficulties score, indicating that presence of illness is associated with poorer mental health over and above background factors and carer status. In particular, having a family member with a drug or alcohol problem or a mental health condition had the strongest association with having a medium/high total difficulties score.

**Figure 10: Step 3 – mental health and wellbeing.**



In terms of the young carer's mental health and wellbeing, it seems that although being a carer does impact on having a medium/high difficulties score, the presence of illness, particularly having a family member with a drug or alcohol problem or a mental health condition, has the biggest association with having a medium/high difficulties score.

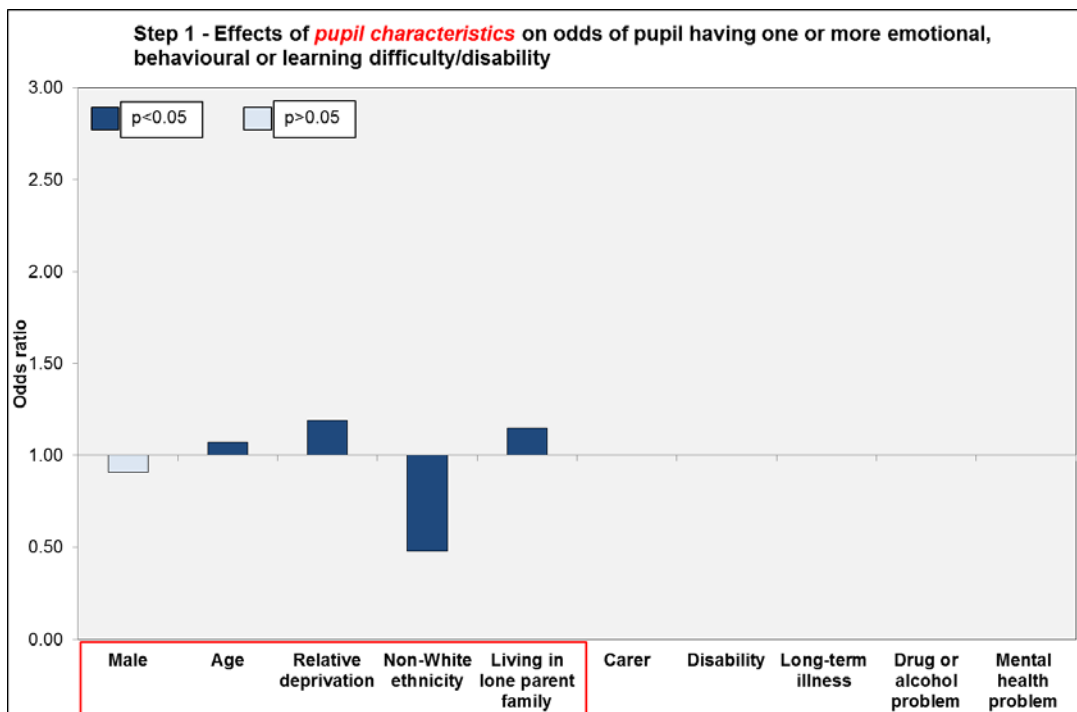


### 6.3 Emotional, behavioural or learning difficulties/disabilities

The first section showed that there were differences between carers and non-carers in self-reporting a range of emotional, behavioural and learning (EBL) disabilities<sup>f</sup>. A binary variable, EBL, was constructed where pupils were in one of two categories: they had indicated they had one or more of the conditions, or they had not reported any.

As can be seen in Figure 11, most of the background factors have a significant association with EBL. Non-White pupils were less likely to report emotional, behavioural or learning difficulties/disabilities, however those in lone parent families and older pupils were more likely to report them.

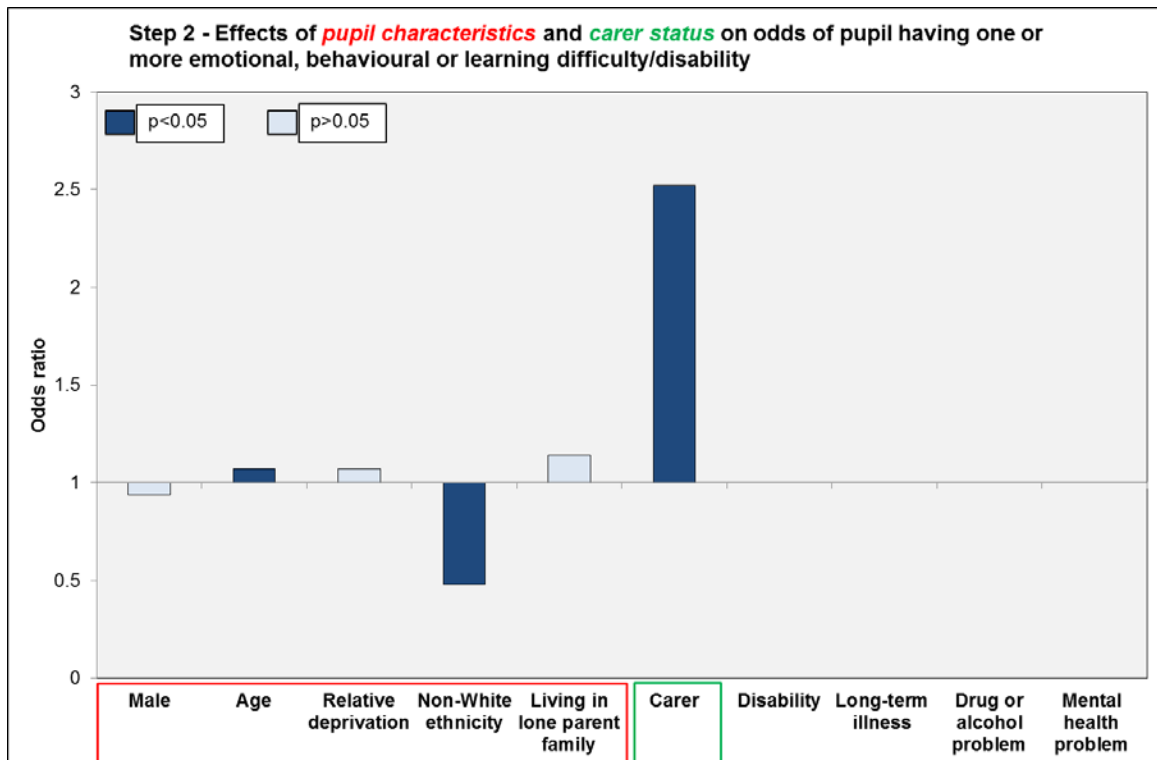
Figure 11: Step 1 – emotional, behavioural and learning disabilities.



