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# CAREGIVING AMONG YOUNG ADULTS IN IRELAND

HELEN RUSSELL AND EMER SMYTH



# CAREGIVING AMONG YOUNG ADULTS IN IRELAND

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## ABBREVIATIONS

BMI	Body mass index
CES-D	Center for Epidemiological Studies – Depression (a measure of depressive symptoms)
CSO	Central Statistics Office
DCEDIY	Department of Children, Equality, Disability, Integration and Youth
DEIS	Delivering Equality of Opportunity in Schools
EQLS	European Quality of Life Survey
ESRI	Economic and Social Research Institute
GUI	<i>Growing Up in Ireland</i>
HBSC	Health Behaviour of School-Aged Children
HH	Household
HSCL	Home School Community Liaison
NEET	Not in education, employment or training
SCP	School Completion Programme
TCD	Trinity College Dublin

## EXECUTIVE SUMMARY

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### INTRODUCTION

Care is fundamental to the fabric of social relationships and a significant proportion of the adult population is engaged in regular care for children and/or adults with illnesses or disabilities. Increasing attention internationally is being paid to the role of young carers (those under 18) and young adult carers (usually 18–25 years of age). However, much of the research conducted has been cross-sectional in nature and has focused on care for those with illnesses, rather than the full spectrum of care for others. This report draws on rich data on over 4,000 young people from Cohort '98 of the *Growing Up in Ireland* (GUI) study to take a longitudinal perspective, documenting the profile of young adult carers at 17 and 20 years of age and exploring the implications of such caregiving for their wellbeing, relationships and educational pathways.

In this study, we address the following research questions:

1. What is the profile of young adult carers, in terms of gender, social background, family size and structure, migrant status, urban/rural location, and own and parental illness/disability? To whom do they provide care and how much time do they allocate to caregiving?
2. What factors predict young people's caring at ages 17 and 20?
3. How are care responsibilities associated with young people's wellbeing, physical health and family relationships?
4. How are care responsibilities at age 17 associated with the post-school pathway pursued at age 20 (higher education, further education and labour market entry), controlling for other factors? Does a care role constrain post-school choices, either directly through ongoing involvement in care, or indirectly via a potential effect on academic performance?

### THE PROFILE OF YOUNG ADULT CARERS

The definition of caring used in this study includes all forms of regular informal care provided by young people to parents, grandparents, siblings and others, and is not limited to caring for a family member with an illness, disability or additional needs. One-quarter of 17 year olds are engaged in regular caregiving for a family member, most commonly a younger sibling (15 per cent) or grandparent/other older relative (12 per cent). By the age of 20, the proportion involved in caregiving falls somewhat, to one-fifth of the cohort; again, younger siblings and grandparents are the main care recipients (11 per cent and 10 per cent respectively). One-tenth of 17 year olds and 8 per cent of 20 year olds are involved in caring for a parent. Over half (53 per cent) of young caregivers were providing care to multiple recipients at age 17 – for example, to younger siblings and a grandparent – and this increased to 57 per cent of caregivers at age 20. Combining information from the two

timepoints, over one-third (36 per cent) provide regular care at some stage, but for most, this experience is transitory, with 9 per cent providing care at both ages. Among carers at age 20,<sup>1</sup> 13 per cent report that caregiving takes up a lot, or quite a lot, of their time, 38 per cent say it takes up some of their time, while 49 per cent indicate it does not take up very much of their time. Those involved in caring for parents or grandparents are more likely to report spending a lot of time on their care responsibilities.

Young adult carers are a highly heterogenous group. The number of younger siblings in the family is the strongest predictor of care involvement. There is some variation by family resources. Young people from more advantaged families (in terms of parental education) are less likely to be involved in caregiving at age 17, but this difference no longer holds at age 20. Income does not make a significant difference overall, though higher income does reduce the likelihood of involvement in caring for older siblings at age 17. No difference is found by family structure, with similar rates of caregiving among young adults from lone-parent and two-parent households. For many young adults, caregiving begins early, with those reporting caring for younger siblings or grandparents at 13 much more likely to be still involved in caring when they reach young adulthood. Providing parental care at age 17 is more common where the young person's mother is experiencing depression.

Contrary to patterns for adults, no significant gender differences in caregiving are found at age 17, and by age 20, young men are more likely to provide care, particularly to younger siblings and parents. At age 20, young people from a migrant background are more likely to be caring for younger siblings or parents than other young people.

## CAREGIVING AND OUTCOMES AMONG YOUNG ADULTS

This study examined the relationship between caregiving and three sets of outcomes: physical and mental wellbeing; educational pathways; and family relationships. The strongest relationship was found with educational outcomes. Young people involved in care at 17 years of age tend to receive lower Leaving Certificate grades than their counterparts, even taking account of prior achievement, particularly if they are caring for multiple family members. They are less likely to progress to higher education, largely because of their lower grades, and where they do so, are potentially constrained in their choices by placing a strong emphasis on being able to live at home in selecting an institution. They are less likely to have moved out of the parental home by the age of 20, even when we take account of lower participation in higher education.

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1 This question on time intensity was not asked at age 17.

Little evidence was found of a systematic relationship between caregiving and physical health, though higher rates of obesity and poorer self-reported health are found among those with more intensive care involvement. Similarly, little evidence was found of a structured relationship between mental wellbeing and caregiving. GUI data allow us to separate out the effects of parental illness from those of involvement in caregiving. We find that parental, particularly maternal, depression is associated with lower levels of life satisfaction and higher depression rates for the young adult concerned. This pattern applies whether or not the young adult reported being directly involved in parental care. Caring for siblings or parents appeared to be associated with more positive relationships with family members. However, the prevalence of fighting between mothers and young adults appeared to be related to caring for younger siblings.

## **IMPLICATIONS FOR POLICY**

This study provides new insights into the profile of, and outcomes among, young adult carers in Ireland, adopting a broad perspective on care, ranging from babysitting for younger siblings to intensive care for parents or grandparents. For most, caregiving is transitory in nature and not highly time intensive. However, it is evident that many young people become involved in caregiving for siblings or grandparents at an early age and, for some of this group, these duties persist over time. The heterogeneity of young carers poses challenges in identifying and supporting this group using traditional metrics such as household income or receipt of means-tested benefits. However, supports for early years provision and a statutory home care scheme would likely benefit young adult carers, as well as parents and care recipients. The findings highlight the importance of educational supports for young carers, with some potential for the School Completion Programme to include carers as a target group, even from primary level onwards, and for higher education access initiatives to consider the needs of this group. The study findings draw attention to the situation of the young adult children of parents with depression, suggesting the potential value of expanding access to family-focused mental health services.

## CHAPTER 1

### Introduction

The provision and receipt of care is a core element of being human. There is a wide body of evidence from the *Growing Up in Ireland* (GUI) study on the care that children receive from parents, grandparents and others, in both informal and formal settings, and the importance of this care in their development. This study switches the focus to consider care provided by young people themselves, looking at young adults aged 17 to 20 years.

There is growing recognition of the role of young people in providing care. Figures on the prevalence of caring among young people vary, depending upon the age groups considered, the definitions of care applied (for example, within the household only or not) and whether the responses come from young people themselves or others in the household (Warren and Edwards, 2017). International studies estimate that between 2 and 10 per cent of young people aged under 25 provide regular unpaid care to an older person or someone with a chronic illness or disability (Leu and Becker, 2017; Hamilton and Redmond, 2019; Stamatopoulos, 2015). A much higher level of caring was found in the Longitudinal Study of Australian Children (Warren and Edwards 2017): at age 14–15 years, 39 per cent of young people were providing care to someone who was older or had a long-term health condition or disability. Census figures for Ireland in 2016 indicate that those aged 17 or under make up around 3 per cent of all carers, with care involvement increasing with age (DCYA, 2018), and that 1.6 per cent of those aged 15–24 years provide regular care.<sup>2</sup> Using a national survey of students, Gavin et al. (2020) estimate that 13.3 per cent of 10–17 year olds in Ireland provide regular unpaid personal help for a family member with a long-term illness or disability.<sup>3</sup> The figure for 15–17 year olds (in the same study) was 12.4 per cent (ibid., Table 2).<sup>4</sup>

Previous research has outlined the consequences of caring for young people's mental health, family relationships, educational and employment opportunities, and leisure and social connections. Caring can involve significant time investments, which restricts involvement in educational activities (Kaiser and Schulze, 2015; Siskowski, 2006; Kavanaugh, 2014), employment (Brimblecombe et al., 2020; Sempik and Becker, 2014) and leisure activities, leading to social isolation and loneliness (Hamilton and Adamson, 2013; Haugland et al., 2022). Caring for someone with complex health needs can bring stresses and worries. A young person caring for a parent also reverses usual social roles, which may lead to social and psychological pressures (see Roling et al., 2020), though there is also evidence

2 Own calculations, based on CSO statbank tables E3001 and E9051; see <https://data.cso.ie/table/E9051>.

3 The research is based on the Health Behaviour in School-Aged Children study, which surveyed 15,557 students in 2018. See further discussion of the study below.

4 The differences in methods and definitions are discussed in greater detail below.

that caring can have positive impacts on young people's lives, leading to closer relationships (Hunt et al., 2005).

In this study, we address the following research questions:

1. What is the profile of young adult carers, in terms of gender, social background, family size and structure, migrant status, urban/rural location, and own and parental illness/disability? To whom do they provide care and how much time do they allocate to caregiving?
2. What factors predict young people caring at ages 17 and 20?
3. How are care responsibilities associated with young people's wellbeing, physical health and family relationships?
4. How are care responsibilities at age 17 associated with the post-school pathway pursued at age 20 (higher education, further education and labour market entry), controlling for other factors? Does a care role constrain post-school choices, either directly through ongoing involvement in care, or indirectly via a potential effect on academic performance?

We first outline previous research findings (Section 1.1), before outlining the policy context (Section 1.2). In Section 1.3, we describe the methods and data used in the research presented in this report.

## **1.1 PREVIOUS RESEARCH ON CAREGIVING AMONG YOUNG ADULTS**

### **1.1.1 Defining care and young adult carers**

Reviews of the literature on young carers have highlighted the lack of consensus on definitions (Shifren and Chong, 2012; Kavanaugh et al., 2016). While discussions of 'young carers' have typically focused on those aged under the age of 18 (Becker, 2000), in practice a variety of minimum and maximum ages is imposed, with some studies including those aged up to 21. 'Young adult carers' have been defined as being aged between 18 and 25 years (Day, 2015; Family Carers Ireland, n.d.), though others have defined this group as being aged 16–25 years (Brimblecombe et al., 2020).

The definition of caring also varies across studies. Studies of young carers often focus on those caring for a family member, often a parent, with a particular illness or disability, such as cancer, HIV, multiple sclerosis, or motor neuron disease (Saragosa et al., 2022). While some definitions are restricted to care provided for family members, others include non-family recipients, and in other cases the definition applies only to those living with the young person. The Irish Census 2022 defines carers as those who 'provide regular unpaid personal help or support to a

family member, neighbour or friend with a long-term illness, health problem or an issue related to old age or disability’.<sup>5</sup>

The majority of studies do not encompass young people’s caregiving to younger siblings, except where this is for a sibling with a disability or care needs, or where such caring is taken on because of a parent’s illness or disability. Yet this misses a significant element of young people’s caregiving (Wikle et al., 2018). Such care may be labour intensive and it may potentially have effects similar to those of other forms of caring. There are also differences depending on the care recipient – providing care to a younger sibling does not contravene conventional social norms in the way that caring for a parent does; however, it may still involve commitments that affect young people’s educational, employment and social activities. Care of younger siblings without additional needs is also likely to decrease over time as siblings become more independent, while the needs of an older relative or those with a chronic illness or disability may increase over time.

A recent review of young carers outlines that binary distinctions between carers and non-carers are overly simplistic and may mask differences in outcomes (Fleitas Alfonzo et al., 2022). Fives et al. (2010) make a similar point about recognising the variability of care experiences. They note that young carers rarely care alone but more typically are part of a ‘care team’ (Fives et al., 2010, p. 17). The experience and effects of caring are therefore likely to relate to the level of both formal and informal support available to the young person. The intensity of care is likely to be a relevant factor for capturing the continuum of caregiving. Similar issues around the boundaries of caregiving also apply in the case of adult carers (Folbre, 2006, 2015).

Previous estimates of the prevalence of caring among young people in Ireland using different definitions range from 1.6 per cent from the Census, which is completed by the householder or another adult member of the household, to over 13 per cent from the Health Behaviour of School-Aged Children (HBSC) study, in which children themselves are the respondents. Census 2016 results indicate that rates of involvement are 0.7 per cent for 10–14 year olds, a figure that doubles for 15–19 year olds (1.5 per cent for females and 1.3 per cent for males) and grows higher again for 20–24 year olds (2.1 per cent for females and 1.7 per cent for males) (CSO Census database). The HBSC survey of 10–17 year olds uses a similar definition of care to that in the Census (but excludes care for a friend). Its reports of care involvement are relatively stable across the 10–11, 12–14 and 15–17 age groups (Gavin et al., 2020). There is no ready explanation for the disparity in numbers; it may be that adults completing the Census underestimate the care involvement of children and/or that children and young people have a more inclusive definition of care provision. Family Carers Ireland (2020) highlight the

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5 The Census wording in 2016 was, ‘Do you provide regular unpaid personal help for a family member with a long-term illness, health problem or disability?’



consequences of these discrepancies in estimates and the need to address them to better inform policy development.<sup>6</sup>

In Northern Ireland, the Kids Life and Times (KLT) survey found that 12 per cent of 10–11 year olds ‘looked after or gave special help to’ someone who was living with them (Lloyd, 2013). Those who answered ‘yes’ were asked to whom they provided such help. In reply, 43 per cent reported that they looked after more than one person; the most common recipient was a grandmother (44 per cent), followed by mother (33 per cent), brother (33 per cent), grandfather (27 per cent), father (26 per cent) and sister (26 per cent). The KLT estimate is significantly higher than the proportion of young carers identified in the Northern Ireland Census in 2011, which found that 4.5 per cent of those aged 5–24 years provided informal care to family members, friends, neighbours or others because of either a long-term physical or mental ill-health/disability or problems related to old age. This varied from 2.7 per cent of those aged 5–17 years, to 7.9 per cent of those aged 18–24 years (Tseliou et al., 2018).

In the current study, we include in our definition of caring all forms of care provided by young people to parents, grandparents, siblings and others.

### 1.1.2 Factors influencing caregiving by young adults

Drawing on the bioecological model, caregiving by young adults is likely to be influenced by factors at: the micro level (personal characteristics of the young person, for example, their gender, age and personality); the micro-system level (which encompasses the characteristics of the family, such as the number of siblings, parental characteristics); and the macrosystem (such as the welfare system, education system and labour market).

Among the adult population, care responsibilities are structured by age, gender, life stage, family structure, participation in paid employment, education and socio-economic status (Gracia and Ghysels, 2017; McGinnity and Russell, 2008; Russell et al., 2019). In Ireland, previous research found that women spend twice as much time on care activities as men, and that strong gender differences persist even among men and women doing the same amount of paid work (Russell et al., 2019). Children growing up in Irish households are therefore likely to be influenced by these gender norms.

Previous research has found that care among young people is also associated with similar socio-economic characteristics. A longitudinal cohort study in the UK has

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6 Using a broader definition of care including care of children and adults using the European Quality of Life Survey, Russell et al. (2019) report that among those aged 18–35 years, 40 per cent of women and 19 per cent of men provide care on a daily basis; in the majority of cases this is childcare.

found that young adult carers (aged 16–29 years)<sup>7</sup> are more likely to be female, to come from a disadvantaged socio-economic background in terms of income and parental occupation and to be members of an ethnic minority (di Gessa et al., 2022). Female caregivers were also found to report longer hours of caring than male caregivers. Similarly, a national, school survey of 8 to 15 year olds in Australia found no significant difference in care roles by gender but found that those from non-English speaking backgrounds and from materially disadvantaged households were more likely to be providing care (Hamilton and Redmond, 2019). Research based on the Longitudinal Study of Australian Children also found that household income was lower among young caregivers than non-caregivers (aged 14–15), and that caregivers were more likely to live in: households where no-one was in employment; lone-parent households; and households where the mother had a lower level of education (Warren and Edwards, 2016). However, when the need for care was taken into account, only household income remained significant, and the authors conclude that the primary factor influencing the likelihood of providing care or assistance among young people is whether there is a family member who requires additional assistance; for example, if a young person is living with someone who is over 65 or who has a disability. There was no overall difference in the prevalence of caregiving between boys and girls, though there was some evidence that care intensity was greater for girls.

Contemporary studies of young people caring for their siblings are rare. In their 2018 study on this topic, in the US, Wilke et al. note that their study is the only recent one on the prevalence of sibling caretaking that used a large, nationally representative sample (the American Time Use Study). They found gendered patterns in the provision of care to siblings, both in the incidence and nature of caregiving, which mirrored time-use findings for adults (Wilke et al., 2018). Adolescent girls were more likely to spend more time caring for younger siblings than boys, and were more likely to provide physical care; for example, help with dressing, feeding and bathing. Previous GUI research in Ireland found that girls did more domestic chores at ages 9 and 13 than boys, including helping with younger siblings (O'Reilly and Quayle, 2021).

Social policies, such as those relating to childcare and social care provision, as well as leave schemes, taxation and employer policy all play a significant role in shaping differences in levels and distribution of unpaid care by adults across countries (Esping-Andersen, 1990; Ciccia and Bleijenbergh, 2014; Craig and Mullan, 2011; Gornick and Meyers, 2003; Gracia and Esping-Andersen, 2015). The policy context for young adult caregivers is outlined in Section 1.2 below.

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7 This older age cut-off means that many in the oldest age category (25–29 years) were caring for their own children or partners.

### 1.1.3 Influence of caregiving on young people's outcomes

While there is a growing body of research on young carers, there are still many gaps in knowledge about the consequences of caring in terms of young people's education, employment, relationships, mental and physical health. There is a particular scarcity of both quantitative research that can be generalised to the population and longitudinal research on young carers that assesses the longer-term effects of caring and addresses issues of causality. A recent systematic review of quantitative studies on the mental health effects of caring on young people concluded that there was a lack of evidence of high methodological quality (Fleitas Alfonso et al., 2022). The authors note that population-based studies with a comparison group of non-carers are scant, with many studies relying on non-representative convenience samples with small sample sizes.

### Educational experiences

In a narrative review of US research, Kavanaugh et al. (2016) identified only 22 peer-reviewed US studies of young caregivers (who they define as under 18 years), compared to over 2,000 studies of family caregiving. The majority of the samples consisted of fewer than 40 young caregivers. While the authors conclude that 'school performance and attendance, mental health and wellbeing are clearly impacted' by caregiving, they note gaps in relation to the role of socio-economic status, race, ethnicity, social support and access to healthcare. A number of the studies reviewed find poorer educational outcomes among carers compared to non-carers: school problems (Hunt et al., 2005); school performance (Siskowski, 2006); and school attendance (Diaz et al., 2007).<sup>8</sup> In a recent addition to this literature, a population study in Australia (Hamilton and Redmond, 2019) found significant differences in school engagement, which is an important predictor of educational outcomes. Young carers aged 8–14 years caring for someone with a disability did not show a significantly different level of school engagement than non-carers, but school engagement among young carers of people with a mental illness or using alcohol/drugs was significantly lower than among non-carers.

### Transitions in early adulthood

During early adulthood, the focus of the current research, the impact of caring on post-school transitions is a key issue of interest. There is relatively little research that addresses this topic directly. In their review of the literature, Roling et al. (2020) identified 13 studies that investigate the relationship between caring and the transition into adulthood. Seven of the studies are retrospective: they ask respondents to consider how their past role as young carers influenced their transition to adulthood. For the non-retrospective studies, the respondents were aged between 16 and 25 years. The majority of the studies were qualitative (eight) in design, while the remaining six used mixed methods (qualitative and

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8 The first two studies are representative samples, while the third consists of Latino students.

quantitative). In general, the number of participants was small (in 8 cases less than 40). A number of the studies reviewed highlighted the difficulties young carers face in leaving the parental home and in choosing a place to study or work due to their responsibility caring for a chronically ill or disabled parent. However, one of the qualitative studies found parental (mental) illness was a trigger for leaving home early. In one of the qualitative retrospective studies reviewed (Frank et al., 1999), it is noted that a significant number of the 41 respondents mentioned that their education and career opportunities suffered as a result of their caring responsibilities. A separate review of qualitative research revealed that caring influenced young people's career choices in other ways; for example, by leading them to pursue medical or healthcare careers (Saragosa et al., 2022).

In a rare quantitative longitudinal study on the effects of caring on the employment transitions of young adults, Brimblecombe et al. (2020) find that young people (aged 16 to 24 years) providing care are less likely to be in employment and more likely to have significantly lower earnings one year later than non-carers.<sup>9</sup> Among those who had been employed, carers were more likely to have left employment one year later. The study also found that young carers had worse mental health scores one year on, though they did not differ on physical health scores.

Overall, there is a distinct gap in the literature in terms of quantitative, longitudinal research on the impact of caring on early career and post-school transitions.

### Family relationships

The provision of care by a young adult for a parent can lead to conflict and strains in the relationship (Stamatopoulos, 2018; Becker and Becker, 2008). Qualitative research has highlighted that this conflict can arise over disputes about the care needed or the sharing of care between family members (see review by Roling et al., 2020). Relationships may also be strained because the young person does not share with other families the degree of stress they are under (Moberg et al., 2017). Despite this, young carers also describe how caring can lead to stronger bonds and how their caring responsibilities can lead to personal development and greater empathy (see review by Saragosa et al., 2022). Kavanaugh et al. (2016) report two US studies that find a positive relationship between caregiving and the quality of the carers' relationship with parents and grandparents and others (Beach, 1997; Hamill, 2012); however, as those studies are cross-sectional, it was not possible to establish the direction of causality. Two studies in Roling et al.'s 2019 review of young adult carers also noted positive effects on familial relationships.

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9 The study is based on the UK Household Longitudinal Study, also known as Understanding Society. The definition of care includes care for someone who is sick, disabled or older, who the young person looks after or gives special help to within their household, or for whom they provide 'some regular service or help' outside their household.

Caring can impact on wider social relationships and young people's opportunity to participate in social activities (Moore et al., 2010) due to both a lack of time and a lack of resources (Roling et al., 2020). None of the studies identified apply a quantitative longitudinal approach to assessing the effects of caring on family relationships.

### **Physical and mental health**

There is a considerable body of qualitative evidence on the strains of caring for young people's wellbeing and health, both mental and physical (Stamatopoulos, 2018; Kavanaugh, 2014; Roling et al., 2020). Quantitative studies of this relationship are less common. A recent systematic review of quantitative studies on the mental health effects of caring on young people concluded that there was a lack of evidence of high methodological quality (Fleitas Alfonzo et al., 2022). The authors note that population-based studies with a comparison group of non-carers are scant, with many studies relying on non-representative, convenience samples with small sample sizes. Of the ten quantitative studies identified that compared mental health outcomes of carers and non-carers aged under 25 years, only three used longitudinal data. This limited the studies' insights into causal processes. Across the included studies, the authors found that 'being a young carer was consistently associated with poorer mental health but information to support a causal effect was limited' (Fleitas Alfonzo et al., 2022, p. 2355). One of the ten studies found no differences in the mental health of carers and non-carers, but this study only identified young carers as those who were caring for a parent. The majority of the studies did not contain information on the extent of caring; however, where this was measured, there were significant differences in the mental health status of those providing long hours of care versus no care hours. They concluded that future research should address the methodological limitations in the literature.

The need for more quantitative and longitudinal research was also the conclusion of Lacey et al. (2022) in their systematic review of the mental and physical health consequences of caregiving among young people. The review identified 13 studies of young carers (<18 years) that had comparison groups of non-carers, only one of which was longitudinal. The review found that, on average, young carers have poorer mental and physical health compared to their peers.

One of the studies included in the review – Tseliou et al. (2018) – was carried out in Northern Ireland. Using a novel approach that matched Census data and mortality data, the study found that young carers (aged between 5 and 24 years) had a significantly higher standardised mortality rate than non-carers. Moreover, the mortality risk increased with the intensity of care provided.<sup>10</sup> The same study

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10 Analysis included all deaths from the national register between the Census and December 2015.

found that young carers were less likely to have chronic mobility problems than non-carers but significantly higher rates of poor mental health.

A recent addition to this literature, a study based on the Millennium Cohort Study in the UK (Nakanishi et al., 2022), found that adolescent carers, measured at age 17, demonstrated higher levels of psychological symptoms and lower psychological wellbeing at the baseline in 2018/2019 and in the subsequent COVID-19 waves in 2020 and 2021.<sup>11</sup> These associations were explained by higher psychosocial risk factors at baseline and during the pandemic. Carers recorded significantly higher levels of gambling, smoking, self-harm and suicide attempts, as well as less sleep, at baseline compared to non-carers. Carers also reported lower levels of social support and higher levels of loneliness in all three waves. Net of these factors, carers did not see a greater increase in psychological distress or a greater decline in wellbeing during the COVID-19 pandemic than non-carers, though the cohort as a whole showed significant deterioration on both measures.

### **Positive effects and benefit finding**

In addition to the findings of positive effects in family relationships noted earlier, a number of studies find that some young carers derive satisfaction from caring and highlight positive aspects of their role – for example greater maturity, empathy and tolerance (Charles et al., 2012). Cassidy et al. (2014) explore the circumstances in which benefit finding occurs, using an eight-item scale on the positive impact of caring.<sup>12</sup> Among their sample of young carers aged 12–16 years, they conclude that benefit finding is more common when the caregiver receives family support and when they feel their role is socially recognised. Benefit finding is less common among those with more intensive care responsibilities.

#### **1.1.4 Research in Ireland**

In Ireland, qualitative research has provided insights into the experiences of young people providing care to family members with a disability or illness. Drawing on a study with 26 young carers aged 5 to 17 years, Fives et al. (2010) found that the majority of participants had been caring from before the age of 9. The young carers reported both positive and negative impacts of caring; at least five reported that they felt closer to the person they cared for. Twenty of the interviewees reported negative educational impacts, while nine reported positive educational experiences, such as receiving support from teachers. Educational impacts ranged from feeling tired and being distracted due to concerns about other family members, to missing school due to caring needs and, in one case, leaving school. Some young carers recounted experiences of being unable to participate in social activities because of care responsibilities. Participants also reported physical

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11 Measured by the Kessler Psychological Distress Scale and the Warwick–Edinburgh Mental Wellbeing Scale.

12 The scale on the positive impact of caring includes items such as ‘having an ill or disabled relative helps me think about the good things in life’.

impacts of caring, including back strain and difficulty sleeping. Nine of the participants were primary carers and in this group eight reported negative educational impacts, seven reported negative emotional impacts and four negative social impacts. The study also highlighted the supports that the young carers wanted: foremost was the desire for more home help, followed by respite care, peer support and support from teachers. Interviews were also carried out with 30 agency staff who identified a range of policy issues and supports needed.

A recent study by Family Carers Ireland (2023) and researchers at the University of Limerick and University College Cork involved a survey of 131 young carers, 48 of whom were young adult carers,<sup>13</sup> and seven participatory workshops. The research echoes many of the research findings outlined above, with young people struggling to combine the emotional and time demands of caring alongside school, work and social activities, but also reporting positive aspects. Half of the young adult carers disagreed that they had enough time to spend on school/college work and one-third disagreed that their school/college was understanding about their caring role. Some 61 per cent reported difficulty balancing care and employment. Worryingly, 64 per cent of the young adult participants were at clinical risk of depression and 79 per cent said that they were very lonely. The pandemic exacerbated these problems, with 40 per cent of young adult carers reporting that they felt more stressed about their caring role since the pandemic had begun. Young adult carers were more likely to report a need for help with finances and mental health supports, educational support, respite care and support to stay healthy than younger carers. The report calls for improved awareness and identification of young carers and young adult carers, as well as educational supports, financial support and supports for emotional, social and physical wellbeing.

The HBSC survey in 2018 mentioned earlier (Gavin et al., 2020) surveyed 15,557 students in 2018. Caring was somewhat more common for boys (13.8 per cent) than girls (11.2 per cent) and there was little variation by social class, but no significance levels are reported. Prevalence by migrant status and other factors is not reported. The cross-sectional findings show that young carers aged 10 to 17 years had significantly lower life satisfaction than non-carers, but there were no significant differences between the two groups in relation to happiness levels or general self-reported health. Young carers were also more likely to have experienced an injury requiring medical attention in the previous 12 months (51 per cent versus 41 per cent). Respondents aged 15–17 years completed the five-item World Health Organisation Well-Being Index (WHO-5) and the Mental Health Inventory. Caregivers scored significantly lower than non-carers on both scales. However, these findings do not control for any other confounding factors, such as gender, income or social class.

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13 Participants were recruited through student unions at higher education institutes, the Irish Second Level Students' Union, carers groups and social media, and therefore do not represent a representative sample.



In Northern Ireland, Lloyd (2013) conducted research on young carers, based on a representative sample of 10 and 11 year olds, as part of the KLT survey in Northern Ireland. The study found young carers were less likely to have sat the transfer exam for grammar school than non-carers, and that those who did sit the exam scored significantly lower grades and had significantly lower educational aspirations than non-carers.<sup>14</sup> The young carers were also more likely to experience bullying than children not involved in caring.

Overall, there are significant gaps in the literature, both national and international, on the effects of caring on the lives of young adults. Research in the area often speaks of the invisibility of young carers; the GUI data provide the opportunity to look at care responsibilities among young adults over the crucial period of transition from second-level education to further/higher education or employment. The richness of the GUI data allows us to investigate a wide range of outcomes – educational, psychological, relational and physical health – and to control for a range of confounding factors. The size of the sample and the range of data mean, for example, that the effects of parental mental and physical illness can be separated from the effect of providing care in a way that has not been possible in most of the previous research. It also allows us to take account of household resources that may mediate the impact of parental illness or disability on young people's outcomes. Previous research has highlighted that people with a disability experience much higher rates of poverty in Ireland (Roantree et al., 2022; Watson et al., 2016) and require higher levels of income to attain the same standard of living as those without a disability (Indecon, 2021). Importantly, the longitudinal design allows us to consider the effects of earlier care responsibilities on subsequent outcomes.

## 1.2 POLICY CONTEXT

While care is a fundamental part of humanity and family life, the time a person spends caring and the distribution of caring across different individuals is influenced by the policy environment. The accessibility and affordability of formal care for children and for adults with additional needs influence the extent to which families undertake informal care (Saraceno and Keck, 2011). In Ireland, along with other liberal welfare states, there is a greater reliance on the market for the provision of care services, which leads to higher costs and a greater reliance on informal care. A comparative analysis of policies of care supports for older people and adults with additional care needs (Hoyer and Reich, 2017) found that Ireland has a strong reliance on informal care, with fewer options for formal care. Other research has highlighted the significant unmet demand for home care packages and other services such as long-term stay and respite services; this means additional informal care is needed to close the gap (Wren et al., 2017; Walsh et al.,

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14 The survey was completed by 4,192 children in 292 primary schools, which represents 19 per cent of all students in this age group in Northern Ireland.



2021). Privalko et al. (2019) found that over 30 per cent of households with (self-reported) care needs in Ireland reported an unmet need for home care; this was among the highest of the countries examined.

In the case of childcare, Ireland has routinely featured among the countries with the most expensive costs for parents (OECD, 2020). While there has been significant policy development and investment in recent years, the cost of childcare means a higher reliance on informal care than in systems with highly subsidised childcare (Privalko et al., 2019). Recent analysis found that Ireland had the third highest unpaid work hours (caring plus housework) in the EU, both for men and women, and that women spent twice as long on these activities as men (Russell et al., 2019). While the need for informal familial care falls mainly on mothers, others in the household, including siblings, are likely to pick up some of the care displaced by the lower formal care access.

Young people providing care have been much less visible in policy than adult carers (Joseph et al., 2020; Family Carers Ireland, 2023). On an international level, studies that focus on young carers and young adult carers are rare and policy supports for this group have only recently been developed; in some countries they are still absent (Leu et al., 2022). An important step in addressing the needs of young adult carers is addressing this invisibility and quantifying the nature and extent of care that they provide. In Ireland, the National Carers' Strategy published in 2012 (Department of Health, 2012) directed 4 of its 42 actions to young carers. These were:

1. Raise awareness of the signs that children and young people are carers;
2. Review how agencies respond to young carers/young adult carers;
3. Identify supports needed by young carers and create mechanisms to contact service providers; and
4. Investigate the situation of children and young people undertaking caring roles.

For five years following its introduction, progress on the strategy was monitored through annual reports by the National Carer's Strategy Monitoring Group. Family Carers Ireland and Care Alliance Ireland produced a scorecard based on the monitoring reports. The scorecard based on the final monitoring report noted good progress on item 1 above, initial progress on item 2, and no progress on items 3 and 4 (Family Carers Ireland and Care Alliance Ireland, 2017).

The national framework for children and young people, *Better Outcomes Brighter Futures*, does not refer to young carers or young adult carers, except in the context of its Aim 5.2, which is concerned with social integration where it identifies young carers as a group that may experience challenges: 'children and young people may experience difficulties maintaining friendships due to social exclusion, rural

isolation and/or the need for them to take on caring responsibilities within their families'. The National Youth Strategy 2015–2020 made a commitment to establish a cross-agency young carer working group to consider the needs of young carers and develop an 'integrated and coordinated response to their needs' (Action 5.6). This action is still outstanding, with the recent Family Carers report (2023) calling again for the working group's establishment; among its other recommendations were a call for increased supports for young carers to transition to further and higher education via access programmes; the provision of educational bursaries; greater access to respite care; and improved mental health supports.

### 1.3 DATA AND METHODOLOGY

#### 1.3.1 Defining and measuring caregiving

This study draws on data from Cohort '98 of the GUI study, with respondents first surveyed at 9 years of age, and followed up at 13, 17–18 and 20 years.<sup>15</sup> At 17 and 20 years, the young adults were asked whether they were providing care to another family member on a regular basis and, if they were doing so, the nature of their relationship with the care recipient and (at 20) the amount of time they spent on such care (see Table 1.1 for the wording of these questions). Information on care intensity is not collected at age 17. In addition, at 9 and 13 years of age, young people had been asked about the extent to which they undertook a range of chores at home; the specified list included helping with younger siblings and helping with older or sick relatives.

The definition of care in the GUI study is therefore quite broad, encompassing both care for a relative with a long-term illness or disability and care for a younger child. In taking this approach, GUI is similar to the European Quality of Life Survey (EQLS), which asks about how often, and for how many hours per week, (adult) respondents provided care to children and to elderly or disabled relatives. Using this definition (for the period 2003–2016), a very significant proportion of adults in Ireland are found to provide care for others (children and/or adults) on a daily basis: 45 per cent of women and 29 per cent of men (Russell et al., 2019).

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15 Hereafter, the 'age 17–18 years' group is referred to by '17 years' or 'age 17', for convenience.

**TABLE 1.1 MEASURES OF CARE: AGES 9 TO 20**

Wave	Question wording
<b>Age 9</b>	Do you do any of these chores at home? (often, occasionally, never) Helping with your younger brothers or sisters Helping an elderly or sick relative in the family
<b>Age 13</b>	Do you do any of these chores at home? (every day; 4/5 times a week; 2/3 times a week; less often; never) Helping with your younger brothers or sisters Helping an elderly or sick relative in the family
<b>Ages 17 and 20</b>	Do you care for or look after another family member on a regular basis? By ‘caring’ I mean things like cooking for them, helping them wash or dress, making sure they take medication, supervising them when there is no-one else at home. (yes, no) If yes how is this person related to you? (multiple responses permitted) a. Grandparent or other elderly relative (yes, no) b. A parent or step-parent (yes, no) c. A younger sibling (yes, no) d. A sibling of the same age or older than you (yes, no) e. Someone else (yes, no) If yes to providing care to younger sibling(s), the young person is asked if they would describe this as ‘babysitting’ or something more than this (e.g., ‘childcare’ in place of someone like a childminder or helping them with a medical condition).
<b>Age 20</b>	Care intensity Would you describe this care you provide as taking up: ‘a large amount of my time’; ‘quite a lot of my time’; ‘some of my time’; or ‘not very much of my time’?

Source: Growing Up in Ireland Cohort '98, Waves 1 to 4.

### 1.3.2 Factors associated with caregiving

Involvement in caregiving is hypothesised to reflect both potential care demands (in terms of household composition) and the resources available to the family to avail of other sources of care. In the analyses presented in Chapter 2, we therefore take account of gender, household income quintile (measured at age 17), maternal education, whether the family lives in an urban or rural area and whether the parent(s) are in paid employment. Having family living in the local area is potentially a resource for care support. Unfortunately, this was asked only at Wave 1 (age nine) but is nonetheless included in the models as it is a composite scale for frequency of contact between the child and non-household relatives at age 9 (to reflect the closeness of family ties).

Potential care demands are measured in terms of family structure (whether a lone- or two-parent family), the number of younger and older siblings, and whether any non-nuclear family member is living in the household. The presence of other family members, such as older siblings, in the household may also be a support; they may share some of the care responsibilities.

At age nine, the primary caregiver (mother) was asked whether there was someone in the household who affected their ability to look after the child; this is included

in the analyses but unfortunately the question was not repeated in later waves of the study. In addition, information is included on whether the mother and father reported a chronic illness or disability and whether they were above the threshold for depression on the Center for Epidemiological Studies measure of depressive symptoms (CES-D) at each wave. Other potential demands on young adults are measured in terms of whether they were in their Leaving Certificate year at the time of the Wave 3 survey (at 17) and the pathway they had taken on leaving school (higher education, further education or labour market/inactivity) (at 20).

We also test the effect of other factors considered in previous research including gender, migrant background (both parents were born outside Ireland or lone parent born outside Ireland), and living in an urban or rural area, which might influence the availability of care services.

### **1.3.3 Outcomes among caregivers**

As well as examining the profile of young adults engaged in caregiving, the analyses explore the potential consequences of such involvement for other domains of their lives (see Chapter 3). This part of the analysis focuses on three main domains: physical and mental health and wellbeing; educational outcomes and post-school transitions; and the quality of relationships with family members.