<sup>f</sup> The conditions were: dyslexia; Attention Deficit Hyperactivity Disorder; Autism Spectrum Disorder/Asperger's; mental health/emotional illness; or other emotional, behavioural or learning disability/difficulty.

When carer status was added in at step 2, it was strong and significantly associated with the reporting of EBL, as can be seen in Figure 12. Carers were more than twice as likely as non-carers to report emotional, behavioural or learning difficulties/disabilities.

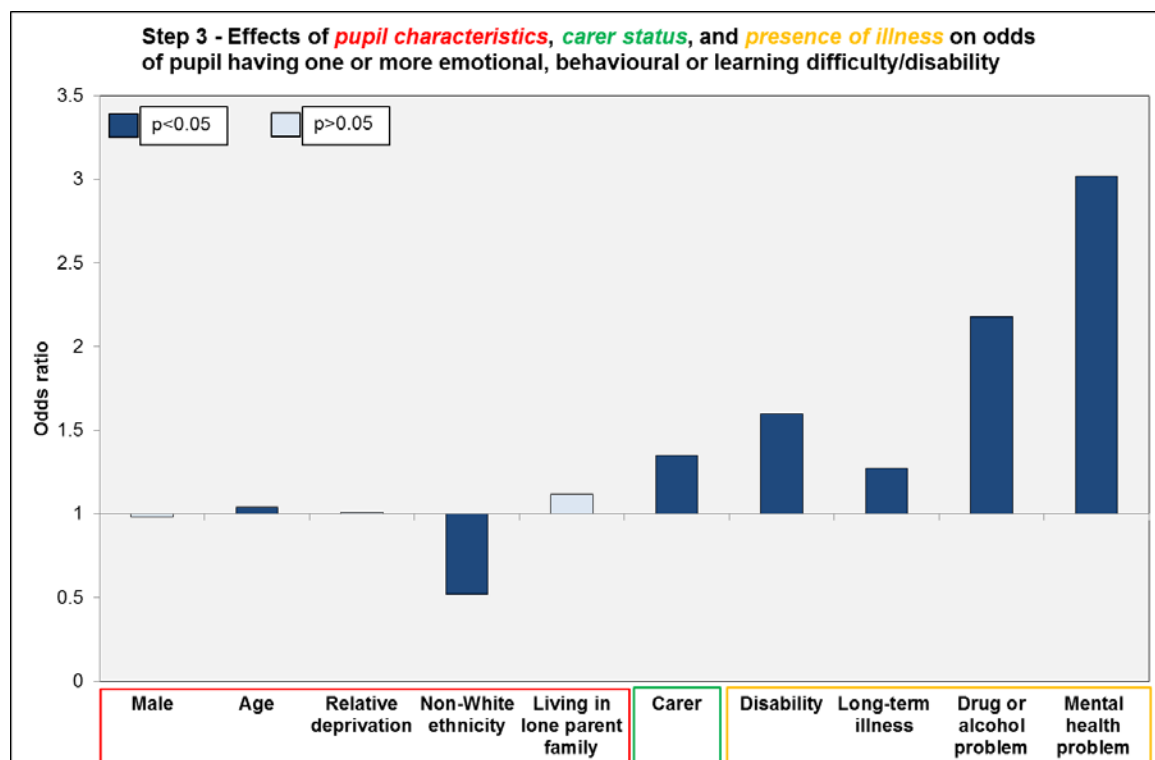
**Figure 12: Step 2 – emotional, behavioural and learning disabilities.**



At step 3, when all four illness variables were added into the model, carers' status had less association with emotional, behavioural or learning difficulties/disabilities, although it still remained significant as can be seen in Figure 13. While all four of the presence of illness variables were significant, the association was particularly strong in two instances:

- I. If a family member had drug or alcohol problems, then young carers were more than *twice as likely* to report emotional, behavioural or learning difficulties/disabilities.
- II. If a family member had a mental health problem, then young carers were more than *three times as likely* to report emotional, behavioural or learning difficulties/disabilities.