Physical health is measured using weight status at age 20 and self-reported health. Weight status is calculated on the basis of objective measures of height and weight, which are used to construct a body mass index (BMI) measure. BMI scores are coded into obese/overweight categories. Health status is based on self-reported health quality, with five categories ranging from 'excellent' to 'poor'. Wellbeing is measured through life satisfaction and mental health is assessed via questions on depressive symptoms. The young adult was asked, 'If you were to describe how satisfied you are with your own life in general, how would you rate it on a scale of zero to ten? Zero meaning you are extremely unsatisfied with your life in general, and ten meaning that you are extremely satisfied with your life'. At age 17 and age 20, young adults reported depressive symptoms using the threshold for the CES-D depression scale, an eight-item short self-report screening instrument for depression in the general population. The reference point relates to the previous seven days and items include 'I felt depressed' and 'I had crying spells'. Answers are given on a four-point rating scale, ranging from rarely or none of the time (less than 1 day) to most or all of the time (5–7 days), with a composite score calculated by summing responses across the eight items (range: 0–24). Composite scores of seven or more are classified as 'depressed' and scores below seven defined as 'not depressed'. While a score above or equal to seven suggests a clinically significant level of psychological distress, it does not necessarily mean that the participant has a clinical diagnosis of depression.

Educational outcomes are measured in terms of Leaving Certificate points, as reported by the young adult, which were grouped into categories, and whether the young person had gone on to higher education or further education by age 20 (even for a brief period). At age 20, the young adults were asked to rate the importance of different factors when deciding which further/higher educational institution to attend. The analyses focus on the perceived importance of being able to live at home and of good transport links with home and we assess whether these considerations are more salient for young people with care roles. The analyses also explore whether caregiving is related to the young adult having left the parental home by age 20.

Measures of the quality of family relationships were collected from both young adults and their mothers. At age 20, the young adult was asked how well members of their family got on, on a ten-point scale ranging from zero ('We don't get on at all') to ten ('We get on very well'). Mothers were asked how they would describe their relationship with the young adult, on a ten-point scale ranging from zero ('really bad') to ten ('absolutely perfect'). In addition, mothers were asked about the frequency of arguing, fighting or having a lot of difficulty with the young adult over the previous three months, with responses ranging from 'almost every day' to 'never', with a separate category for not having seen the young person in the relevant period.

### **1.3.4 Analytical approach**

Logistic regression models are used to look at the factors associated with caregiving at ages 17 and 20. Analyses relate to the 4,245 young adults who took part in all four waves of the survey and answered the relevant questions on caregiving. We present the results as average marginal effects, which show the percentage point change in the probability of the outcome that can be attributed to the explanatory variable, compared to the reference category. In examining the relationship between caregiving and outcomes for the young adults, the analyses control for the socio-demographic and care demand factors discussed above. In addition, they include measures of parental illness (focusing on those who described being hampered by that illness) and of parental depression. This allows us to separate out the potential impact of family illness from that of caregiving responsibilities.

## **1.4 REPORT OUTLINE**

The remainder of the report is structured as followed. In Chapter 2 we outline the extent, nature and intensity of care among young adults in Ireland between the ages of 17 and 20 years. The chapter analyses the factors associated with caregiving and those associated with moving in and out of caring roles between the ages of 17 and 20 years. Chapter 3 investigates the relationship between caring and a range of outcomes across four domains – wellbeing, physical health,

educational and post-school outcomes, and family relationships. Chapter 4 summarises the main findings of the study and discusses the implications for policy development.

## CHAPTER 2

### Profile of caregiving among young people in Ireland

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In this chapter we describe young people's involvement in providing care to others. While the focus is on young adults aged 17–20 years, we also consider the evidence of care provision by younger children aged 9–13 years. We investigate the types of care that young adults provide and the intensity of their involvement. This chapter also sets out to investigate the factors associated with care provision among young adults in Ireland: what characteristics of the young person themselves, their family and their wider environment are associated with caregiving? The longitudinal nature of the *Growing Up in Ireland* (GUI) data allows us to examine care trajectories and the factors associated with either taking up a caring role or exiting a caring role during early adulthood (between ages 17 and 20). This is a life course period of significant educational and life transitions; therefore, the relationship between caring and post-school pathways is also considered.

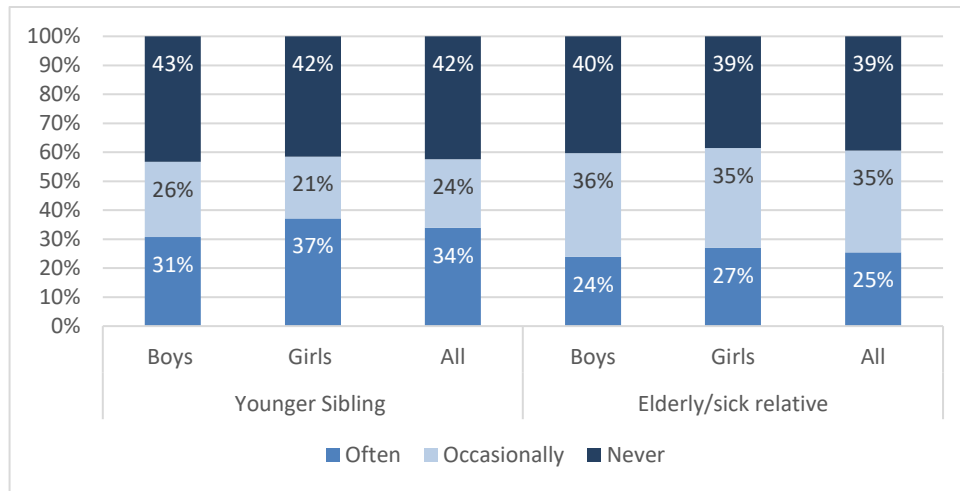
#### 2.1 EXTENT OF CARING FROM MIDDLE CHILDHOOD (9 YEARS) TO EARLY ADULTHOOD (20 YEARS)

##### 2.1.1 Caregiving at age 9 to age 13

At age 9, a very high proportion of children report that they provide care for a younger sibling (58 per cent) or an elderly/sick relative (61 per cent), at least occasionally. One-third report regular care (i.e., doing so often) for younger siblings, and one-quarter report regular care for an 'elderly or sick relative'. Girls were more likely than boys to report that they 'often' provide regular care for younger siblings (see Figure 2.1).<sup>16</sup> Over one-half (51 per cent) of girls and 44 per cent of boys 'often' provide care to either an elderly/sick relative or a younger sibling ( $p < .05$ ).

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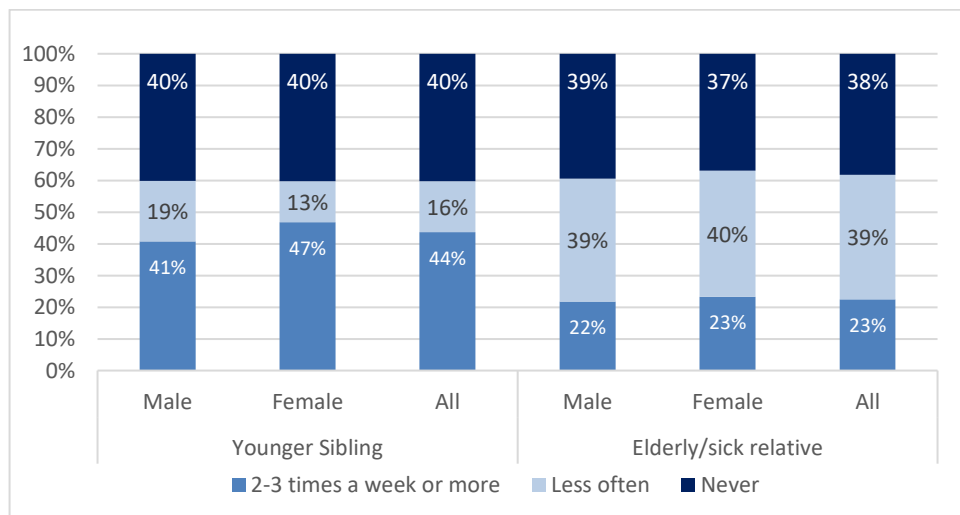
16 The gender difference is statistically significant. See Table 1.1 for question wording.

**FIGURE 2.1 CAREGIVING AT AGE 9**


Source: Growing Up in Ireland Cohort '98, Wave 1.

Notes: Longitudinal sample; restricted to those who are in all panel waves. Weighted.

A similarly high proportion of children reported that they care for younger siblings at age 13. Regular caregiving was more common in the case of care for younger siblings than for grandparents, with 41 per cent of boys and 47 per cent of girls reporting that they provide such care at least two to three times a week. This gender difference is statistically significant. Providing regular care to grandparents was less frequent and there was no difference between boys and girls (See Figure 2.2). In total, 53 per cent of 13 year olds provide regular care, two to three times a week or more, to a younger sibling or grandparent: 55 per cent of girls and 50 per cent of boys.

**FIGURE 2.2 CAREGIVING AT AGE 13**


Source: Growing Up in Ireland Cohort '98, Wave 2.

Notes: Longitudinal sample; restricted to those who are in all panel waves. Weighted.

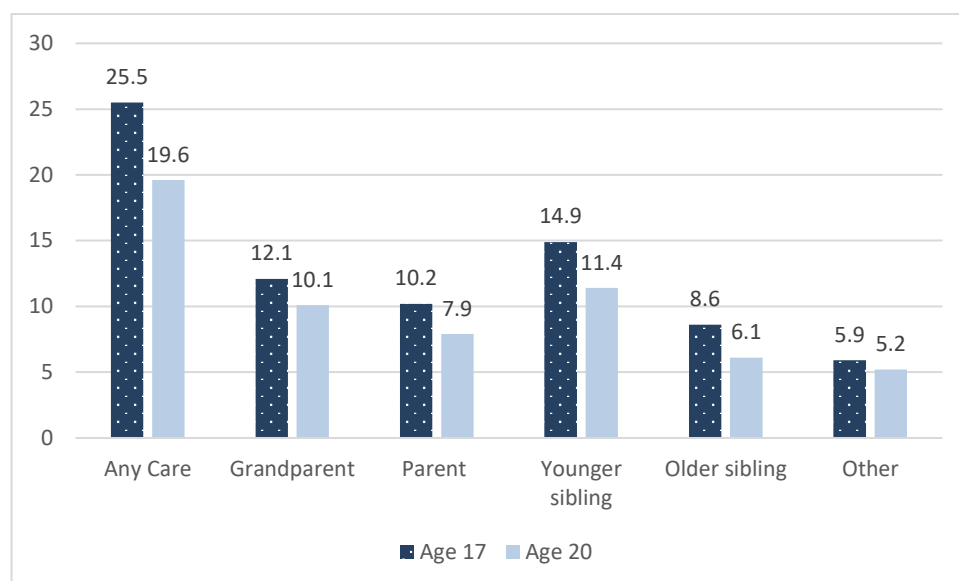


### 2.1.2 Caregiving at ages 17 and 20

At age 17, just over one-quarter of young people reported that they are providing care to a family member. The decline in reported caregiving between 13 and 17 is likely to reflect a different understanding of what it means to provide care, as well as changes in the question wording that are appropriate to respondents' age. At age 17, young people were asked about regular care that involved activities such as 'cooking for them, helping them wash or dress, making sure they take medication, supervising them when there is no-one else at home' (see Table 1.1). If they answered yes to this question, they were subsequently asked who they provided that help to, with multiple responses allowed. Overall, 12 per cent of 17 year olds provided care to a grandparent, 15 per cent to a younger sibling, 10 per cent to a parent, 9 per cent to an older sibling and 6 per cent to someone else (see Figure 2.3). Young men were more likely to provide care for an older sibling than young women (9.7 per cent versus 7.4 per cent;  $p=.006$ ). No significant gender differences were found for the other types of care.

Less than 2 per cent of the sample have their own children by age 20; due to the small numbers involved, further descriptive analysis cannot be undertaken. The care questions at 17 and 20 years explicitly exclude care of the respondent's own child unless they have additional needs (see Table 1.1); therefore, the care analysis does not include this type of care. There is no further information on who the 'other care' category are providing care to, but given the wording of the question it is most likely to be a non-elderly relative who is not a parent, grandparent or sibling.

A decline in caring is noted between age 17 and age 20, using the same measures. Overall, 19.6 per cent of 20 year olds reported regularly caring for someone. The decline was notable for all care categories but was greatest for care of younger siblings (see Figure 2.3). This decline may reflect changes in living arrangements as young people leave home to attend third-level education or enter the workforce. Younger siblings may require less care as they grow up, thus reducing demand for care within the household. The factors associated with exits from caring are examined in Section 2.4 below. At age 20, we find that young men are more likely to care for a grandparent (11.1 per cent) than are young women (9.1 per cent;  $p<.05$ ). The proportion of young men providing any care (20.7 per cent) is also somewhat higher than it is for young women (18.5 per cent), but this difference is only at the margins of statistical significance ( $p=.06$ ). There are no gender differences for the other groups of care recipients.

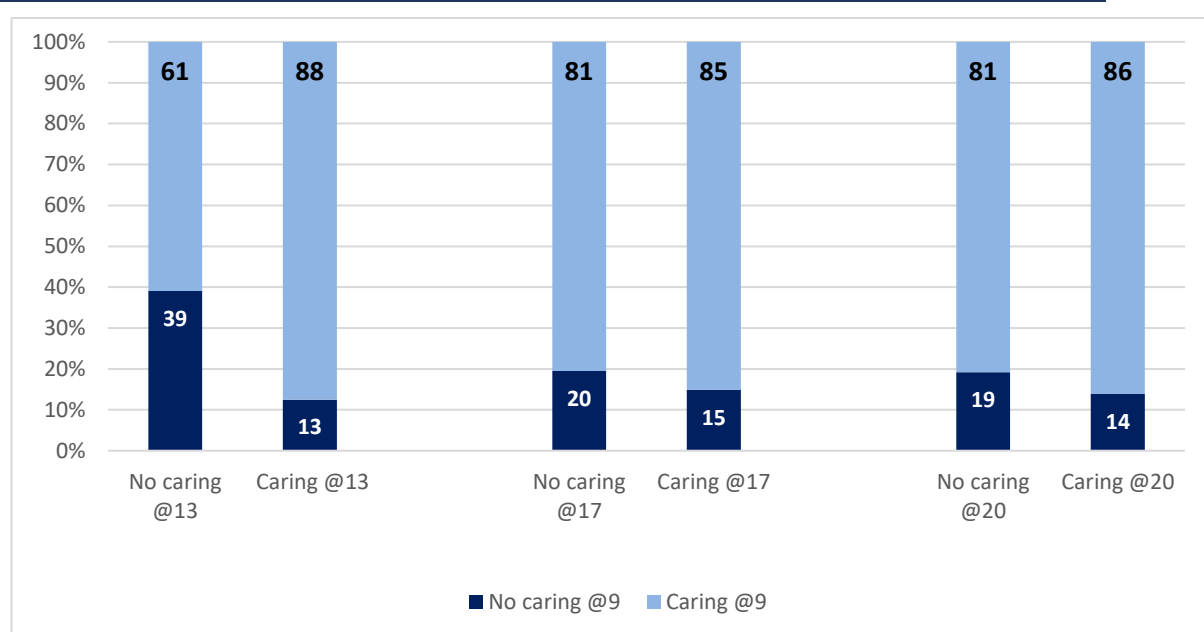
**FIGURE 2.3 CAREGIVING AT AGES 17 AND 20**

Source: *Growing Up in Ireland Cohort '98*, Waves 3 and 4.

Notes: Longitudinal sample; restricted to those who are in all panel waves. Weighted.

### 2.1.3 Persistence of caregiving over time

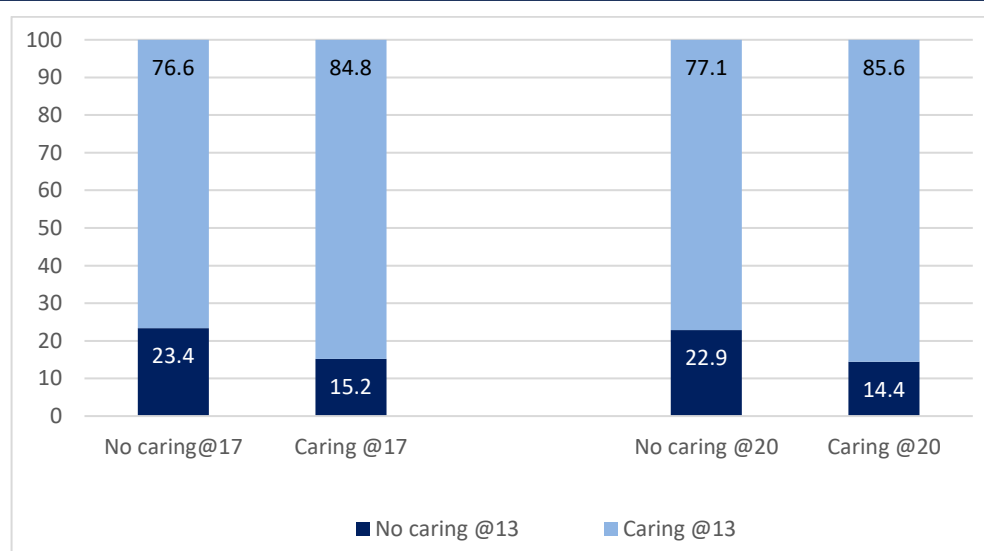
While the measures of caring are quite different, it is clear that many of those providing care as young adults were already providing care at an earlier age. Figure 2.4 shows that among those providing care at age 13 years, 88 per cent also reported providing care at age 9; in comparison, 61 per cent of those not providing care at 13 reported caring at age 9. The association between providing care at 9 years and providing care at 17 years is weaker but still statistically significant. At 17 years, 85 per cent of caregivers report that they were caregiving at age 9, compared to 81 per cent of those not providing care at age 17. There is a similar association between caring at age 9 and caring at age 20: 86 per cent of those caring at age 20 were also caring at 9 years, but this is also true of 81 per cent of those not caregiving at 20. The stronger relationship between caring at 9 and 13 years is likely to reflect both the shorter timeframe but also the greater similarity in the measures for these two age groups.

**FIGURE 2.4 CAREGIVING AT AGES 13, 17 AND 20 BY CAREGIVING AT AGE 9**

Source: Growing Up in Ireland Cohort '98, Waves 1, 2, 3 and 4.

Notes: Longitudinal sample; restricted to those who are in all panel waves. Weighted.

We perform a similar analysis of the relationship between caregiving at age 13 and later caregiving (Figure 2.5). Young people providing care at age 17 are significantly ( $p < .001$ ) more likely to have reported caregiving at age 13 (85 per cent) than young people not caregiving at 17 (77 per cent). The association between caregiving at 13 years and later caregiving also persists at age 20 (the difference between the two groups is statistically significant, at  $P < .001$ ).

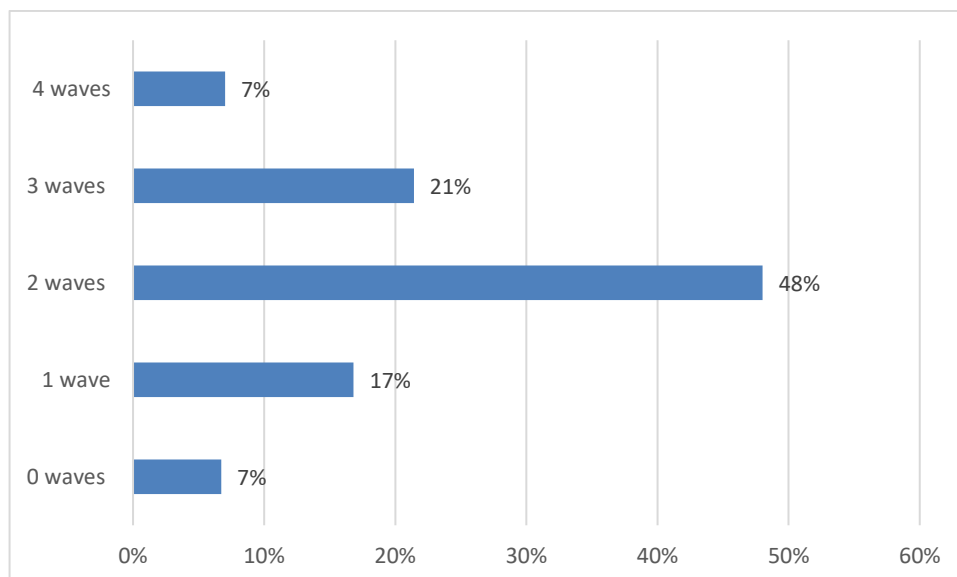
**FIGURE 2.5 CAREGIVING AT AGES 17 AND 20 BY CAREGIVING AT AGE 13**

Source: Growing Up in Ireland Cohort '98, Waves 2, 3 and 4.

Notes: Longitudinal sample; restricted to those who are in all panel waves. Weighted.

Examining the cumulative incidence of caregiving over the four waves of the GUI, we find that 7 per cent of young people were providing care at all four timepoints, and a further 21 per cent were providing care at three timepoints (Figure 2.6). Almost half of young people were providing care at two timepoints. Only 7 per cent of young people never report caregiving.

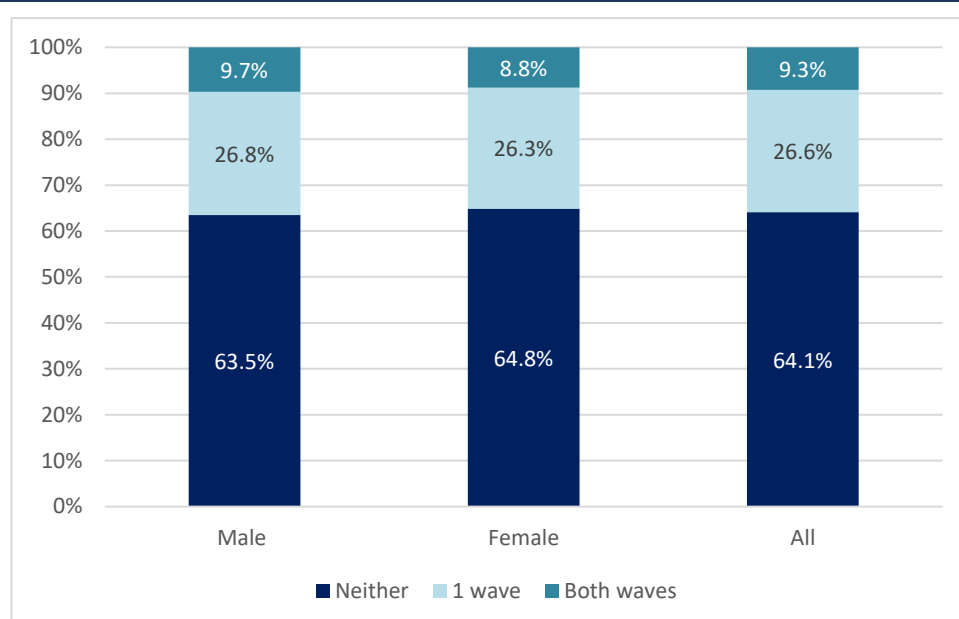
**FIGURE 2.6 NUMBER OF WAVES CAREGIVING BETWEEN AGES 9 AND 20**



Source: *Growing Up in Ireland Cohort '98*, Waves 1, 2, 3 and 4.

Notes: Longitudinal sample; restricted to those who are in all panel waves. Weighted.

Given our focus on young adult carers and their transitions, we are particularly interested in the persistence of caregiving between ages 17 and 20. The measure of caregiving is the same at these two timepoints, which allows for a more robust analysis of change over time. We find that over one-third (36 per cent) of young adults provide regular care at some point during this period of life. For the majority of those providing care, it is a transitory rather than persistent role: 26.6 per cent of young people report caring at only one of the two waves, while 9 per cent are providing care at both waves (see Figure 2.7). We examine the factors influencing care transitions among young adults in Section 2.4 below.

**FIGURE 2.7 PERSISTENCE OF CAREGIVING BETWEEN AGES 17 AND 20**

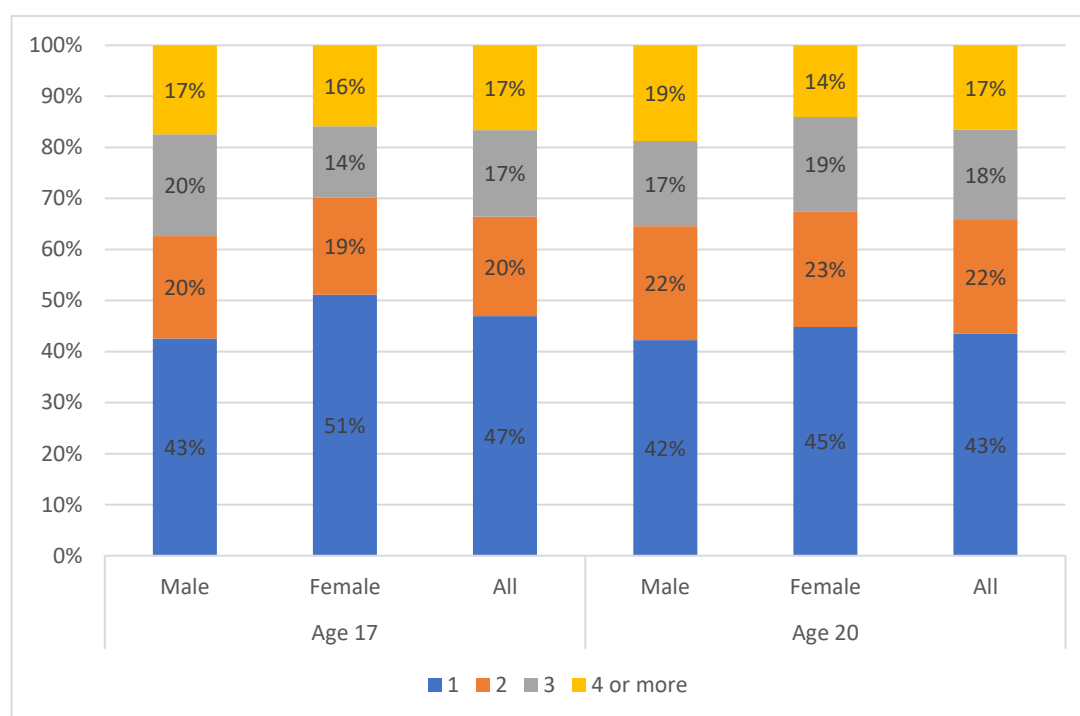
Source: *Growing Up in Ireland Cohort '98, Waves 3 and 4.*

#### 2.1.4 Extensiveness and intensity of care among young adult carers

Respondents can record care across multiple recipients; therefore, we construct a measure of extensiveness that is based on the number of categories of people for whom the young person cares. There are five care categories: grandparents, parents, younger siblings, older siblings and others.<sup>17</sup> At age 17, just over half of young adult carers (53 per cent) reported caring for more than one category of recipients, 20 per cent reported caring for two, 17 per cent for 3 and 17 per cent for four or more. Young men reported greater extensiveness of care on this measure than young women ( $p < .001$ ).

At age 20, although the proportion of young people who provide care fell, the extensiveness increased somewhat. At that age, 57 per cent of carers reported caring for more than one category of recipients, 22 per cent care for two, 28 per cent for 3 and 17 per cent for four or five. The gender difference is not significant at age 20.

17 The number of care recipients may also vary within these groups but we do not have that information.

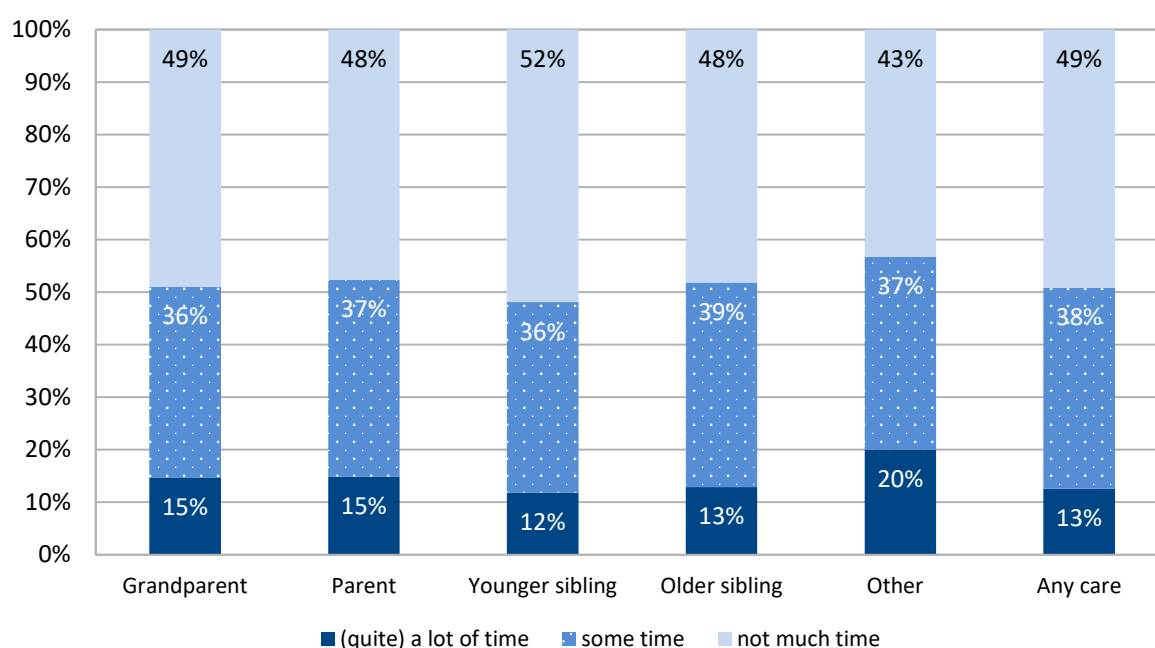
**FIGURE 2.8 NUMBER OF CARE RECIPIENTS BY AGE AND GENDER OF CARER**

**Note:** Restricted to those providing care, unweighted. N=1,032 at age 17 and 885 at age 20. Excludes a small number of carers who do not specify who they were providing care to.

At the age-20 interview, those who said yes to providing care to others were asked how much of their time this takes. Among carers, 13 per cent reported that caring takes up ‘a lot’ or ‘quite a lot’ of their time, 38 per cent said it takes ‘some’ of their time and the remaining 49 per cent said it takes not very much of their time (see Figure 2.9). This means that 2.5 per cent of all 20 year olds are engaged in care that takes a lot or quite a lot of their time.

Care intensity was asked for all types of care combined; however, we can see that those who provide care for parents, grandparents and ‘others’ are slightly more likely to say that care takes some or a lot of their time. There is a moderate relationship between number of care recipients and care time. For example, 22 per cent of those providing care in four or five categories said it took a lot of their time, compared to 10 per cent of those providing care in just one category.<sup>18</sup> We examine the determinants of care intensity in greater detail in Section 2.3 below.

<sup>18</sup> The chi square for the relationship between the two variables, excluding those with no caring responsibilities, is only significant at the 10 per cent level. Including those without any caring responsibilities, there is a significant correlation of .82.

**FIGURE 2.9 TIME SPENT ON CARING AT AGE 20 AMONG THOSE PROVIDING ANY CARE**

Source: *Growing Up in Ireland, Wave 4.*

Notes: Individual respondents can appear in more than one category. Intensity was asked for all care combined, not for each type of care given.

## 2.2 FACTORS INFLUENCING CARE RESPONSIBILITIES

Previous research suggests that caring among young people is influenced both by family demands and resources and by a set of gender and care norms. In this section, we run a set of statistical models to test which factors are the strongest predictors of caring among young adults at ages 17 and 20.

A series of logistic regression models are run for each type of care recorded, and one for any care. The results are reported as marginal effects, which show the probability of engaging in care relative to the reference category. A wide range of explanatory variables are tested including gender, migrant status and urban/rural location. Socio-economic status is measured by income, maternal education and parental employment. Maternal education is included as an indicator of social class background and longer-term social and economic resources of the household. Family structure and family health status (for example, whether either parent ever experienced depression or were ever hampered in their daily activity by an illness or disability) are also taken into account.<sup>19</sup> Availability of wider social support is measured by whether wider family were living nearby and level of contact with wider family (both measured at age 9 years). We also test the association between caring at 17 and earlier levels of involvement in caring at ages 9 and 13.

<sup>19</sup> In the age 17 models, 'ever' means in Waves 1 to 3, while in the age 20 models, 'ever' means in Waves 1 to 4.

### 2.2.1 Results: Predictors of caregiving at age 17

When other factors are controlled, there are no differences in care participation at age 17 by migrant status or gender, except in the case of caring for older siblings, in which case young men are more likely to be involved (see Table 2.1).

Among the indicators of social background, maternal education has the strongest association with care at age 17. Young people whose mothers are educated to degree level are less likely to be involved in all types of care recorded. Their probability of providing any regular care at 17 years is nine percentage points lower than for those whose mother has lower-secondary-level education or less (Table 2.1, Model 1). Controlling for other social background characteristics, current household income is not strongly associated with caring; however, young people in the top income quintile are significantly less likely to provide care to older siblings (Model 5) or to 'others' (Model 6).

In terms of family structure, the strongest predictor of caregiving is the number of younger siblings. Each additional younger sibling increases the probability of caring by five percentage points. The number of younger siblings is significant not only in predicting care of younger siblings (Model 4 and Model 7) but also care of grandparent(s), which suggests that living in a larger family increases demand for other types of caring to be shared across household members. Lone parenthood is not associated with the probability of caregiving.

There is a weaker association between family health status and caregiving than anticipated. Maternal 'hampering illness'/disability was not significant in any of the models, including that for parental care. Paternal 'hampering illness'/disability was only significant in the case of other care (Model 6). Maternal depression is associated with a 3.9 percentage point increase in the probability of providing parental care (Model 3) and a 2.7 percentage point increase in providing extra care for younger siblings (Model 7). Paternal depression is not associated with caregiving at age 17.

Social resources, in the form of potential access to social support from other family members, are not associated with the likelihood of caring, though this may be because the measures of support are not detailed enough and are measured at age 9.



**TABLE 2.1 FACTORS INFLUENCING CARING AT AGE 17 BY TYPE OF CARE; LOGISTIC REGRESSION (MARGINAL EFFECTS)**

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Any care	Grand-parent	Parent	Young sibling	Older sibling	Other	Extra care young sib.
<b>Female</b>	-0.012	-0.004	-0.012	-0.005	-0.034**	-0.012	-0.004
<b>Migrant</b>	0.055	-0.055	0.037	0.056	0.040	0.022	0.021
<b>Bottom income quintile</b>	0	0	0	0	0	0	0
<b>2nd income quintile</b>	-0.048	-0.026	-0.006	-0.043	-0.014	-0.017	-0.005
<b>3rd income quintile</b>	-0.015	-0.034	-0.016	0.012	-0.034	-0.036*	0.016
<b>4th income quintile</b>	-0.047	-0.058*	-0.030	-0.029	-0.039	-0.016	0.02
<b>5th income quintile</b>	-0.02	-0.032	-0.026	-0.009	-0.050*	-0.038*	0.016
<b>Mother lower sec (ref)</b>							
<b>Upper sec</b>	-0.038	-0.049*	-0.024	-0.034	-0.004	-0.018	-0.022
<b>Post-sec</b>	-0.069*	-0.047*	-0.050*	-0.048	-0.019	-0.020	-0.029
<b>Degree</b>	-0.088**	-0.044	-0.051*	-0.076**	-0.033	-0.033*	-0.04**
<b>Mother employed</b>	0.019	0.017	0.012	0.028	0.003	-0.001	0.005
<b>Father employed</b>	-0.012	0.011	0.002	-0.013	0.011	0.001	-0.012
<b>Urban</b>	-0.03	-0.021	-0.028*	-0.005	0.006	-0.023*	-0.003
<b>Family structure</b>							
<b>Lone parent</b>	-0.006	0.008	-0.010	0.001	0.017	-0.007	0.000
<b>N. younger sibling</b>	0.051***	0.018*	0.001	0.044***	0.007	0.007	0.011*
<b>N. older sibling</b>	0.022	0.001	0.001	-0.005	0.041***	0.002	0.01
<b>Other family in household</b>	0.011	0.043*	-0.014	-0.021	-0.019	-0.012	0.012
<b>Family health status</b>							
<b>Mother ever hampered</b>	-0.022	-0.029	-0.008	-0.04	-0.014	0.002	-0.019
<b>Father ever hampered</b>	0.040	0.016	0.028	0.011	0.022	0.030*	0.000
<b>Mother ever depressed</b>	0.023	0.028	0.039*	0.038	0.024	0.000	0.027**
<b>Father ever depressed</b>	0.015	-0.008	-0.026	0.018	0.008	0.002	0.007
<b>Own illness</b>	0.037	0.041*	0.028	0.003	0.034*	0.007	-0.005
<b>Some. in HH at 9 affected ability to look after child</b>	-0.001	0.	-0.022	-0.017	-0.021	0.013	0.024
<b>Wider family support</b>							
<b>Family living in area at 9</b>	0.008	0.028	0.007	-0.008	-0.002	0.017	-0.008
<b>Freq family contact at 9</b>	0.004	0	-0.001	0.001	-0.005	0	-0.002
<b>Sibling care at 13</b>							
<b>ref=Never</b>	0	0	0	0	0	0	0
<b>Everyday</b>	0.058	-0.019	0.03	0.141***	0.042	-0.009	0.040*
<b>4–5 times wk</b>	0.027	-0.041	0	0.110**	-0.017	-0.011	0.048*
<b>2–3 times</b>	-0.017	-0.060*	-0.022	0.058*	0.003	-0.012	0.023*
<b>Less often</b>	-0.047	-0.056*	-0.033	0.013	-0.018	-0.026	0.019

**TABLE 2.1 (CONTD.) FACTORS INFLUENCING CARING AT AGE 17 BY TYPE OF CARE; LOGISTIC REGRESSION (MARGINAL EFFECTS)**

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Any care	Grandpa rent	Parent	Young sibling	Older sibling	Other	Extra care young sib.
<i>Older/sick relat care at 13 ref=Never</i>							
<b>Everyday</b>	0.187***	0.176***	0.026	0.046	0.04	0.046	-0.008
<b>4–5 times wk</b>	0.117*	0.180***	0.055	0.014	0.076	0.103*	0.028
<b>2–3 times</b>	0.065*	0.069**	0.028	0.013	0.015	0.02	0.009
<b>Less often</b>	0.055*	0.045**	0.012	0.02	0.033*	0.017	-0.014
<b>Observations</b>	4,299	4,308	4,308	4,308	4,308	4,308	4,298

Notes: \* p<0.05; \*\* p<0.01; \*\*\* p<0.001. Also controls for sibling and grandparent care at age 9 but these are insignificant. HH=Household.