**Figure 13: Step 3 – emotional, behavioural and learning disabilities.**



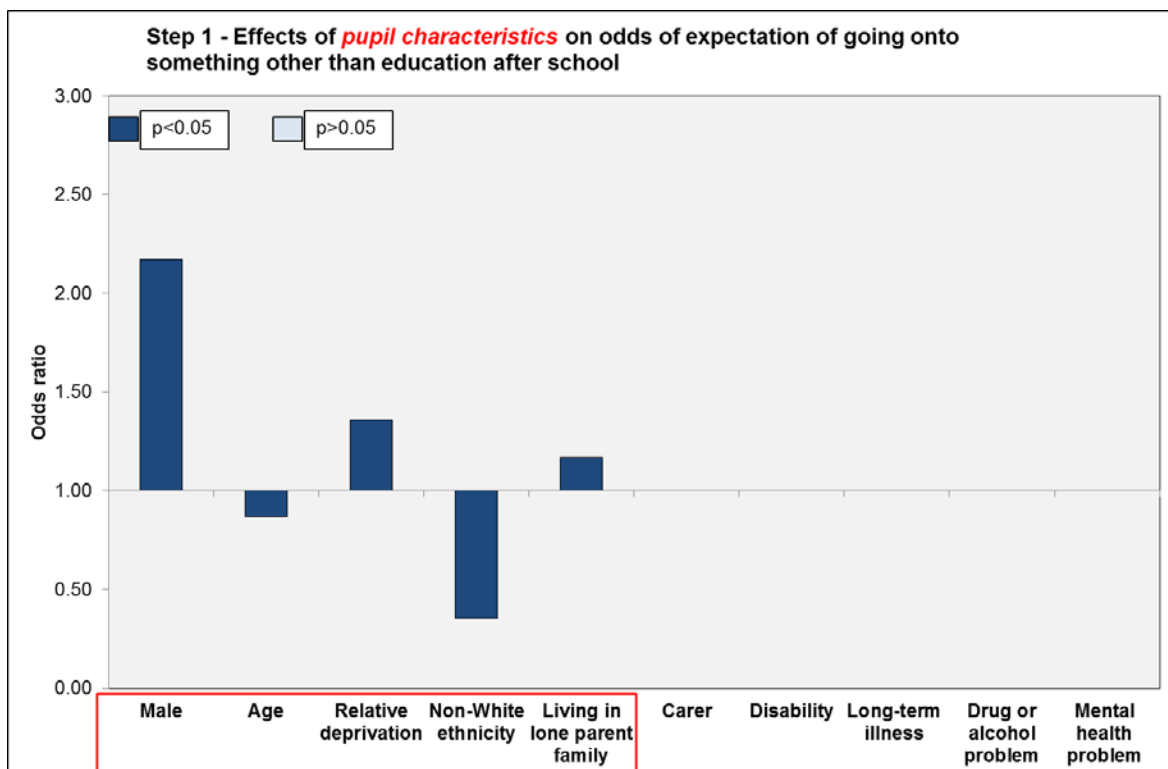
These findings suggest that the reporting of emotional, behavioural or learning difficulties/disabilities is associated with both the presence of family illness, particularly drug or alcohol problems or mental health problems, as well as being a carer, over and above background factors.

## 6.4 Post-school aspirations

The first section of the findings also showed that there were differences between carers and non-carers in terms of what they thought they would do once they left school. The ten options offered to pupils in the school survey question<sup>9</sup> were collapsed into two options. The two collapsed options ('further or higher education' and 'something else') were constructed into an outcome variable to support further analyses.

The first step in this model controlled only for background factors. It shows clearly that all of the factors have a significant association with future aspiration – for example boys were more than twice as likely as girls to think they will be doing 'something else', as can be seen in Figure 14. Those receiving free school meals and living in a lone parent family were more likely to think they would be doing 'something else', while younger pupils and non-White pupils were less likely to think this.