Previous involvement in caring for an older or sick relative at age 13 is a significant predictor of any caring at age 17 (Model 1), and of grandparent care at 17 (Model 2). Those who recorded more intensive involvement at 13 years were significantly more likely to still provide care at 17 years. Similarly, more intensive care for a younger sibling is strongly associated with providing care for younger siblings at age 17 (Models 4 and 7). The negative relationship with grandparent care may be a confounding effect of the age of the younger siblings (the presence of young siblings is likely to be correlated with younger grandparents, who are less likely to require care).

These results suggest that the self-reports of caring at age 13 are meaningful and that for some young carers, the caring role began early; this issue is examined below, in Section 2.4, which is on care trajectories.

### 2.2.2 Predictors of caregiving at age 20

We repeat the analysis for care at 20 years (Table 2.2). Gender and migrant status play a greater role at age 20 than at age 17. Young men are more likely to provide any care (Model 1) and care to parents (Model 3) and younger siblings (Model 4). This may reflect the greater likelihood of young women having left the parental home by age 20, an issue discussed further in Chapter 3. Young people from a migrant background are more likely to provide any care than non-migrant young people (Model 1), specifically for parents (Model 3) and younger siblings (Model 4). This may reflect migrant-origin young adults substituting for the lack of extended family available to help with care, or different cultural norms. While still at school, high educational expectations among migrant parents (relative to their socio-economic background) may have resulted in young people being relatively protected from care duties so that they could engage in study, at age 17.

We find that family socio-economic background has a less significant association with caring at age 20 compared to at age 17. Maternal educational level is no longer significantly related to care involvement (Model 1) or for any of the specific care types. Neither is family income significant in any of the models. However, having a father in employment, which is an indicator of greater household resources, reduces the probability of any care by 4.3 percentage points (Model 1), care for a grandparent by 3.1 percentage points (Model 2) and parental care by 3 percentage points.

The presence of younger siblings continues to be associated with any caring and care of grandparents, parents, younger siblings and others (Models 2, 3, 4 and 6). The presence of other family members beyond the nuclear family in the household decreases the probability of caring for a parent (Model 3) and of providing more intensive care for a younger sibling (Model 7). This suggests that additional household members are a caring resource rather than a source of extra care demand. However, having other family members living nearby or in regular contact (at Wave 1) did not influence caring by 20 year olds.

As was the case at age 17, parental health has less influence than anticipated. Neither maternal nor paternal long-term illness/disability or depression was associated with overall care or different care types at age 20, except that when fathers have experienced depression, young people are more likely to care for younger siblings (Model 4). However, we do find that young people who at age 9 had someone in the household whose ability to care for them was limited were more likely to be caring at age 20 (Model 1).

Finally, we consider post-school pathways. Young people who are attending further education are more likely to be providing regular care to a family member than those attending higher education (Model 1); this applies to grandparent care (Model 2), parent care (Model 3), care of younger siblings (Model 4) and care of older siblings (Model 5). Those who are not employed or in further education are also less likely to care for parents (Model 3) or younger siblings. In the chapter that follows, we explore the direction of causality.

**TABLE 2.2 FACTORS INFLUENCING CARING AT AGE 20 BY TYPE OF CARE; LOGISTIC REGRESSION (MARGINAL EFFECTS)**

	1	2	3	4	5	6	7
	Any	Grand-parent	Parent	Younger sibling	Older sibling	Other	Extra care young. sib.
<b>Female</b>	-0.034*	-0.022	-0.027*	-0.026*	-0.007	-0.004	-0.006
<b>Migrant status</b>	0.068*	0.001	0.044*	0.047*	0.003	0.001	0.014
<i>Bottom inc quintile (ref)</i>	0	0	0	0	0	0	0
<b>2nd income quintile</b>	0.018	0.054*	0.026	0.029	0.021	0.007	-0.009
<b>3rd income quintile</b>	0.007	0.030	-0.006	0.035	-0.006	-0.003	-0.006
<b>4th income quintile</b>	0.007	0.014	-0.025	0.026	-0.023	0.004	0.006
<b>5th income quintile</b>	-0.033	-0.011	-0.020	0.020	-0.013	-0.009	-0.015
<i>Mother ed (ref=Lower sec)</i>	0	0	0	0	0	0	0
<b>Upper secondary</b>	-0.028	-0.010	0.004	-0.016	0.020	-0.005	-0.014
<b>Post-secondary</b>	-0.035	-0.023	-0.015	-0.027	0.000	-0.010	-0.017
<b>Degree</b>	-0.014	-0.004	-0.001	-0.026	-0.009	-0.009	-0.011
<b>Mother employed</b>	-0.014	-0.006	-0.004	-0.015	0.008	0.022	0.001
<b>Father employed</b>	-0.041*	-0.031*	-0.030*	-0.024	-0.001	-0.017	-0.013
<b>Urban</b>	-0.005	-0.033*	-0.002	0.022	0.010	-0.002	0.010
<i>Family structure</i>							
<b>Lone parent</b>	-0.021	-0.022	-0.03	-0.006	-0.008	0.001	-0.018
<b>N. younger siblings</b>	0.043***	0.017*	0.014*	0.043***	0.011	0.013*	0.002
<b>N. older siblings</b>	0.008	0.001	0.003	0.018*	0.039***	0.021***	0.007
<b>Other family member in HH</b>	-0.032	0.006	-0.083**	-0.053	-0.031	-0.025	-0.042*
<i>Family health status</i>							
<b>Mother ever hampered</b>	0.001	-0.009	0.001	-0.030	0.001	-0.002	-0.022
<b>Father ever hampered</b>	0.019	0.005	0.021	0.012	0.002	0.023	-0.002
<b>Mother ever depressed</b>	0.012	0.002	-0.001	-0.004	0.004	0.003	-0.002
<b>Father ever depressed</b>	0.054	0.038	-0.001	0.053*	0.010	-0.031	0.006
<b>Own illness</b>	0.032	0.017	0.014	0.004	0.009	0.020	-0.009
<b>Ability to look after child at 9 affected</b>	0.094*	-0.018	0.023	-0.009	0.028	0.022	0.011
<b>Family living in area at 9</b>	-0.010	0.027	-0.010	-0.005	0.004	-0.013	-0.011
<b>Frequency of contact with family at age 9</b>	-0.002	0.000	0.004	0.000	0.003	-0.003	-0.003
<i>Care yng sib at 13 (ref=never)</i>	0	0	0	0	0	0	0
<b>Everyday</b>	0.096**	0.018	0.054*	0.140***	0.033	0.044	0.056**
<b>4–5 times per week</b>	0.052	0.001	-0.005	0.101***	0.016	0.003	0.046**
<b>2–3 times per week</b>	0.003	-0.031	-0.015	0.079***	-0.004	-0.005	0.021
<b>Less often</b>	-0.011	-0.034	-0.013	0.056**	0.018	0.014	0.031*
<i>Other care at 13 (ref=never)</i>	0	0	0	0	0	0	0
<b>Every day</b>	0.164***	0.176***	0.081*	0.087*	0.030	0.047	0.039
<b>4–5 times wk</b>	0.079	0.108**	0.068*	0.032	0.050	0.05	-0.012
<b>2–3 times</b>	0.042	0.056*	0.069**	0.028	0.034	0.021	0.003
<b>Less often</b>	0.011	0.023	0.021	0.019	0.012	0.012	0.014

**TABLE 2.2 (CONTD.) FACTORS INFLUENCING CARING AT AGE 20 BY TYPE OF CARE; LOGISTIC REGRESSION (MARGINAL EFFECTS)**

	1	2	3	4	5	6	7
	Any	Grandparent	Parent	Younger sibling	Older sibling	Other	Extra care young. sib.
<b>Post-school pathway</b>							
<b>Not employed</b>	-0.069	-0.006	-0.054***	-0.026	-0.024	-0.027	-0.034***
<b>Employed</b>	-0.016	-0.007	0.021	-0.025	0.019	-0.000	-0.022*
<b>Further education</b>	0.076**	0.053*	0.065**	0.059**	0.067***	0.018	0.021
<b>Higher education</b>	0	0	0	0	0	0	0
<b>Observations</b>	4,245	4,249	4,249	4,249	4,249	4,249	4,249

Notes: \* p<0.05; \*\* p<0.01; \*\*\* p<0.001.

### 2.3 INTENSITY OF CARE AT AGE 20

Here, we examine the factors that influence care intensity at age 20 based on the self-reported amount of time spent caregiving (Table 2.3). Young people who do not provide any care are coded as zero on the intensity measure; the other categories are 1 ('not much time'), 2 ('some time') and 3 ('quite a lot/a lot of time').

Overall, we find that there are few significant predictors of care intensity. Neither gender nor migrant background are related to care intensity. Among the socio-economic indicators, neither household income nor maternal educational attainment are associated with care intensity; however, having a father in employment, which will increase family resources, is associated with lower care intensity.

The number of younger siblings is a strong predictor of care intensity. However, other features of the household structure – lone parenthood, number of older siblings and presence of other persons in the household of origin – are not associated with care intensity at 20 years.

Parental experience of illness, disability or depression, which was expected to increase the need for caregiving from young adults, does not have any significant effects. However, the indicator capturing that someone in the household was unable to care for the study child at age 9 because of other care responsibilities is found to significantly predict increased care intensity experienced by the young person at age 20.

Prior involvement in caring at age 13, and the intensity of such care, is significantly associated with care intensity at age 20. Those who reported that they cared for older/sick relatives every day or 4–5 times a week experienced higher care intensity at age 20. Similarly, those who cared for younger siblings at age 13 had a significantly more intensive care role at age 20, again underlining that young adult caring is influenced by caring earlier in childhood.

Finally, we examine young people's post-school pathways. Those who entered further education are more intensely involved in caring than those who go on to higher education. However, those who enter employment or are inactive or unemployed do not differ from the higher education group. Having moved out of the family home is associated with significantly lower care intensity at age 20.<sup>20</sup>

**TABLE 2.3 ORDERED LOGIT MODEL OF CARE INTENSITY AT AGE 20**

	Coefficient
Female	-0.189
Migrant status	0.322
Bottom income quintile	0
2nd	0.063
3rd	0.017
4th	-0.049
5th / Top income quintile	-0.269
Mother Lower secondary education (ref)	0
Upper secondary	-0.068
Post-secondary	-0.150
Degree	-0.023
Mother employed	-0.059
Father employed	-0.253
Urban	-0.019
Lone-parent family	-0.069
N. younger siblings	0.262***
N. older siblings	0.019
Other family in household	-0.174
Mother ever hampered	-0.064
Father ever hampered	0.117
Mother ever depressed	0.143
Father ever depressed	0.132
Own illness	0.241
Some in HH at 9 affected ability to look after child	0.664*
Family living in area at age 9	-0.074
Frequency of contact with family at age 9	0.007

20 Additional analyses (not shown here) indicated no difference in care intensity between those who had left the parental home but still spent more than eight nights a month there and those who stayed over less often.

**TABLE 2.3 (CONTD.) ORDERED LOGIT MODEL OF CARE INTENSITY AT AGE 20**

	Coefficient
<i>Care for sib at 13 (ref=never)</i>	Ref
Every day	0.650*
4–5 times per week	0.304
2–3 times per week	0.015
Less often	-0.095
<i>Care older/sick relative at 13 (ref=never)</i>	Ref
Every day	0.830***
4–5 times per week	0.585*
2–3 times per week	0.262
Less often	0.092
<i>Post-school pathway</i>	
Inactive/unemployed	-0.560
Employed	-0.113
Further education	0.373*
Higher education	Ref
Moved out of family home	-0.557***
Observations	4,242

Note: Also controls for care at age 9 but these are not significant.

The lack of significance of most of the variables in the model indicates that the intensity of care is heterogeneous across the population; therefore, targeting those involved in intense caregiving is challenging.

We also separately consider the factors that influence the intensity of caring among the sub-sample of those providing care (appendix Table A2.1), on the basis that these factors may differ somewhat than doing some versus no care. Among this group, we find that young adult carers with more older siblings experience lower care intensity. This is most likely because care tasks are shared with older siblings. Among carers, we do not find significant difference by the care recipient (sibling, parent, grandparent, etc.). However, we do see that paternal long-standing illness or disability is associated with increased care intensity, suggesting that providing care for a father is more intensive. We find that among those providing some care, moving out of the family home is associated with significantly lower care intensity.

## 2.4 CARE TRAJECTORIES OF YOUNG PEOPLE AGED 17–20 YEARS

In the following analysis, we explore the factors that lead young people to enter or exit caring roles between the ages of 17 and 20 years. Overall, 16 per cent of young people were providing care at age 17 and no longer reported caregiving at age 20

(the 'Exit' group), while 10 per cent did not report caregiving at 17 but did report doing so at age 20 (the 'Enter' group).

**TABLE 2.4      TRANSITIONS IN CAREGIVING BETWEEN AGES 17 AND 20**

	Male	Female	All
Neither	63.5%	64.8%	64.1%
Exit	15.8%	16.7%	16.3%
Enter	10.9%	9.7%	10.3%
Both	9.7%	8.8%	9.3%
Total	100.0	100.0%	100.0%
N	2,330	2,289	4,619

### 2.4.1 Moving out of caring

Here, we explore the factors that influence these exits from caregiving. This model only includes those providing care at 17 years and respondents can provide multiple forms of care. In Model 1, we only include details of the recipient of care. We find, without controlling for other factors, that young people caring for a younger sibling or 'other' family member(s) are less likely to have exited caregiving than other carers. In Model 2, we add the measures of social and economic background and family characteristics. Overall, these have little influence on the likelihood of exiting caring, and only four factors are significant. Firstly, a young person whose father was employed (at age 17) is more likely to have stopped providing care at age 20.<sup>21</sup> This is likely to reflect both household economic resources and the health of the father. Secondly, young people from bigger families with more younger siblings are less likely to have exited caring than those with no younger siblings. Thirdly, those living in families where at age 9 there was someone whose ability to care for the young person was impaired were less likely to have stopped caregiving. Fourthly, the availability of local support from the wider family increases the probability of exiting caring, by 9.5 percentage points.

21 Fathers are not interviewed when the young person is aged 20; therefore, we cannot test changes in paternal employment patterns.



**TABLE 2.5 EXITS FROM CARING BETWEEN AGES 17 AND 20 (AVERAGE MARGINAL EFFECTS)**

	Model 1	Model 2	Model 3	Model 4
<b>Care type at 17 years</b>				
Cares for grandparent	-0.054	-0.066	-0.063	-0.063
Cares for parent	0.089	0.091	0.103*	0.101*
Cares for younger sibling	-0.118**	-0.070	-0.055	-0.055
Cares for older sibling	-0.019	-0.052	-0.056	-0.054
Cares for other	-0.156**	-0.133*	-0.136**	-0.135**
Female		0.046	0.044	0.045
Migrant status		-0.105	-0.112	-0.112
Income Q1 (lowest)		Ref	Ref	Ref
Q2		-0.002	-0.016	-0.017
Q3		0.032	0.013	0.013
Q4		0.009	-0.019	-0.019
Income Q5 (highest)		0.100	0.080	0.078
<b>Mother's education</b>				
Lower secondary		Ref	Ref	Ref
Upper secondary		0.067	0.072	0.073
Post-secondary		0.042	0.054	0.056
Degree		-0.061	-0.063	-0.060
Mother employed		-0.041	-0.032	-0.033
Father employed		0.150**	0.160***	0.160***
Urban		-0.021	0.001	0.000
<b>Household structure</b>				
Lone parent		0.077	0.080	0.082
N younger siblings		-0.028	-0.038	-0.038
N older sib		0.056	0.045	0.045
Other family in household		-0.003	-0.003	-0.003
<b>Family health status</b>				
Mother ever hampered		-0.023	-0.027	-0.027
Father ever hampered		0.004	0.010	0.011
Mother ever depressed		0.016	0.015	0.014
Father ever depressed		0.013	0.031	0.030
Own illness/disability		0.008	0.016	0.015
Some in H affected ability to look after child at 9	-0.227*	-0.211**	-0.210**	
Family living in area at age 9		0.095*	0.103*	0.102*
Frequency of contact with family at age 9		0.016	0.015	0.015
<b>Post-school pathway</b>				
Not employed			0.289***	0.290***
Employed			0.021	0.017
Further education			-0.089	-0.086
Higher education (ref)			Ref	Ref
Moved out of family home			0.025	0.024
Any caregiving at age 13				-0.015
Any caregiving at age 9				0.019
Observations	956	956	956	956

Notes: \* p<0.05; \*\* p<0.01; \*\*\* p<0.001. Variables are measured at Wave 3, unless otherwise indicated. 'Income missing' and 'family income missing' also included as dummy variables.

In Model 3, we consider the relationship between care exits and the young person's post-school pathway. We find that among young carers, those who leave the education system but are not employed are more likely to exit caring compared to those who are in higher education. In the final model, we test the association with leaving home: surprisingly, we find no association between exiting care and living away from the family home (for at least part of the year).

#### **2.4.2 Moves into caring**

Taking up a caring role between ages 17 and 20 is a less common experience. Overall, 10 per cent of young people report caring at 20 but not at 17 years. The models in Table 2.6 examine the factors influencing entry to caregiving.

The probability of taking up care at this age is not associated with gender or socio-economic background. Having a greater number of younger siblings is associated with an increased probability of taking up care; however, none of the other indicators of care demands or social support is significant. Model 3 takes into account young people's post-school pathways. We find that those who take up employment have a lower probability of entering care compared to those who move on to higher education, decreasing the probability by 5.9 percentage points. Moving out of the family home reduces the probability of entering a caregiving role by 8 percentage points.

**TABLE 2.6 ENTRY TO CARING BETWEEN AGES 17 AND 20 (AVERAGE MARGINAL EFFECTS)**

	Model 1	Model 2	Model 3	Model 4
<b>Female</b>	-0.019	-0.015	-0.013	-0.013
<b>Migrant status</b>	0.004	0.022	0.023	0.025
<b>Bottom income quintile 1</b>	Ref	Ref	Ref	Ref
<b>Quintile 2</b>	0.024	0.029	0.029	0.028
<b>Quintile 3</b>	0.011	0.024	0.023	0.023
<b>Quintile 4</b>	-0.003	0.016	0.012	0.011
<b>Top income quintile 5</b>	-0.04	-0.013	-0.014	-0.014
<b>Mother's education (ref=Lower secondary)</b>	Ref	Ref	Ref	Ref
<b>Upper secondary</b>	-0.012	-0.012	-0.006	-0.006
<b>Post-secondary</b>	-0.013	-0.018	-0.010	-0.009
<b>Degree</b>	-0.009	-0.021	-0.008	-0.008
<b>Mother employed</b>	-0.033	-0.029	-0.024	-0.024
<b>Father employed</b>	0.001	-0.022	-0.016	-0.016
<b>Urban</b>	-0.001	-0.001	-0.021	-0.022
<b>Family structure</b>				
<b>Lone parent</b>		-0.024	-0.017	-0.018
<b>Number younger siblings</b>		0.033***	0.034***	0.031***
<b>Number older siblings</b>		0.010	0.008	0.008
<b>Other family</b>		-0.008	-0.017	-0.019
<b>Family health status</b>				
<b>Mother ever hampered</b>		-0.005	-0.006	-0.007
<b>Father ever hampered</b>		0.017	0.016	0.018
<b>Own illness</b>		0.027	0.025	0.026
<b>Mother ever depressed</b>		0.016	0.010	0.011
<b>Father ever depressed</b>		0.054	0.051	0.050
<b>Some in HH at 9 affected ability to mind child</b>		0.062	0.065	0.063
<b>Family living in area at age 9</b>		0.023	0.023	0.022
<b>Frequency of contact with family at age 9</b>		-0.000	0.002	0.002
<b>Post-school pathway</b>				
<b>Not employed</b>			0.088	0.090
<b>Employed</b>			-0.059*	-0.059*
<b>Further education</b>			0.028	0.029
<b>Higher education</b>			Ref	Ref
<b>Move out of home</b>			-0.080***	-0.080***
<b>Any caregiving at 13 years</b>				0.020
<b>Any caregiving at 9 years</b>				0.007
<b>Observations</b>	3,384	3,384	3,384	3,384

Source: Growing Up in Ireland Cohort '98, Waves 1–4.