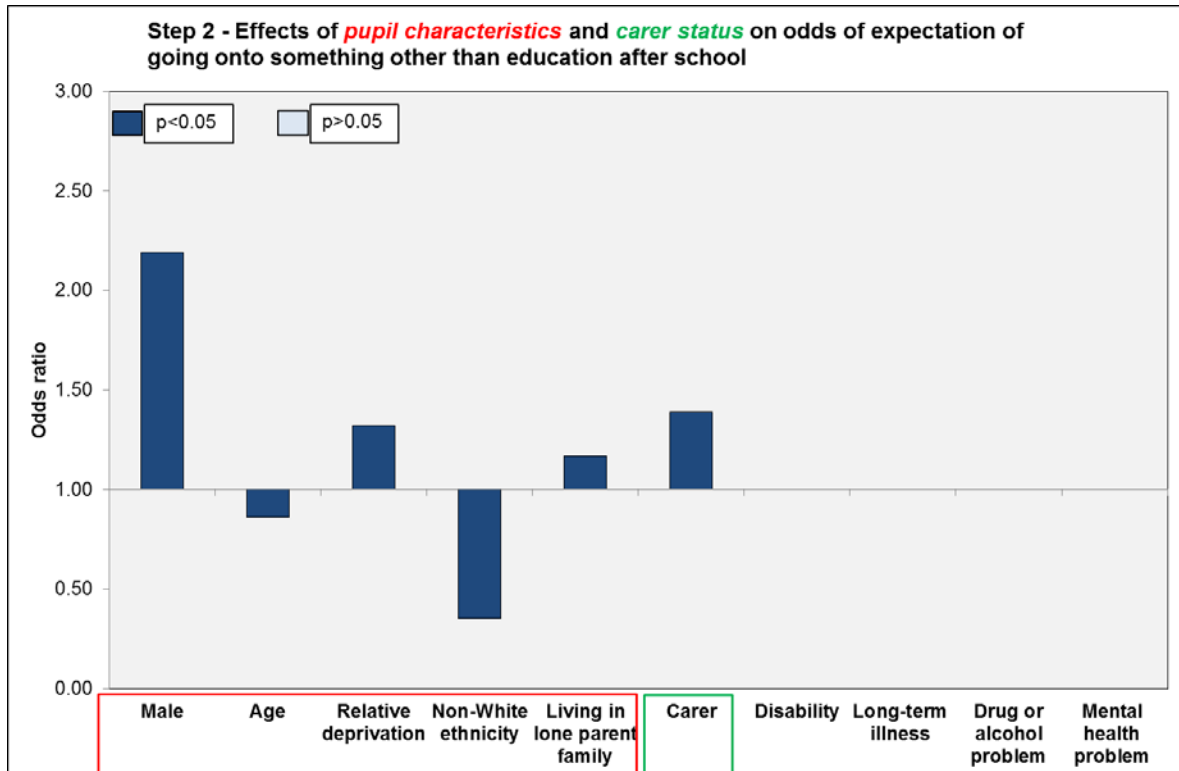
**Figure 14: Step 1 – post-school aspirations.**



<sup>9</sup> The ten options in the original question are: working; trade or modern apprenticeship; university; further education college; take a gap year; volunteering; setting up a business; training programme; don't know; and other.

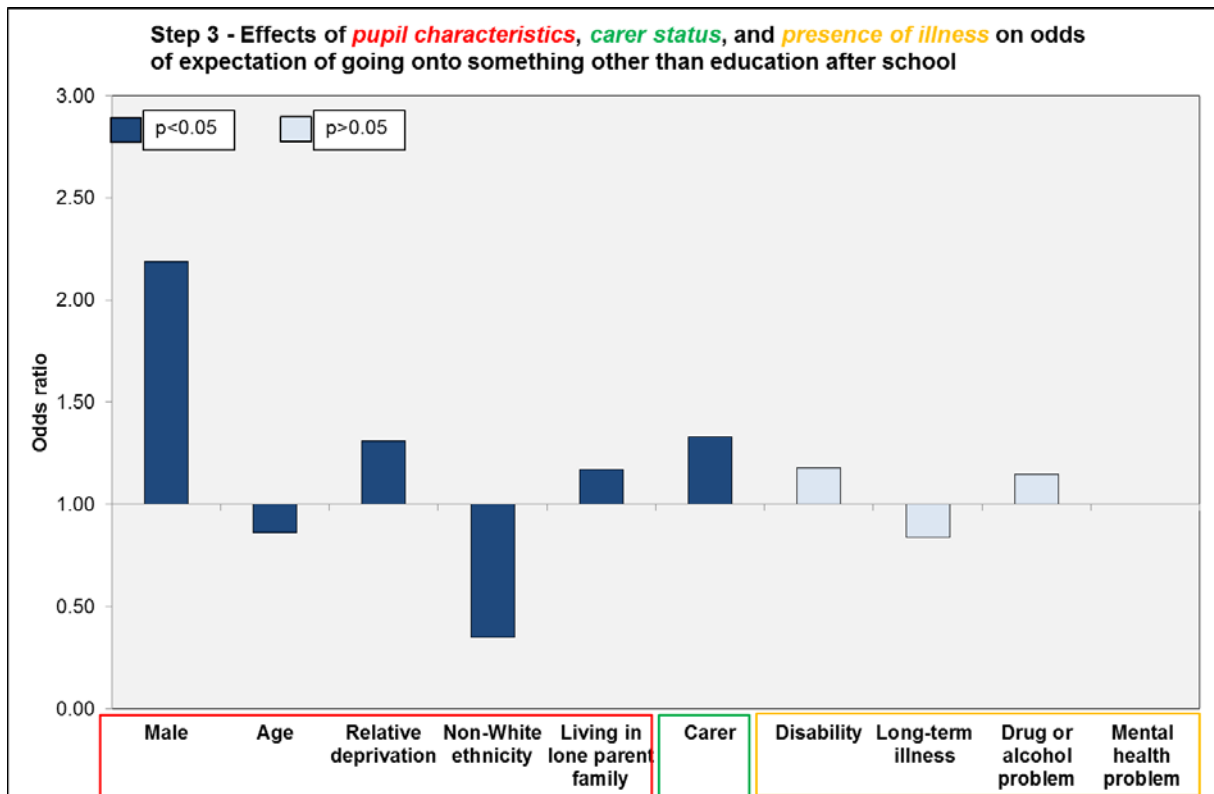
As can be seen in Figure 15, the addition of carer status has little impact on the background variables, but is itself significant. Carers were almost 40% more likely to say 'something else' in terms of their future aspirations, even with background factors controlled for.

**Figure 15: Step 2 – post-school aspirations.**



The addition of all four types of family illness has little impact on either the background or carer variables, as can be seen in Figure 16. The presence of illness coefficients are themselves not significant, suggesting that the presence of illness does not have an association with post-school aspirations over and above being a carer.

**Figure 16: Step 3 – post-school aspirations.**



In terms of aspirational outcomes, this suggests that it is being a carer, as opposed to living with family illness, that has an association with future aspirations.

## 7 Discussion

Overall, the results from this research confirm prior findings – young carers are more deprived, experience worse physical and mental health, and are less likely to think they will go on to further or higher education than non-carers. The specific focus on Glasgow in this report paints a clearer picture of the scale and challenges that the city faces in terms of young carers, although – as the prevalence in the other local authorities suggests – these issues are not confined to Glasgow.

Almost one-in-eight of the pupils surveyed said that they provided care for someone in the household with almost a third of these stating that no one knew about their caring, and of those who did know the largest group by far were friends. If this percentage applied across all secondary school pupils in the city, then a conservative estimate would mean that there was over 3,000 young carers in secondary schools in Glasgow alone<sup>h</sup>; a figure that does not include those in primary school, further education or work, or those who are not engaged with education or employment. In sharp contrast, in Glasgow 300 young carers were identified in 2015<sup>50</sup>, which raises the question: where are the rest of these young carers?

This section will discuss possible reasons for this gap, before looking at extending and developing new approaches with a particular focus on education, mental health, adult services, financial inclusion and Community Planning Partnerships.

### 7.1 Why are young carers not coming forward?

There are many reasons for the under-identification of young carers. From a young person's perspective they may include: fear of unwanted family intervention; fear of bullying; unhelpful past experiences; as well as a degree of reluctance among wider family members to involve services. Equally, wider societal barriers may be at play such as stigmatising attitudes towards specific conditions like physical disabilities, mental health, alcohol and drug issues, that can contribute towards a perceived sense of blame and shame, particularly in the case of lone parent households. A lack of understanding among services can also contribute towards the young person's caring role either being considered as an inherently problematic role, or conversely elevating the role to the status of *'heroes'* or *'angels'*<sup>20</sup>.

It is worth considering what role the issue of labelling played within this survey. The survey questionnaire did not ask the school pupils if they considered themselves to be a 'carer', *per se*. Instead, they were asked if there was anyone in the house with a 'disability, long-term condition, mental health issue, or addictions problem', and whether they ever looked after or cared for this person or others in the household. It

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<sup>h</sup> Estimation based on Glasgow secondary school population from [http://www.understandingglasgow.com/indicators/children/education/school\\_population](http://www.understandingglasgow.com/indicators/children/education/school_population)

is possible that many of those who answered yes to this question do not see themselves as a 'carer' or their role as not normal, but just as 'helping out' or fulfilling family duties<sup>19,20</sup>.

## **7.2 Extending and developing new approaches**

It is important to remember that there are services in place for young carers, whether they need help with social care, respite, education, health, or employability. The analysis in this report suggests that young carers *do* need help, whether it is related to their health or future expectations. However, with many providing 'hidden' care, how can existing services become more accessible in enabling or offering support when the new Act commences in 2018? In a 2015 GCPH seminar series lecture on the 'economics of dignity', Marilyn Waring asked if there was a need to consider a 'capabilities approach' towards young carers. In other words, a radical shift away from a traditional deficits-based approach towards one that considers what a young person is able to do, and addresses both whether they are able to do the things they would value doing, and if they have the means or permission to pursue them<sup>11</sup>. For this to occur, Waring believes that there are important questions that need to be addressed, which are timely with the introduction of the Young Carer Statement in 2018. For instance, among those young people eligible for support, at what point in their caring roles are they given the agency to be paid as caregivers? When assessing the impact of caring on their dignity, whose point of view should take precedence – the young person or the named person, such as a headteacher or pastoral care teacher?

### *Education services*

With almost one-in-eight surveyed pupils providing some sort of care, there are opportunities to move beyond stereotypical views of caring – from heroic praise to a hidden sense of stigma or shame – to recognise that caring can also be associated with resilience. Adopting a whole-school approach could ensure that by introducing the concept of caring into classrooms, hidden care could be recognised and valued as having positive aspects, like developing closer family bonds, gaining satisfaction from the role, or young people feeling that they have an important role within the family. Whole school and community-based approaches could also promote more realistic views of caring and consider what makes young people feel safe and secure about coming forward to ask for help. Moving the emphasis beyond a 'carer identity' could ensure that other important aspects of a young person's identity are not overlooked, such as social class, gender, ethnicity and future aspirations. Additionally, the fact that almost a fifth of the young carers are from minority ethnic backgrounds suggests that there may be specific equalities issues to consider.

Providing support beyond the act of caring could be helpful in terms of a young person's school work, careers advice, or engaging with youth employability initiatives. The slightly higher attendance of young carers in social activities in this



survey suggests that appropriately targeted support is being delivered in Glasgow. However, it will be important to ensure that if support is scaled up, then a balance is achieved between accessing wider support and not overlooking the challenges of caring, such as a lack of time or the ability to attend services because of caring duties.