Notes: \* p&lt;0.05; \*\* p&lt;0.01; \*\*\* p&lt;0.001. HH=Household.

## 2.5 CONCLUSION

In this chapter, we explore the distribution and intensity of care among young adults in Ireland. Overall, we find that 25.5 per cent of 17 year olds and 19 per cent of 20 year olds provided care on a regular basis. These estimates of caregiving are substantially higher than previous figures for Ireland. The reason for this higher estimate is likely to be the inclusion of care provided for siblings that do not have a disability or chronic illness. However, there are other sources of variation, including age of respondents and whether the information is provided directly by the young person or by another household member.

The most common form of caregiving was care provided to younger siblings (15 per cent of young people at 17 years); however, 10 per cent were providing regular care to a parent, 12 per cent to a grandparent and 9 per cent to an older sibling. For a significant proportion of those providing care, a caregiving relationship was reported much earlier, at ages 9 and 13. Even when a wide range of individual and family characteristics are taken into account, more intensive caregiving at age 13 is significantly associated with caring in early adulthood, suggesting that these relationships often become established in early adolescence. Among those providing regular care at 20 years, 13 per cent said it took up a lot or quite a lot of their time. This means 2.5 per cent of 20 year olds are engaged in high intensity care.

Contrary to research among adults, gender does not play a very significant role in the prevalence or intensity of caregiving among young adults. Providing care to younger siblings and parents, and any care at age 20, is somewhat lower among young women than it is young men (being female reduces the probability of caregiving by between 2 and 3 percentage points). These differences were not present at 17 and therefore may reflect some differences in post-school pathways that are not captured by the broad educational/employment and living arrangement factors that we investigate. Young people from a migrant background do not differ from non-migrants at 17; however, by age 20 we find that they are more likely to be providing care overall, as well as care to a parent and to younger siblings. We also find some evidence of higher caring intensity among young migrants.

Family structure is among the factors most predictive of care involvement and intensity among young adults; more specifically, the number of younger siblings in the household. Other dimensions of family structure, such as lone parenthood, were less influential, though being in a lone-parent family influenced the intensity of care for those who were involved in caring.

Somewhat surprisingly, parental length of exposure to an illness/disability that hampered their activities was not a significant predictor of care involvement or care intensity. This is partly because of the multiple forms of care that are measured. However, the indicator that someone in the household was impaired in their ability to look after the young person when they were 9 years seemed to better capture the need for care within the household.

Family financial and social resources also play a role, but this is not consistently the case. At age 17, those in the highest income households are less likely to provide care to an older sibling or to 'others', and those with mothers with higher educational levels (an indicator of social class) are less likely to participate in most forms of caregiving. This suggests that, controlling for health status of its members and household structure, families are better able to substitute formal care for informal care where there are more resources. Family income and maternal education are not associated with caregiving at age 20. Furthermore, income and maternal education were not associated with entries and exits from caring; neither did they influence intensity of care at age 20. However, paternal employment was associated with higher exits from caring between ages 17 and 20.

Where there are family members living nearby, young people are more likely to exit caring between ages 17 and 20. However, the social support indicators were generally not significant; this may arise because they are measured at Wave 1 (9 years) and not at later waves. In the next chapter, we will investigate whether such supports moderate the effect of caring on young people's wellbeing and other outcomes, even if they do not strongly predict involvement or intensity of caring.

Caregiving among young adults declines somewhat between ages 17 and 20. We find that exits from caring are not strongly related to the factors we test, including personal and family characteristics and post-school pathways. Those caring for a parent have a higher probability of exiting this role by age 20. This does not seem to be driven by the post-school pathway. Surprisingly, those who do not continue their education and are unemployed, or who are 'NEET' (not in employment, education, or training), are most likely to stop caregiving. This group is relatively small and may include those who have health problems themselves, those with children or those taking time to travel or pursue other interests. In the next chapter, we will further explore the relationship between caring and post-school pathways by examining the role of caregiving at age 17 on subsequent pathways.

Overall, the finding that many of the factors analysed do not have a significant influence on the probability of being a young adult carer, or on the intensity of care provided, suggests that this population is heterogenous and therefore difficult to target in policy terms.

## CHAPTER 3

### Outcomes among young carers in Ireland

#### 3.1 INTRODUCTION

This chapter examines the relationship between engagement in informal care among young adults and other aspects of their lives. The analyses focus on three main domains: physical health and wellbeing, educational outcomes and family relationships. Previous research on caregiving has indicated that wellbeing may be poorer among carers (see Chapter 1), so wellbeing is measured in terms of both positive and negative aspects, namely: life satisfaction and being over the threshold on the Center for Epidemiologic Studies Depression Scale (CES-D). Caregiving, especially more intensive involvement, might be expected to result in young adults neglecting exercise and/or eating more convenient, less healthy food. Therefore, physical health is measured in terms of overweight/obesity and self-reported health quality. Educational qualifications are strongly predictive of future life chances in Ireland. Outcomes are therefore assessed by looking at Leaving Certificate performance,<sup>22</sup> rates of progression to higher education and, often related to post-school pathway, whether the young adult has moved out of the parental home. Finally, as caregiving may cause tensions within the family, the quality of family relationships is examined based on reports by both the young adult and their mother.

For each outcome, the analyses look separately at the relationship with different dimensions of caregiving, including involvement in any informal care, the type and number of care recipients, and the intensity of that care (at age 20) (see Chapter 1). The models then include measures of parental illness: whether the mother and/or father had experienced depression at any wave of the survey and whether they reported being hampered by an illness/disability at any wave. The models also control for a range of individual and background factors and, at age 20, take account of the related outcome measured at age 17. This approach allows us to ensure that the relationship between the outcome and caregiving is not due to the profile of carers and to separate out the effects of caregiving from those of parental illness, a distinction that has been neglected in previous research.

#### 3.2 CAREGIVING AND WELLBEING

This section looks at the relationship between involvement in caregiving and wellbeing at ages 17 and 20. Table 3.1 presents the models examining the relationship between caregiving and life satisfaction at age 17. Because life

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22 The prevalence of early school leaving among carers was not examined because of the small numbers involved.

satisfaction tends to skew towards positive responses, a Poisson regression model is used. The coefficients are presented as average marginal effects, which can be interpreted as the percentage difference in the outcome made by the explanatory variable. There is no significant difference in life satisfaction between those involved in any caregiving at 17 and those not involved, even after taking account of a range of background factors (compare Models 3a and 3b). Furthermore, the number of different types of care recipients is not significantly related to life satisfaction (Model 2). However, slightly higher life satisfaction (a difference of four percentage points) is found among those who are engaged in care for their younger siblings (Model 3). Maternal depression is associated with lower life satisfaction, but there are no significant effects of paternal depression or parents being hampered by illness.

**TABLE 3.1 POISSON REGRESSION MODEL OF LIFE SATISFACTION AND CAREGIVING AT AGE 17 (AVERAGE MARGINAL EFFECTS)**

	Model 1 Type of recipient	Model 2 Number of recipients	Model 3a Any caregiving	Model 3b Caregiving and parental illness
<b>Care recipient:</b>				
Grandparent/elderly relative	-0.019			
Parent	0.030			
Younger sibling(s)	0.042*			
Older sibling(s)	-0.024			
Other	-0.027			
<b>Total no. of groups of care recipients:</b>				
1		0.013		
2		0.025		
3		0.027		
4		0.021		
5		-0.044		
(Ref.: None)				
<b>Any caregiving at 17</b>			0.005	0.010
<b>Family mental health</b>				
Mother depressed at one or more waves				-0.043*
Father depressed at one or more waves				-0.024
<b>Family health hampered</b>				
Mother's health hampered at one or more waves				-0.016
Father's health hampered at one or more waves				-0.002
Someone in household affected ability to look after child (age 9)				-0.060
<b>N</b>		4,404		

Source: Growing Up in Ireland Cohort '98.

Notes: \*\*\* p<.001; \*\* p<.01; \* p<.05. Model 3b controls for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; frequency of contact with family (at age 9); and whether in sixth year (Leaving Certificate) at time of survey.

Turning to life satisfaction at 20, as at 17 years of age, there is no significant difference between those involved in caregiving and those not involved (Table 3.2). Similarly, there is no significant variation in life satisfaction by the number and type of care recipients or the intensity of such care involvement. However, care involvement at age 17 is associated with slightly higher life satisfaction levels at age 20 for those who are no longer involved in caregiving.<sup>23</sup> This difference persists when a range of other background factors are taken into account. As with life satisfaction at 17, wellbeing at 20 is related to maternal depression, with those whose mothers have had depression five per cent lower in their life satisfaction levels (Model 4b). The positive coefficient for mothers being hampered by

23 Additional analyses (not shown here) confirm that taking account of the dynamics of care involvement, those who were involved in care at age 17 but no longer at 20 had higher life satisfaction than those who were not involved at either timepoint.



illness/disability should be treated with caution as it is negative when maternal depression is excluded from the model. The effect of maternal depression on life satisfaction at 20 is only partly mediated through earlier life satisfaction and through the post-school pathway taken by the young adult. Thus, there is a decline in life satisfaction between 17 and 20 years for those whose mothers were depressed. Additional analyses (not shown here) explored whether the pattern of change in life satisfaction between ages 17 and 20 was related to caregiving but no such difference was found.

**TABLE 3.2 POISSON REGRESSION MODEL OF LIFE SATISFACTION AND CAREGIVING AT 20 (AVERAGE MARGINAL EFFECTS)**

	Model 1 Type of recipient	Model 2 No. of recipients	Model 3 Care intensity	Model 4a Any caring	Model 4b Caring & parental illness	Model 4c Previous LS & pathway
<b>Care recipient (at 20):</b>						
Grandparent/elderly relative	0.023					
Parent	0.044					
Younger sibling(s)	-0.009					
Older sibling(s)	-0.023					
Other	0.006					
<b>Total no. of groups of care recipients (at 20):</b>						
1		-0.029				
2		0.010				
3		0.047				
4		-0.014				
5		0.103				
(Ref.: None)						
<b>Care intensity at 20:</b>						
A lot/quite a lot			0.017			
Some time			-0.014			
Not much time			0.015			
(Ref. No care time)						
Any caregiving at 17				0.035**	0.039**	0.034*
Any caregiving at 20				-0.005	-0.002	0.005
<b>Family mental health</b>						
Mother depressed at one or more waves					-0.054***	-0.035*
Father depressed at one or more waves					-0.035	-0.032
<b>Family health hampered</b>						
Mother's health hampered at one or more waves					0.029	0.035*
Father's health hampered at one or more waves					0.010	0.008
Someone in household affected ability to look after child (age 9)					-0.043	-0.032
Life satisfaction at 17						0.044***
<b>Post-school pathway:</b>						
Higher education						0.036*
Labour market/inactivity						0.020
(Ref. Further education)						
<b>N</b>	4,332					

Source: Growing Up in Ireland Cohort '98.

Note: \*\*\* p&lt;.001; \*\* p&lt;.01; \* p&lt;.05. Models 4b and 4c control for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; and frequency of contact with family (at age 9). LS = Life satisfaction at 17.

Whether the young adult was above the CES-D depression threshold at ages 17 and 20 yields further insights into their wellbeing. Overall, there are no significant differences in depression levels at 17 between those involved in caregiving and those not (Table 3.3). However, those who are involved in caring for multiple groups of recipients have higher depression levels. Depression levels are higher among those engaged in caring for their grandparent (or other elderly relative) but no such difference is found at 20, so this finding should be treated with caution. Maternal depression is associated with higher depression rates among 17 year olds; this effect is large, with those whose mothers have depression reporting depression rates that are 38 per cent higher than others. Additional analyses (not shown here) were conducted to explore whether changes in depression levels between 13 and 17 were influenced by caregiving but no such interaction was apparent.<sup>24</sup>

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24 At 13, the somewhat different Short Moods and Feelings Questionnaire (SMFQ) was used to measure depression symptoms.

**TABLE 3.3 LOGISTIC REGRESSION MODEL OF WHETHER ABOVE DEPRESSION THRESHOLD AND CAREGIVING AT 17 (AVERAGE MARGINAL EFFECTS)**

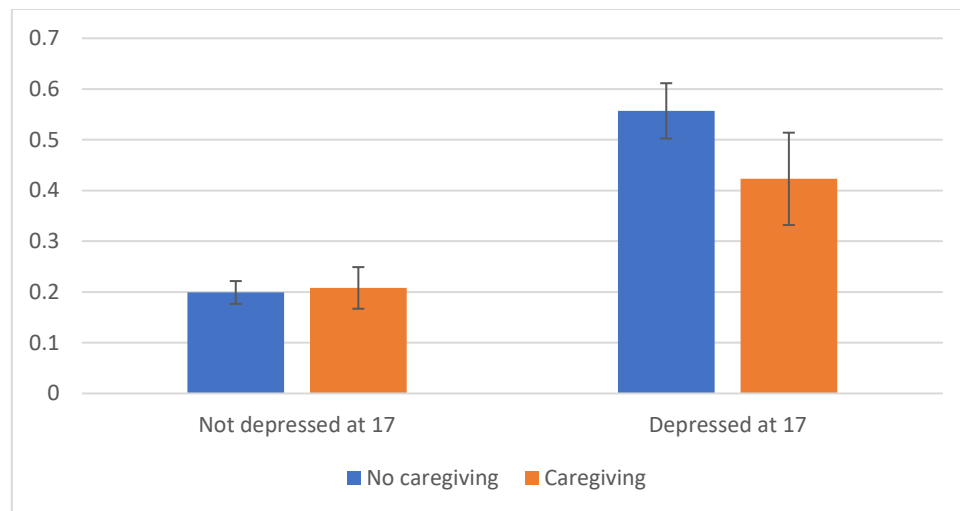
	Model 1 Type of recipient	Model 2 Number of recipients	Model 3a Any caregiving	Model 3b Caregiving and parental illness
<b>Care recipient:</b>				
Grandparent/elderly relative	0.416*			
Parent	-0.330			
Younger sibling(s)	-0.002			
Older sibling(s)	0.255			
Other	0.342			
<b>Total no. of groups of care recipients:</b>				
1		0.064		
2		0.307		
3		0.231		
4		0.201		
5		0.903*		
(Ref.: None)				
<b>Any caregiving at 17</b>			0.213	0.209
<b>Family mental health</b>				
Mother depressed at one or more waves				0.380**
Father depressed at one or more waves				0.216
<b>Family health hampered</b>				
Mother's health hampered at one or more waves				0.177
Father's health hampered at one or more waves				0.128
Someone in household affected ability to look after child (age 9)				0.091
<b>N</b>		4,406		

Source: Growing Up in Ireland Cohort '98.

Note: \*\*\* p<.001; \*\* p<.01; \* p<.05. Model 3b controls for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; frequency of contact with family (at age 9); and whether in sixth year (Leaving Certificate) at time of survey.

At 20 years of age, there is no systematic variation in depression levels by overall involvement in caregiving at ages 17 and/or 20, by number or type of care recipient or by the intensity of such care (Table 3.4). Depression levels are found to be higher where parents experience depression, with a difference of 36 per cent for maternal depression and 33 per cent for paternal depression. Those who were above the depression threshold at age 17 are much more likely to experience depression at 20. However, this relationship is weaker where young adults were involved in caregiving at 17, suggesting some protective effects from informal care involvement (Figure 3.1). Depression levels are lower among those who went on to higher education after leaving school, but this relationship should not be regarded as causal; depression may have served as a barrier to higher education participation in the first instance.

**FIGURE 3.1 PREDICTED DEPRESSION STATUS AT 20 BY CAREGIVING AND DEPRESSION STATUS AT 17**



*Source:* Growing Up in Ireland Cohort '98.

*Note:* The difference between no caregiving and caregiving among those depressed at age 17 is significant at the  $p < .05$  level.

**TABLE 3.4 LOGISTIC REGRESSION MODEL OF CAREGIVING AND WHETHER ABOVE DEPRESSION THRESHOLD AT 20 (AVERAGE MARGINAL EFFECTS)**

	Model 1 Type of recipient	Model 2 No. of recipients	Model 3 Care intensity	Model 4a Any caring	Model 4b Caring & parental illness	Model 4c Previous depression & pathway
<b>Care recipient (at 20):</b>						
Grandparent/elderly relative	-0.284					
Parent	0.083					
Younger sibling(s)	-0.007					
Older sibling(s)	-0.015					
Other	0.237					
<b>Total no. of groups of care recipients (at 20):</b>						
1		0.116				
2		-0.635**				
3		0.184				
4		0.105				
5		-0.117				
(Ref.: None)						
<b>Care intensity at 20:</b>						
A lot/quite a lot			0.512			
Some time			0.173			
Not much time			-0.350			
(Ref. No care time)						
Any caregiving at 17				0.012	0.011	-0.105
Any caregiving at 20				-0.046	-0.041	-0.041
<b>Family mental health</b>						
Mother depressed at one or more waves					0.443***	0.362**
Father depressed at one or more waves					0.343*	0.330*
<b>Family health</b>						
Mother's health hampered at one or more waves					0.038	-0.007
Father's health hampered at one or more waves					0.115	0.127
Someone in household affected ability to look after child (age 9)					0.422	0.432
Depressed at 17						1.460***
<b>Post-school pathway:</b>						
Higher education						-0.559***
LM/inactivity						-0.367
(Ref. Further ed.)						
<b>N</b>				4,328		

Source: Growing Up in Ireland Cohort '98.

Notes: \*\*\* p<.001; \*\* p<.01; \* p<.05. Models 4b and 4c control for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; and frequency of contact with family (at age 9). LM = Labour market.

### 3.3 CAREGIVING AND PHYSICAL HEALTH OUTCOMES

This section looks at young adults' weight status, distinguishing both the overweight/obese and the obese groups, and self-reported health status (with categories ranging from 'excellent' to 'poor').

Table 3.5 looks at the relationship between caregiving and weight status at age 20. The analyses show that those involved in caregiving at 20 are more likely to be overweight or obese and that this is particularly marked for those involved in more intensive care. However, the picture changes when we take account of family illness and prior weight status. When these factors are taken into account, caregiving, even more intensive involvement, is no longer significantly related to weight status at 20. There is little relationship between parental illness and the young adult's weight status.

The analyses were repeated contrasting the smaller group deemed obese with all others (see Table A3.1 in the appendix). Obesity rates are found to be higher among those involved in caregiving at 20 than among those not involved, but this is due to higher prior obesity rates among the same group. However, those involved in more intense caregiving are significantly more likely to be obese and this difference is evident even when prior obesity is taken into account. Caregivers who have a lot or quite a lot of involvement are 18 percentage points more likely to be obese than those not involved in informal care. Those whose mothers were depressed are more likely to be obese, a pattern that is related to higher rates of prior obesity.