Young carers in this survey were less likely to see themselves going on to further or higher education after leaving school, over and above their deprived circumstances, which may be partially explained by the concept of ‘bounded agency’ whereby their sense of agency can be influenced by geography and caring responsibilities with choices and decisions about their future being bounded by these responsibilities<sup>42</sup>. Although moving on to work after completing school is not in itself problematic, when the decision is shaped by external factors, and the work is of low-skill and low pay – both of which is the case with young carers<sup>22</sup> – it becomes more troubling.

### *Improving mental health*

Across Greater Glasgow, approaches to improve mental health for children and young people are supported by a framework covering themes which include resilience, peer help, navigating services and social media. With young carers preferring accessible services provided by the voluntary sector, there may be opportunities to build on current mental health work being undertaken by the voluntary sector across Glasgow. For example, [Place2Be](#) and [Lifelink](#) both provide mental health services in schools and the [Glasgow Association for Mental Health](#) delivers a specialist Young Carers Project. Consequently, these organisations could help ensure that those at risk of or experiencing mental health problems can access the Young Carer Statement, and if eligible receive timely support. Moreover, trusted relationships created by this sector, as well as by school staff, peer networks and social media could help address emerging concerns, such as pupil reluctance to access the Young Care Statement due to a parent having a stigmatising condition, or fears that it would routinely lead to family separation.

### *Adult health and social care services – is there a role?*

Prior research has identified gaps in the ‘whole family approach’ to health and social care, with young people who provide care reporting being passed over by adult services, whether this is health and social care, mental health, addictions, or primary care<sup>51</sup>. Adult services adopting a routine enquiry approach could help identify if children are involved in caring and ensure that the child’s interests are considered. Moreover, established children and young people’s networks could help create new links with adult services (e.g. mental health and addictions) to address possible concerns. Similarly, General Practice (GP), particularly the Deep End GP project<sup>i</sup>,

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<sup>i</sup> General Practitioners at the Deep End work in general practices serving the 100 most deprived populations in Scotland, based on the proportion of patients on the practice list with postcodes in the

and Health and Social Care Partnerships in regular contact with adults with disabilities or long-term conditions, could encourage access to assessment and support among young carers.

### *Building on current financial inclusion responses*

In terms of providing money advice support to vulnerable young people, the challenges are recognised by advice service providers in Glasgow. A local study found that a significant number of young people, particularly females, had money worries and that their first contact was primarily a parent or carer with around only 1-in-10 contacting services<sup>52</sup>. Solutions to improve uptake included initial contact through the internet, an element of face-to-face support at some point and a greater use of peer support. Although young carers were not the primary focus of the study, arguably they are less likely than other young people to approach the cared-for parent with their money worries. With caring roles and financial concerns both impacting on the young person's destination after leaving school, it may be timely to consider how this wider learning could strengthen existing responses. It could also provide support to those tasked with taking forward Glasgow's new Financial Inclusion Strategy in 2018, as they respond to a range of new social security changes.

In September 2018 Glasgow will be the last Scottish local authority to roll out Universal Credit, which replaces a number of benefits and contains a carer component which can be paid from the age of 16 if the claimant is caring for someone for more than 35 hours a week. Alongside these UK government welfare changes, the Scottish Government has said that it is exploring the concept of a young carers' allowance, and also proposes to use its new social security powers in order to introduce a new Job Grant for young people, who have been unemployed for more than six months, and who are entering the labour market<sup>53</sup>.

### *Community planning partnerships*

Just over one-in-ten of the young carers identified by this research were caring for someone with a drug or alcohol problem. Caring for a parent with an alcohol problem and managing future aspirations illustrates the overlapping connections between themes in this report and Glasgow City's Community Planning Partnership (CPP) three priorities: addressing alcohol-related harms; supporting vulnerable groups; and tackling youth employment. The Youth Employment Board set up by the CPP developed an action plan which involves improving connections between schools, colleges and employers to support school leavers. Learning from this study could support and strengthen this work on various levels. Firstly, promoting awareness among Board Members of the prevalence of caring among secondary pupils, and

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most deprived 15% of Scottish data zones.

<http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/>

how caring, even when accounting for deprivation and family illness, still impacts on what young carers think they will do when they leave school. Secondly, with future expectations contributing towards the scarring effects of youth unemployment, which may persist into adulthood and may lead to lower pay, high unemployment, fewer life chances and poorer health<sup>54</sup>, there is scope for Board Members to consider how bounded agency restricts the future choices and decisions of young carers and how this could be addressed. This could be timely if the young carers' allowance and new Job Grant are introduced.

### **7.3 Limitations**

It is possible that there was an overestimation of young carers among the pupils surveyed in the health and wellbeing secondary school survey. The criteria for the inclusion in the 'young carer' category could be considered a blunt measurement as neither the type nor the amount of caring was exactly known. However, it was precisely for this reason that all of those who identified themselves as carers were included in the analysis. Additionally, it is unclear to what extent a self-complete questionnaire would lead to an over-identification of young carers. However, even if only those who reported they provided care 'every day' were investigated, then this would be equivalent to 4.9% of the overall sample; higher than previous estimates. The 2015 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), which primarily gathers data on substance use among 13-15 year olds, used cognitive testing to refine their 2015 question on young carers to ensure only those who would be considered young carers answered<sup>55</sup>. Overall, 10% of that sample described themselves as a young carer<sup>56</sup>.