**TABLE 3.5 LOGISTIC REGRESSION MODEL OF CAREGIVING AND WHETHER OVERWEIGHT OR OBESE AT 20 (AVERAGE MARGINAL EFFECTS)**

	Model 1 Type of recipient	Model 2 No. of recipients	Model 3 Care intensity	Model 4a Any caring	Model 4b Caring & parental illness	Model 4c Previous obesity & pathway
<b>Care recipient (at 20):</b>						
Grandparent/elderly relative	0.226					
Parent	-0.134					
Younger sibling(s)	0.324					
Older sibling(s)	-0.040					
Other	-0.091					
<b>Total no. of groups of care recipients (at 20):</b>						
1		0.208				
2		0.202				
3		0.308				
4		0.323				
5		0.244				
(Ref.: None)						
<b>Care intensity at 20:</b>						
A lot/quite a lot			0.819**			
Some time			0.263			
Not much time			0.126			
(Ref. No care time)						
Any caregiving at 17				-0.120	-0.084	0.061
Any caregiving at 20				0.249*	0.234	-0.005
<b>Family mental health</b>						
Mother depressed at one or more waves					0.066	-0.144
Father depressed at one or more waves					-0.037	0.036
<b>Family health</b>						
Mother's health hampered at one or more waves					0.197	0.300
Father's health hampered at one or more waves					0.177	0.216
Someone in household affected ability to look after child (age 9)					0.300	0.199
<b>Overweight/obese at 17</b>						3.376***
<b>Post-school pathway</b>						
Higher education						-0.323
Labour market/ inactivity						-0.709**
(Ref. Further education)						
<b>N</b>	4,123					

Source: Growing Up in Ireland Cohort '98.

Notes: \*\*\* p&lt;.001; \*\* p&lt;.01; \* p&lt;.05. Models 4b and 4c control for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; and frequency of contact with family (at age 9).



Table 3.6 shows the relationship between caregiving and self-reported health status at age 20, before including any other factors. There is little systematic variation between caregivers and others, though there is a tendency for those involved in more intensive caregiving to be more likely to report their health as poor. However, this effect is no longer significant when background factors and prior health status are taken into account (analyses not shown here). There is no significant relationship between the young person's own health and the physical or mental health of their parents.

**TABLE 3.6      MULTINOMIAL LOGISTIC REGRESSION MODEL OF CAREGIVING AND SELF-REPORTED HEALTH STATUS AT 20 (BASE CATEGORY: VERY GOOD HEALTH)**

	Excellent	Good	Fair	Poor
<b>Any caregiving at 17</b>	0.058	-0.078	-0.273	-0.086
<b>Any caregiving at 20</b>	-0.190	0.243	-0.265	0.404
<b>Care intensity at 20:</b>				
<b>A lot/quite a lot</b>	-0.162	0.759*	0.960	2.275*
<b>Some time</b>	-0.435*	0.215	-0.680	0.246
<b>Not much time</b>	-0.053	0.033	-0.644	0.596
<b>(Ref. No care time)</b>				
<b>N</b>	4,335			

Source: *Growing Up in Ireland Cohort '98.*

Note: \*\*\* p<.001; \*\* p<.01; \* p<.05.

### 3.4 CAREGIVING AND EDUCATIONAL OUTCOMES

This section looks at whether caregiving responsibilities are associated with: educational outcomes, namely, performance in the Leaving Certificate; whether the young adult went on to higher education; and the extent to which choice of educational institution was potentially constrained by wanting to remain living in the parental home or being well-connected to it by public transport. It also examines patterns of leaving the parental home, which are often closely related to higher education participation.

Table 3.7 looks at the relationship between caregiving and Leaving Certificate performance. Because Leaving Certificate points are recoded into categories in the data available to researchers, an ordinal logistic regression model is used. The coefficients are expressed in terms of odds ratios, with values greater than one indicating a factor is associated with higher grades and values less than one reflecting an association with lower grades. Providing any care at age 17 is significantly related to lower Leaving Certificate grades. Breaking this down by type of care recipient, significantly lower grades are found among those caring for grandparents, older siblings and others (compared with non-carers). Grades decline with the number of different groups of recipients being cared for. Maternal depression is also associated with lower grades. Looking at whether the effect of

care varies by prior achievement, we find that care is associated with lower grades only among those with higher levels of prior achievement.

**TABLE 3.7 ORDINAL LOGISTIC REGRESSION MODEL OF LEAVING CERTIFICATE POINTS AND CAREGIVING (ODDS RATIOS)**

	Model 1 Type of recipient	Model 2 Number of recipients	Model 3a Any caregiving	Model 3b Caregiving and parental illness	Model 1 and Junior Certificate grades
<i>Care recipient:</i>					
Grandparent/elderly relative	0.601***				
Parent	0.966				
Younger sibling(s)	0.927				
Older sibling(s)	0.599**				
Other	0.530***				
<i>Total no. of groups of care recipients:</i>					
1		0.644***			
2		0.678*			
3		0.391***			
4		0.269***			
5		0.164***			
(Ref.: None)					
Any caregiving at 17			0.485***	0.536***	0.753**
<i>Family mental health</i>					
Mother depressed at one or more waves				0.728**	0.898
Father depressed at one or more waves				0.808	0.746
<i>Family health</i>					
Mother's health hampered at one or more waves				0.875	0.908
Father's health hampered at one or more waves				0.905	1.047
Someone in household affected ability to look after child (age 9)				0.862	0.804
Junior Certificate grade point average					4.522***
N			4,409		

Source: Growing Up in Ireland Cohort '98.

Notes: \*\*\* p<.001; \*\* p<.01; \* p<.05. Model 3b controls for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; frequency of contact with family (at age 9); and whether in sixth year (Leaving Certificate) at time of survey.

Young adults providing care at age 17 were much less likely than their peers to go on to higher education, with around half of the transition rate of others (Table 3.8). Breaking this down by type of recipient, only those providing care to others (not parents, siblings or grandparents) have significantly lower rates of progression. Providing care to a wider group of care recipients is further linked to lower transition rates. Progression to higher education is not significantly related to parental illness. The difference in progression rates between caregivers and others

is explained by lower Leaving Certificate grades among the former group (compare Models 3b and 3c). Additional analyses were conducted (not shown here) to explore whether the effect of caregiving on higher education entry was stronger for some social groups. No difference in the effect was found by gender, maternal education, income, family structure or urban/rural location.

**TABLE 3.8** LOGISTIC REGRESSION OF WHETHER WENT ON TO HIGHER EDUCATION BY AGE 20 AND CAREGIVING (AVERAGE MARGINAL EFFECTS)

	Model 1 Type of recipient	Model 2 No. of recipients	Model 3a Any caring	Model 3b Any caring and parental illness	Model 3c and Leaving Certificate points
<b>Care recipient (at 17):</b>					
Grandparent/elderly relative	-0.349				
Parent	0.076				
Younger sibling(s)	0.046				
Older sibling(s)	-0.159				
Other	-0.916***				
<b>Total no. of groups of care recipients (at 17):</b>					
1		-0.193			
2		-0.363			
3		-0.685**			
4		-0.489			
5		-1.365***			
(Ref.: None)					
<b>Any caregiving at 17</b>			-0.496***	-0.329*	0.014
<b>Family mental health</b>					
Mother depressed at one or more waves				-0.246	-0.069
Father depressed at one or more waves				0.080	0.329
<b>Family health</b>					
Mother's health hampered at one or more waves				-0.170	-0.087
Father's health hampered at one or more waves				-0.109	-0.189
Someone in household affected ability to look after child (age 9)				0.141	0.352
<b>Leaving Certificate points:</b>					
2					-0.208
3					1.308***
4					2.569***
5					3.643***
6					3.911***
<b>N</b>			4,409		

Source: Growing Up in Ireland Cohort '98.

Notes: \*\*\* p<.001; \*\* p<.01; \* p<.05. Models 4b and 4c control for: gender; household income; maternal education, family structure and composition; having other family living locally; maternal and paternal employment status; and frequency of contact with family (at age 9). Leaving Certificate points are grouped into six categories on the dataset.

At age 20, the young adults were asked to rate the importance of different factors in deciding which further/higher educational institution to attend. In order to

assess potential constraints from care roles,<sup>25</sup> we focus on the perceived importance of being able to live at home and of good transport links with home (Table 3.9). Those engaged in care at 17 years of age rate being able to live at home as more important, but do not differ in the rating of good transport links. Caring for a grandparent was more strongly linked to the importance of living at home; the coefficients for caring for older siblings and for others are similar in size to that for grandparents but are not statistically significant. Family illness is not systematically related to the importance of these factors, though having good transport links is more highly related among those living in households with care demands when they were nine years of age.

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25 Other constraints, especially financial, should be captured by the family background factors included in the model, but are not the focus of the current study.

**TABLE 3.9 ORDINAL LOGISTIC REGRESSION MODEL OF CAREGIVING AND RELATIVE IMPORTANCE OF BEING ABLE TO LIVE AT HOME AND OF GOOD TRANSPORT LINKS IN CHOOSING AN EDUCATIONAL INSTITUTION (ODDS RATIOS)**

	Living at home				Good transport links			
	Model 1	Model 2	Model 3	Model 4	Model 1	Model 2	Model 3	Model 4
<i>Care recipient (at 17):</i>								
Grandparent/elderly relative	1.371*				0.886			
Parent	0.880				1.102			
Younger sibling(s)	0.966				0.944			
Older sibling(s)	1.224				1.426			
Other	1.225				1.121			
<i>Total no. of groups of care recipients (at 17):</i>								
1						1.220		
2		1.076				1.152		
3		1.292				1.072		
4		1.401				1.218		
5		1.310				1.560		
(Ref.: None)		1.799						
Any caregiving at 17			1.277*	1.298*			1.212	1.210
<i>Family mental health</i>								
Mother depressed at one or more waves				1.107				1.064
Father depressed at one or more waves				1.148				0.977
<i>Family health</i>								
Mother's health hampered at one or more waves				1.088				1.080
Father's health hampered at one or more waves				1.064				1.147
Someone in household affected ability to look after child (age 9)				1.006				1.669*
N	4,117							

Source: Growing Up in Ireland Cohort '98.

Notes: \*\*\* p<.001; \*\* p<.01; \* p<.05. Model 3b controls for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; frequency of contact with family (at age 9); and whether in sixth year (Leaving Certificate) at time of survey.

**TABLE 3.10** LOGISTIC REGRESSION MODEL OF WHETHER HAD MOVED OUT OF THE PARENTAL HOME BY 20 AND CAREGIVING (AVERAGE MARGINAL EFFECTS)

	Model 1 Type of recipient	Model 2 Number of recipients	Model 3a Any caregiving	Model 3b Caregiving & parental illness	Model 3c Caregiving & post-school pathway
<b>Care recipient (at 17):</b>					
Grandparent/elderly relative	-0.176				
Parent	-0.151				
Younger sibling(s)	0.009				
Older sibling(s)	-0.236				
Other	-0.093				
<b>Total no. of groups of care recipients (at 17):</b>					
1		-0.207			
2		-0.098			
3		-0.413			
4		-0.450			
5		-0.810			
(Ref.: None)					
<b>Any caregiving at 17</b>			-0.306**	-0.402***	-0.368**
<b>Family mental health</b>					
Mother depressed at one or more waves				-0.142	-0.099
Father depressed at one or more waves				-0.047	-0.033
<b>Family health</b>					
Mother's health hampered at one or more waves				-0.081	-0.079
Father's health hampered at one or more waves				-0.064	-0.058
Someone in household affected ability to look after child (age 9)				-0.050	-0.074
<b>Post-school pathway:</b>					
Labour market/ inactivity					1.088***
Higher education					1.482***
(Ref. Further education)					
<b>N</b>	4,345				

Source: Growing Up in Ireland Cohort '98.

Notes: \*\*\* p&lt;.001; \*\* p&lt;.01; \* p&lt;.05. Model 3b controls for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; and frequency of contact with family (at age 9).

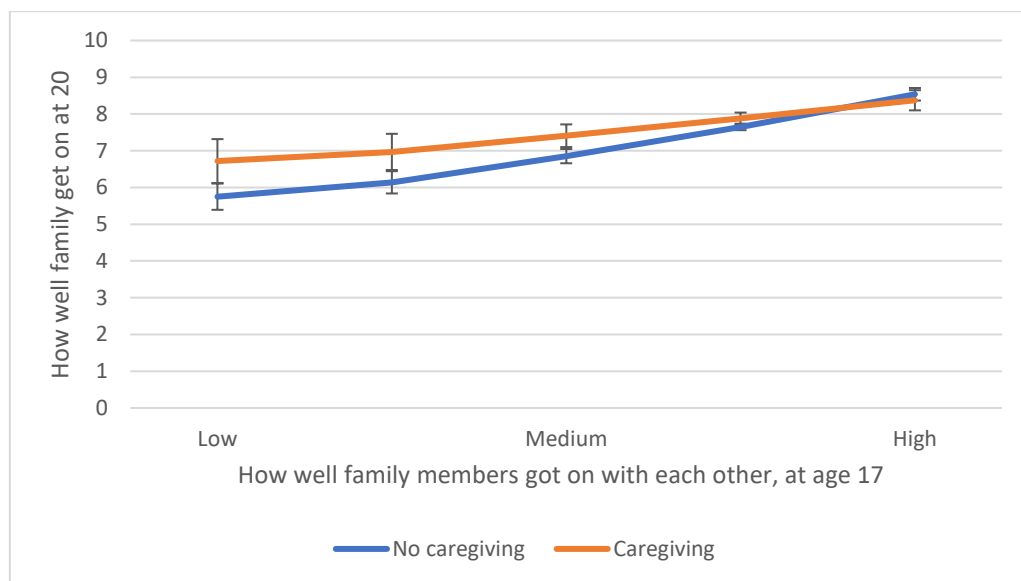
Table 3.10 shows the relationship between caregiving and whether the young adult had moved out of the parental home. Overall, those involved in caregiving at age 17 were much less likely to move out of home, though this pattern did not vary by type or number of care recipients. There was no significant relationship between family illness and moving out of home. Model 3c shows that moving out of home was more common among those who went on to higher education and those who

entered the labour market than it was among those who took part in further education. However, only a small part of the difference between caregivers and non-caregivers in leaving home was explained by the post-school pathway pursued.

### 3.5 CAREGIVING AND FAMILY RELATIONSHIPS

This section examines the quality of family relationships as reported by both young adults and their mothers. Table 3.11 examines the factors associated with how well the family gets on, as reported by the 20 year old, with higher scores indicating higher quality relationships. The findings suggest that caring for younger siblings (at age 17) and for parents (at age 20) are associated with better family relationships. However, only less intensive caring (not involving much time) has this positive effect. Being involved in caregiving at 17 but not at 20 is linked to a greater improvement in the quality of family relationships between 17 and 20 years. Maternal and paternal depression are linked to poorer quality relationships, with the effect of maternal depression being explained by how family members get on with each other at 17 years of age. There is a significant interaction between being involved in care at 17 and family relations at the same age, indicating that caregiving has a greater protective effect for those with more negative family relations at 17 (Figure 3.2). There is no significant interaction between care roles at 20 and prior family relationships.

**FIGURE 3.2 PREDICTED FAMILY RELATIONSHIP QUALITY AT 20 BY CAREGIVING AND FAMILY RELATIONSHIPS AT 17**



Source: *Growing Up in Ireland Cohort '98*.

Note: The interaction between caregiving at age 17 and how well family members got on with each other at the same timepoint is significant at the  $p < .05$  level.



**TABLE 3.11 POISSON REGRESSION MODEL OF HOW FAMILY MEMBERS ‘GET ON’ AT 20, AS REPORTED BY THE YOUNG ADULT, AND CAREGIVING (AVERAGE MARGINAL EFFECTS)**

	Model 1	Model 2	Model 3	Model 4	Model 4b	Model 4c	Model 5
<i>Care recipient (at 17):</i>							
Grandparent/elderly relative	-0.001						
Parent	0.012						
Younger sibling(s)	0.043**						
Older sibling(s)	0.001						
Other	0.010						
<i>Care recipient (at 20):</i>							
Grandparent/elderly relative		-0.002					
Parent		0.051*					
Younger sibling(s)		-0.009					
Older sibling(s)		0.030					
Other		0.008					
<i>Total no. of groups of care recipients (at 20): (Ref. 0)</i>							
1			-0.026				
2			0.000				
3			0.070*				
4			0.037				
5			0.115**				
<i>Care intensity at 20: (Ref. No care time)</i>							
A lot/quite a lot				-0.092			
Some time				0.003			
Not much time				0.035*			
Any caregiving at 17					0.022	0.023	0.027*
Any caregiving at 20					0.008	0.012	0.004
<i>Family mental health</i>							
Mother depressed at one or more waves						-0.040**	-0.023
Father depressed at one or more waves						-0.047**	-0.048**
<i>Family health</i>							
Mother’s health hampered at one or more waves						0.015	0.013
Father’s health hampered at one or more waves						0.015	0.019
Someone in household affected ability to look after child (age 9)						-0.029	-0.016
How well family gets on at 17							0.038***

Source: Growing Up in Ireland Cohort '98.

Note: \*\*\* p&lt;.001; \*\* p&lt;.01; \* p&lt;.05.

**TABLE 3.12 POISSON REGRESSION MODEL OF THE QUALITY OF THE RELATIONSHIP BETWEEN THE MOTHER AND THE YOUNG ADULT, AS REPORTED BY THE MOTHER, AND CAREGIVING (AVERAGE MARGINAL EFFECTS)**

	Model 1	Model 2	Model 3	Model 4	Model 4b	Model 4c	Model 5
<i>Care recipient (at 17):</i>							
Grandparent/elderly relative	-0.006						
Parent	0.006						
Younger sibling(s)	0.035						
Older sibling(s)	0.005						
Other	-0.051						
<i>Care recipient (at 20):</i>							
Grandparent/elderly relative		0.013					
Parent		0.016					
Younger sibling(s)		-0.026					
Older sibling(s)		0.011					
Other		0.007					
<i>Total no. groups of care recipients (at 20) (Ref.0)</i>							
1			-0.021				
2			-0.011				
3			0.051				
4			-0.025				
5			0.020				
<i>Care intensity at 20 (Ref. No care time)</i>							
A lot/quite a lot				-0.065			
Some time				-0.010			
Not much time				0.007			
Any caregiving at 17					0.002	0.014	0.013
Any caregiving at 20					-0.005	0.0004	0.003
<i>Family mental health</i>							
Mother depressed at one or more waves						-0.088***	-0.079***
Father depressed at one or more waves						-0.041	-0.041
<i>Family health</i>							
Mother's health hampered at one or more waves						-0.004	-0.005
Father's health hampered at one or more waves						-0.036	-0.028
Someone in household affected ability to look after child (age 9)						0.003	0.007
Maternal conflict at 17							-0.041***
N	3,570						

Source: Growing Up in Ireland Cohort '98.

Note: \*\*\* p&lt;.001; \*\* p&lt;.01; \* p&lt;.05.

The mothers of young adult respondents were asked to report on the quality of the relationship, from her perspective (Table 3.12). No significant variation was found by involvement in caregiving at 17 and/or 20 years of age. Mothers who experience depression reported feeling less close to their children than others. Those who reported higher levels of conflict when the young person was age 17 also reported feeling less close to them at 20, though there is no significant interaction between prior conflict and caregiving at 17 or 20.