Complete case analysis is used widely and is the default method of dealing with missing data in statistical software packages. However, it does involve excluding data that could be informative for the analysis. Data checks were undertaken to ensure that the complete case samples did not differ greatly to the overall sample. However, it is possible that this method reduced the power of this analysis.

## **8 Conclusion**

Almost a third of young carers in this study concealed their status as carers. To identify all carers and ensure they are offered assessment and the support to which they are entitled will present a range of challenges when the new Carers Act commences in 2018. This not only applies to public authorities required to offer a Young Carer Statement, but also to local services tasked with providing support. The learning from this study has cross-cutting implications at a Glasgow City level, as well as for other Scottish local authorities required to provide support to carers. In Glasgow, these include current Community Planning Partnership's priorities, plans to renew the city's Financial Inclusion Strategy in 2018, and ongoing efforts to improve children and young people's mental health. Alongside specific policy and delivery challenges, there is scope to consider how adopting a 'capabilities approach' could support the implementation of the Carers Act in 2018 by ensuring that young people caring for family members can do the things they value doing and have the means or permission to pursue them.

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## Appendix

### Participants

A complete case analysis was conducted, whereby participants with missing data on any of the variables included in the analysis were removed – therefore the bases of the results presented in section 1 and 2 of the findings differ. Participants' ages ranged from 11-18 years, mean = 14.30, SD = 1.69.

### Measures

#### Family health and caregiving

Participants were asked “Does anyone in your family, who you live with, have any of the following: A disability; a long-term illness; a drug or alcohol problem; a mental health problem?” Participants were asked to select either yes or no to each of these health problems. This resulted in four dummy coded variables, each of which was coded yes = 1 and no = 0.

Those who responded yes to any of these questions were further asked, “do you ever help to look after or care for this person, or others in your household?” and responded by selecting either yes or no. This variable was dummy coded where yes = 1 and no and not applicable (participants who did not report any health problem in the family) = 0.

#### Relative deprivation

Receipt of free school meals was used as a proxy for relative deprivation. Participants were asked, “Do you get free school meals, or vouchers for free school meals?” to which 1,664 participants (25.7%) responded yes. Overall in Glasgow, 28.8% of secondary school pupils are registered for free school meals.

#### Mental health

Mental health was measured using the Total Difficulties scale of the Strengths and Difficulties questionnaire. Those who had a medium or high score (14 or above) were coded as 1; those who had a lower score were coded as 0.

#### Physical health

Physical health was measured by whether participants had selected one or more self-reported physical health conditions. Those who had were coded 1, and those who had not were coded 0.

#### Emotional, behavioural or learning difficulties/disabilities

Emotional, behavioural or learning difficulties/disabilities were measured by whether the participants had selected one or more emotional, behavioural or emotional conditions in the questionnaire. Those who had were coded as a 1, and those who had not were coded 0.

## Post-school aspirations

The range of post-school aspirations were collapsed into a binary variable, with further and higher education as one outcome, and working, apprenticeship, gap year, volunteering, setting up a business, training programme, don't know or other as the other.

## Data analysis

Logistic regression analysis was conducted to examine the associations of family members' health problems and providing care for family members with participants' outcomes. Participants' demographics were entered in the first step. Whether participants provide care for a family member was entered on the second step. In the third step, four variables indicating the presence of illness in the household were entered. In the fourth step, five care giving / demographic interaction terms were entered. The outputs of these models are displayed in the following tables.

In the final step of the model, five interaction terms were entered to test whether the effect of providing care was moderated by participants' age or gender, relative deprivation, ethnicity or living in a lone parent family household. The interaction terms were not significant in any of the models.

**Table A1. Total difficulties score full regression models.**

	Step 1		Step 2		Step 3		Step 4	
High total difficulties score	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>
Male	0.57	0.52, 0.63	0.58	0.53, 0.64	0.59	0.54, 0.65	0.60	0.54, 0.66
Age	1.14	1.11, 1.18	1.14	1.11, 1.17	1.13	1.09, 1.16	1.15	1.11, 1.18
Relative deprivation	1.23	1.1, 1.37	1.16	1.04, 1.30	1.13	1, 1.26	1.16	1.02, 1.32
Non-White ethnicity	0.73	0.64, 0.84	0.74	0.64, 0.85	0.78	0.68, 0.9	0.79	0.68, 0.92
Living in lone parent family	1.20	1.08, 1.32	1.19	1.08, 1.32	1.18	1.07, 1.31	1.20	1.07, 1.34
Carer			1.81	1.6, 2.05	1.18	1, 1.39	1.33	1.06, 1.69
Disability in household					1.28	1.1, 1.5	1.28	1.1, 1.5
Long-term illness in household					1.31	1.11, 1.55	1.31	1.11, 1.55
Drug or alcohol problem in household					1.98	1.58, 2.49	2.00	1.59, 2.51
Mental health problem in household					2.19	1.84, 2.6	2.18	1.84, 2.59
Age X provides care							0.89	0.83, 0.97
Male X provides care							0.93	0.71, 1.21
Lone parent family X provides care							0.93	0.71, 1.23
Non-White ethnicity X provides care							0.92	0.63, 1.34
Relative deprivation X provides care							0.87	0.65, 1.15