Mothers were also asked about the frequency with which they fought with their 20-year-old children (Table 3.13). Caring for younger siblings and for others appeared to be a basis for increased mother–child conflict. However, conflict did not appear to systematically reflect the number of care recipients or the intensity of involvement. Fighting was more prevalent in cases of maternal depression and where conflict had been greater at 17 years of age. There was less fighting in cases where the father’s health was hampered by illness, but no significant effect was found in cases where the mother’s own health was hampered. Those involved in care at 20 reported a lower incidence of fighting than might be expected given their prior conflict levels, suggesting a slight protective effect from caregiving.

**TABLE 3.13      ORDINAL LOGIT MODEL OF FREQUENCY OF FIGHTING BETWEEN MOTHER AND YOUNG ADULT, AS REPORTED BY THE MOTHER, AND CAREGIVING (ODDS RATIOS)**

	Model 1	Model 2	Model 3a	Model 3b	Model 3c	Model 3d
<b>Care recipient (at 17)</b>						
Grandparent/elderly relative						
Parent						
Younger sibling(s)						
Older sibling(s)						
Other						
<b>Care recipient (at 20)</b>						
Grandparent/elderly relative	-0.040					
Parent	-0.296					
Younger sibling(s)	0.324*					
Older sibling(s)	-0.190					
Other	0.507*					
<b>No. care recipient groups (Ref. 0)</b>						
1		0.260				
2		0.429*				
3		-0.238				
4		0.292				
5		0.025				
<b>Care intensity at 20</b>						
A lot/quite a lot			0.482			
Some time			0.310*			
Not much time			0.043			
(Ref. No care time)						
Any caregiving at 17				0.025	0.037	0.028
Any caregiving at 20				0.160	0.136	0.140
<b>Family mental health</b>						
Mother depressed at one or more waves					0.450***	0.408***
Father depressed at one or more waves					0.086	0.040
<b>Family health</b>						
Mother's health hampered at one or more waves					-0.057	-0.004
Father's health hampered at one or more waves					-0.280*	-0.309*
Someone in household affected ability to look after child (age 9)					0.057	0.043
Maternal conflict at 17						0.260***
<b>N</b>						

Source: Growing Up in Ireland Cohort '98.

Notes: \*\*\* p<.001; \*\* p<.01; \* p<.05. Models 3c and 3d control for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; and frequency of contact with family (at age 9).

### 3.6 CONCLUSIONS

This chapter has looked at the relationship between young adult involvement in caregiving and: their educational outcomes: their physical and mental wellbeing; and the quality of their relationship with their family. Young adults involved in care

at 17 tend to receive lower grades in their Leaving Certificate than their peers, with a greater negative effect found for those involved in caring for multiple family members. The impact is also greater for those who had received higher grades at Junior Certificate level. Young adults with caregiving responsibilities are less likely than others to go on to higher education, largely because of their lower Leaving Certificate grades. Even among those who do go on to further/higher education, being able to live in the parental home plays a more important role in their choice of institution for caregivers than for others, potentially constraining the options open to them. Young adult carers are much less likely to have moved out of the parental home by the age of 20 than their peers, even taking account of their lower rates of participation in higher education.

There is little systematic relationship between caregiving and physical health, except for a tendency for more time spent on caring to be associated with higher rates of obesity and poorer health, even taking account of other factors. Levels of overweight are higher among carers but this is related to higher prior overweight, indicating the importance of using longitudinal rather than cross-sectional data. Neither is the relationship between caregiving and socio-emotional wellbeing clearcut; these findings are also in contrast with the findings of other studies (see, for example, Family Carers Ireland, 2023), which highlight poorer wellbeing among young carers. This may relate to comparatively low levels of care intensity among the group, with only 2 per cent of all 20 year olds reporting that they spent a lot or quite a lot of time on caregiving (see Chapter 2). Thus, many young adult carers in the population as a whole may not have sufficient involvement in caring to benefit from engaging with services for carers. Indeed, there seems to be some modest protective effects from involvement in caregiving, with higher life satisfaction and less increase in depressive symptoms at 20 among those who had been involved at 17. Further, young adults engaged in caring for younger siblings or parents report more positive relationships with their family, though caring for younger siblings does appear to be linked to more fighting between mothers and young adults.

An alternative explanation for the lack of evidence of poorer wellbeing among young adult carers is that research has not generally separated out the effects of caregiving from those of parental illness, a contribution of this study. We find relatively strong relationships between maternal depression and life satisfaction and depression status for the young adult. Parental depression is also associated with poorer quality family relationships overall, with maternal depression linked to greater mother–child conflict and lower levels of closeness.

## CHAPTER 4

### Conclusions and implications for policy

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#### 4.1 INTRODUCTION

Irish research shows that a very large proportion of adults (45 per cent of women and 29 per cent of men) are engaged in unpaid care for children and/or adults (Russell et al., 2019). The numbers looking after those with a long-term illness or disability are estimated to be lower, at 3 per cent of males and 5 per cent of females (CSO Census 2016 database). Census figures indicate that young carers (those aged 17 or under) make up around 3 per cent of all carers, with care involvement more common among older teenagers (DCYA, 2018).

Cross-sectional analyses indicate poorer mental health and wellbeing among 10–17 year olds looking after an ill or disabled relative (Family Carers Ireland, 2020), while qualitative research has indicated that challenges present for young carers in relation to balancing care responsibilities with school or work, and in relation to negative consequences in terms of stress and loneliness (Family Carers Ireland, 2023). To date, however, there has been a lack of systematic Irish evidence on the profile of young adult carers and the consequences of caregiving for other aspects of their lives, taking account of the prior characteristics of those involved in informal care. This report fills this gap by drawing on Cohort '98 data from the *Growing Up in Ireland* (GUI) study to examine care responsibilities among young adults over the crucial period of transition from second-level education to further/higher education or employment.

The main research questions are:

1. What is the profile of young adult carers, in terms of gender, social background, family size and structure, migrant status, urban/rural location, and own and parental illness/disability? To whom do they provide care and how much time do they allocate to caregiving?
2. What factors predict young people's caring at ages 17 and 20?
3. How are care responsibilities associated with young people's wellbeing outcomes, measured in terms of life satisfaction and depressive symptoms, physical health and family relationships?
4. How are care responsibilities at age 17 associated with the post-school pathway pursued at age 20 (higher education, further education and labour market entry), controlling for other factors? Does a care role constrain a young person's post-school choices, either directly through

ongoing involvement in care, or indirectly via a potential effect on academic performance?

This chapter outlines the main findings of the study and discusses the implications for policy development.

## **4.2 MAIN FINDINGS**

### **4.2.1 The prevalence of caregiving among young adults**

The GUI study collected detailed information on whether young people were involved in caring for other family members at 17 and 20 years of age. The definition of caring is not restricted to care provided to those with a long-term illness or disability, making it broader than that used in both the Census and the Health Behaviour in School-aged Children (HBSC) study.

One-quarter of 17 year olds were regularly caring for someone else, most commonly a younger sibling (15 per cent) or grandparent/other elderly relative (12 per cent). By the age of 20, the proportion involved in caregiving had fallen somewhat, to one-fifth of the cohort; again, younger siblings and grandparents were the main care recipients (11 per cent and 10 per cent respectively). Looking at the two survey waves together, over one-third (36 per cent) had some caregiving responsibility during their young adulthood, but this was largely a transitory role, with only 9 per cent of young adults providing care at both timepoints. Thus, the study findings indicate that, taking a broad definition of care, a significant proportion of young adults are involved in regular caregiving.

The study also yielded insights into the intensity of care involvement – the amount of time devoted to the role and extensiveness – and the number of types of care recipients. Over half of young adults involved in care were looking after more than one type of recipient (for example, a grandparent and a younger sibling). Only a minority reported very time-intensive care responsibilities: 13 per cent of carers at age 20 reported that caring took up a lot or quite a lot of their time, with 49 per cent indicating it did not take very much of their time. Caregiving for parents, grandparents and others was more likely to be time intensive than care for siblings.

### **4.2.2 The profile of young adult carers**

The most striking finding relates to the heterogeneity of the young adult carer group, with only modest levels of systematic variation by individual and family background factors. The strongest driver of caregiving is the number of younger siblings in the household and, at age 20, having more siblings is also associated with caring for other groups (such as grandparents). Contrary to findings on adult carers in general (see, for example, Russell et al., 2019), there is little evidence of

a greater care burden for young women than for men. In fact, male rates of involvement are somewhat higher than female rates at age 20, which is in keeping with HBSC patterns among 10–17 year olds (Gavin et al., 2020). No difference is found by family structure, with similar rates of caregiving among young adults from lone-parent and two-parent households. There is some variation by family resources, with greater resources appearing to reduce the prevalence of caregiving. Young people from more highly educated families are less likely to be involved in caregiving at 17, most likely reflecting educational ambitions on the part of the young adult and their parents. At age 20, neither household income nor maternal education are associated with caregiving. However paternal employment, also an indicator of broader resources, is linked to less care involvement at 20 and also to less intensive levels of involvement. Having another family member living in the household (other than children and parents) reduces involvement in both parental care and more intensive (non-babysitting) care for younger siblings, reflecting the availability of additional support for caregiving within the family. Migrant families are less likely to have local family members to draw on for care support and there may be language or cultural barriers to accessing services (Sprong and Skopek, 2023). This is reflected in migrant-origin young people being more likely to care for their parents and/or younger siblings at age 20 and to spend more of their time on care responsibilities. This pattern is not evident at age 17 when these young people were (largely) still at school and may reflect educational expectations among migrant parents.

It was hypothesised that caregiving involvement would increase in response to parental illness or disability. The pattern found was not clearcut, perhaps because of the focus on care more generally rather than care specifically for those with illnesses. Maternal depression is associated with greater involvement in parental care and care of others (at 17 years), while paternal depression is linked to caring for younger siblings (at 20 years). However, parental illness or disability had no systematic relationship with caregiving overall.

A new finding related to the relationship between early involvement in care and later caregiving. Those who reported being frequently involved in caring for an older or sick relative when they were 13 years of age were more likely to provide care to grandparents at ages 17 and 20. Similarly, caring for younger siblings at age 13 was predictive of later sibling care. It thus appears that at least some young people become involved in care responsibilities at a young age and maintain this involvement into early adulthood.

#### **4.2.3 Outcomes among young carers**

This study has examined the relationship between caregiving and a range of outcomes among young adults, including their education and post-school



pathways, their physical and emotional wellbeing, and their relationships with their family. Young people involved in caregiving at the age of 17 tend to receive lower Leaving Certificate grades than others, especially if they are involved in caring for multiple types of care recipient. As a result, they are less likely than others to go on to higher education, the dominant post-school pathway among this cohort of young adults. When they go on to further/higher education, they potentially constrain their choices, placing more emphasis on being able to live at home in their decision making, and are more likely to be living in the parental home at age 20.

The consequences of caregiving for physical and mental health are less clearcut than those for educational outcomes. There is tentative evidence of higher rates of obesity and poorer health among those involved in more intensive caregiving. However, there appear to be some modest protective effects for socio-emotional wellbeing, with higher life satisfaction and less increase in depressive symptoms at age 20 among those who had been involved in caregiving at 17. In fact, maternal and, to some extent, paternal depression emerge as stronger drivers of poorer wellbeing than caregiving per se, being associated with lower life satisfaction, higher depression rates and poorer quality family relationships. Caring for younger siblings or parents appears to increase bonding and enhance the quality of family relationships. At the same time, however, more fighting between mothers and young adults appears to be linked to (the young person being expected to) care for younger siblings.

### **4.3 IMPLICATIONS FOR POLICY**

The study indicates that a significant proportion of young adults are involved in family caregiving, but that they comprise a heterogeneous group, reflecting the broad definition of care adopted in the GUI study. For most young people, caregiving is not highly time intensive and is transitory in nature. However, there is evidence that some young people become involved in caregiving for grandparents and siblings at a young age and that these responsibilities persist over time. In some respects, the findings echo previous research (Privalko et al., 2019; Russell et al., 2019; Sprong and Skopek, 2023) in highlighting the importance of informal care for families with low levels of resources and smaller family networks. However, the heterogeneity of young carers poses challenges for identifying and targeting welfare supports to this group on the basis of traditional metrics such as family income or parental receipt of illness/disability payments. The involvement of some in caregiving from a very young age poses particular challenges in terms of providing supports to this group. Nonetheless, the ongoing rollout of subsidised supports for early childhood care and education and the Sláintecare proposals around a statutory home care scheme would likely be of some benefit to young carers, as well as parents and care recipients.

The study provides new insights into the effects of caregiving on outcomes for young adults, taking into account their prior characteristics. The strongest effects are found for educational outcomes, with lower Leaving Certificate grades and less progression to higher education among those involved in caregiving. This disparity is important; given the very high returns to third-level qualifications in the Irish context, caregiving is therefore likely to have a long-term effect on adult life chances. There appear to be no available educational supports in Ireland for young people involved in caregiving, though there has been a lack of research on practice at the school level. Practice elsewhere has pointed to the importance of providing information to school principals and teachers to help promote awareness of the needs of young carers, to provide a supportive environment for them and to work more closely with their families (NSW Department of Education, 2020). The School Completion Programme (SCP) targets students at risk of school disengagement in Ireland. One of the criteria for targeting refers to ‘family circumstances’, but it is not clear if this is taken to include young carers; there would be benefits in specifically naming young carers in the criteria in order to help them access the necessary learning and socio-emotional supports through the programme. The fact that the SCP spans both primary and second-level education is an advantage given the findings regarding a potentially negative educational trajectory for those involved in caregiving from a young age. In addition, Home School Community Liaison Coordinators (HSCL) provide an important conduit between the school and families, offering the potential to identify young carers in need of support. At the same time, SCP and HSCL involvement is (largely) limited to DEIS schools (Delivering Equality of Opportunity in Schools) serving more socio-economically disadvantaged populations. Given the heterogeneity of the caregiver group, there is scope to promote awareness and develop supports across all schools, regardless of their socio-economic composition.

Family Carers Ireland (2023) mention the importance of higher education access programmes for young carers. The Higher Education Access Route programme uses criteria such as low income and welfare receipt, which are likely to identify at least some young carers, particularly in families with persistent parental illness/disability. However, there could be benefits to examining ways in which caregivers could be explicitly recognised as a group whose progression chances have been affected by their family circumstances.

The detailed nature of GUI data means that we can disentangle, at least partially, the impact of parental illness and involvement in caregiving. The heterogeneous nature of the young carer group means that the consequences for their wellbeing are nuanced. It is not a wholly negative picture: caregiving reflects love and reciprocity among family members. It further enhances family bonding and has some positive effects in terms of later wellbeing. However, parental (especially maternal) depression is associated with poorer outcomes for young adults in terms

of lower life satisfaction, higher depression rates, lower Leaving Certificate grades and poorer mother–child relationships. The National Carers Strategy (2019) emphasises the importance of supporting carers to manage their physical and mental health and wellbeing, with a specific objective to protect children and young people ‘from adverse impacts of caring’. Family Carers Ireland (2023) also argues for the need for psychological and counselling supports for young carers. The study findings highlight the young adult children of parents with depression as an important target group for support, whether they explicitly identify themselves as being involved in caregiving or not. International research has pointed to the potential protective effects of family-based interventions for the children of parents with mental health difficulties (Siegenthaler et al., 2012; Thanhauser et al., 2017). Research in Ireland highlights considerable potential to expand access to family-focused mental health services (McGilloway et al., 2022).

Considerable variation is found, across countries, in policies on the identification and support for young carers (Leu and Becker, 2017; Leu et al., 2022). A cross-national analysis identified the UK situation as ‘advanced’ from this perspective, with a legislative commitment for local authorities to identify, assess and, where necessary, support young carers (those under 18 years) in terms of their mental health and wellbeing. Ireland (on the basis of data from 2017 and 2021) was characterised as ‘emerging’, with growing awareness and recognition of the situation of young carers but few specific supports in place for them (Leu and Becker, 2017; Leu et al., 2022). This analysis points to the role of specific legal rights, extensive guidance for professionals and a strong research base in moving systems from ‘emerging’ to ‘advanced’ in supporting young carers (Leu and Becker, 2017). Current supports are largely channelled through Family Carers Ireland, whose work involves information provision, advocacy, counselling supports and guidelines for schools. However, there is a lack of research to date on the extent to which young carers are accessing such supports and schools are adopting these guidelines. There appears to be considerable scope to put in place more supports for young carers, recognising the spectrum from those providing highly intensive involvement in caring for parents or family members with illness or depression to those for whom caregiving is a transitory but life-enhancing experience.

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## APPENDIX 1

### Additional tables

TABLE A2.1 ORDERED LOGIT MODEL OF CARE INTENSITY AT AGE 20: CAREGIVERS ONLY

	Coefficient
Female	0.551**
Migrant status	-1.032
Bottom income quintile	0
2nd	-0.062
3rd	-0.382
4th	-0.531
5th /top income quintile	-0.366
Mother Lower secondary education (ref)	0
Upper secondary	0.951**
Post-secondary	0.638*
Degree	0.52
Mother employed	0.008
Father employed	0.156
Urban	0.108
Lone-parent family	0.446
N. younger siblings	-0.115
N. older siblings	-0.383**
Other family in HH	0.102
Mother ever hampered	-0.279
Father ever hampered	0.644*
Mother ever depressed	0.351
Father ever depressed	-0.323
Own illness	0.367
Some in HH at 9 affected ability to look after child	0.293
Family living in area at age 9	-0.246
Frequency of contact with family at age 9	0.069
<i>Post-school pathway (ref: Higher education)</i>	
Inactive/unemployed	-0.677
Employed	0.696
Further education	0.13
Moved out of family home	-0.564*
Cares for grandparent	0.056
Cares for younger sibling	0.06
Cares for older sibling	0.304
Cares for parent	-0.288
Cares for other	0.273
Observations	755

Note: Model also controls for care provision at age 9 and at age 13, which are insignificant. \*\*\* p<.001; \*\* p<.01; \* p<.05.

**TABLE A3.1 LOGISTIC REGRESSION MODEL OF CAREGIVING AND WHETHER OBESE AT 20 (AVERAGE MARGINAL EFFECTS)**

	Any caregiving		Care intensity	
	Model 1a	Model 1b	Model 2a	Model 2b
Any caregiving at 17	-0.009	-0.012		
Any caregiving at 20	0.042*	0.022		
<b>Care intensity at 20</b>				
A lot/quite a lot			0.197**	0.182*
Some time			0.037	-0.001
Not much time			0.032	0.025
(Ref. No care time)				
<b>Family mental health</b>				
Mother depressed at one or more waves		0.019		0.018
Father depressed at one or more waves		-0.001		0.007
<b>Family health</b>				
Mother's health hampered at one or more waves		0.014		0.014
Father's health hampered at one or more waves		-0.008		-0.017
Someone in household affected ability to look after child (age 9)		-0.034		-0.005
<b>Obese at 17</b>		0.289***		0.292***

Source: Growing Up in Ireland Cohort '98.

Notes: \*\*\* p<.001; \*\* p<.01; \* p<.05. Models 1b and 2b control for: gender; household income; maternal education; family structure and composition; having other family living locally; maternal and paternal employment status; frequency of contact with family (at age 9); and post-school pathway.

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