**Table A2. Presence of one or more physical health conditions full regression models.**

	Step 1		Step 2		Step 3		Step 4	
Physical health conditions	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>
Male	0.81	0.74, 0.89	0.83	0.75, 0.90	0.84	0.77, 0.92	0.85	0.77, 0.94
Age	1.04	1.02, 1.07	1.04	1.01, 1.07	1.03	1.00, 1.06	1.02	0.99, 1.05
Relative deprivation	1.19	1.07, 1.33	1.14	1.02, 1.27	1.10	0.99, 1.24	1.11	0.98, 1.26
Non-White ethnicity	0.81	0.71, 0.93	0.82	0.72, 0.93	0.85	0.74, 0.97	0.82	0.71, 0.95
Living in lone parent family	1.13	1.02, 1.24	1.12	1.02, 1.24	1.12	1.01, 1.24	1.12	1.01, 1.25
Carer			1.73	1.52, 1.96	1.15	0.97, 1.36	1.16	0.91, 1.47
Disability in household					1.33	1.14, 1.56	1.33	1.14, 1.56
Long-term illness in household					1.39	1.18, 1.65	1.39	1.17, 1.65
Drug or alcohol problem in household					1.56	1.23, 1.97	1.57	1.24, 1.99
Mental health problem in household					1.79	1.50, 2.14	1.79	1.49, 2.13
Age X provides care							1.03	0.95, 1.11
Male X provides care							0.93	0.72, 1.21
Lone parent family X provides care							0.99	0.75, 1.31
Non-White ethnicity X provides care							1.23	0.85, 1.78
Relative deprivation X provides care							0.96	0.72, 1.28

**Table A3. Presence of one or more emotional, behavioural or learning disabilities full regression models.**

	Step 1		Step 2		Step 3		Step 4	
	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>
Emotional, behavioural or learning disabilities								
Male	0.91	0.81, 1.03	0.94	0.83, 1.06	0.98	0.86, 1.11	0.98	0.85, 1.13
Age	1.07	1.03, 1.11	1.07	1.03, 1.10	1.04	1.00, 1.08	1.04	0.99, 1.08
Relative deprivation	1.19	1.03, 1.38	1.07	0.92, 1.25	1.01	0.87, 1.17	1.06	0.89, 1.27
Non-White ethnicity	0.48	0.39, 0.6	0.48	0.39, 0.60	0.52	0.42, 0.64	0.52	0.41, 0.66
Living in lone parent family	1.15	1.01, 1.31	1.14	1.00, 1.3	1.12	0.98, 1.28	1.10	0.95, 1.28
Carer			2.52	2.17, 2.92	1.35	1.11, 1.64	1.40	1.06, 1.84
Disability in household					1.60	1.33, 1.93	1.61	1.34, 1.93
Long-term illness in household					1.27	1.03, 1.56	1.27	1.03, 1.56
Drug or alcohol problem in household					2.18	1.68, 2.83	2.17	1.67, 2.82
Mental health problem in household					3.02	2.50, 3.66	3.03	2.50, 3.67
Age X provides care							1.02	0.93, 1.12
Male X provides care							0.98	0.72, 1.34
Lone parent family X provides care							1.09	0.79, 1.50
Non-White ethnicity X provides care							1.01	0.61, 1.67
Relative deprivation X provides care							0.82	0.58, 1.15

**Table A4. Post-school expectations 'something else' full regression models.**

	Step 1		Step 2		Step 3		Step 4	
Post school expectations	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>	<i>Exp(B)</i>	<i>95% CI</i>
Male	2.17	1.96, 2.40	2.19	1.99, 2.43	2.19	1.98, 2.42	2.21	1.99, 2.47
Age	0.87	0.84, 0.89	0.86	0.84, 0.89	0.86	0.84, 0.89	0.86	0.83, 0.89
Relative deprivation	1.36	1.20, 1.54	1.32	1.17, 1.50	1.31	1.16, 1.49	1.36	1.18, 1.56
Non-White ethnicity	0.35	0.30, 0.42	0.35	0.30, 0.42	0.35	0.30, 0.42	0.36	0.30, 0.43
Living in lone parent family	1.17	1.05, 1.30	1.17	1.04, 1.30	1.17	1.05, 1.30	1.12	0.99, 1.26
Carer			1.39	1.20, 1.61	1.33	1.1, 1.62	1.32	1.00, 1.75
Disability in household					1.18	0.98, 1.41	1.19	0.99, 1.42
Long-term illness in household					0.84	0.69, 1.03	0.84	0.69, 1.02
Drug or alcohol problem in household					1.15	0.88, 1.51	1.15	0.88, 1.51
Mental health problem in household					1.00	0.81, 1.23	0.99	0.80, 1.22
Age X provides care							1.01	0.92, 1.11
Male X provides care							0.91	0.68, 1.23
Lone parent family X provides care							1.38	1.00, 1.89
Non-White ethnicity X provides care							0.92	0.57, 1.49
Relative deprivation X provides care							0.82	0.59, 1.14





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