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RESEARCH PAPER

Happiness and Well-Being of Young Carers: Extent, Nature and Correlates of Caring Among 10 and 11 Year Old School Children

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Abstract Young carers often take on practical and/or emotional caring responsibilities that would normally be expected of an adult. For many of these children and young people, caring has been shown to have a detrimental effect on their lives. For example, caring at a young age appears to be associated with poor health and well-being, bullying and poorer educational outcomes. However, previous research has tended to be retrospective, carried out using small surveys of secondary school-aged children or to use qualitative methods with young people associated with caring projects. In contrast, little is known about the extent and nature of caring undertaken by younger children. This paper reports findings from a random sample survey of 10 and 11 year old children in the final year of their primary school education. 4,192 children completed the Kids' Life and Times (KLT) online survey in 2011. Twelve percent of respondents to KLT said they helped look after someone in their household who was sick, elderly or disabled. Supporting previous qualitative research, this survey showed that children who were carers had poorer health and well-being, reported less happiness with their lives, were more likely to be bullied at school and had poorer educational aspirations and outcomes than their peers who were not carers. These findings suggest that teachers need to discuss the issue of caring with children in the classroom in a general and supportive way so that young carers feel able to confide in them and seek support if they need it.

Keywords Well-being · Happiness · Caring · Children · Bullying · Educational achievement

1 Introduction

Carers provide unpaid care by looking after ill, frail or disabled family members, friends or partners. They can be adults supporting other adults, parents caring for ill or disabled children or young people caring for another family member (Ferguson and

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Devine 2011). Young carers often take on practical and/or emotional caring responsibilities that would normally be expected of an adult. The tasks undertaken can vary according to the nature of the illness or disability, the level and frequency of need for care and the structure of the family as a whole. For many of these children and young people, caring takes up many hours per week, which may have a detrimental effect on their lives (Devine and Lloyd 2008). According to Sahoo and Suar (2010) children who are carers can experience negative feelings such as insecurity, distrust and worry; however, they also reported that caring teaches children positive values including nurturance, endurance and sympathy. Becker (2007) notes that while there 'may be some 'positives' associated with caring—such as enhanced coping mechanisms, the development of life, social and other skills, maturity, a sense of purpose and closer attachments' (p. 25), many children who take on regular or substantial caring responsibilities experience 'significant restrictions in their development, participation and opportunities, and educational attainment' (p. 25).

Much of the research into caring among children and young people tends to use samples of carers identified through carer projects and to use qualitative methods such as focus groups and in-depth interviews which provide rich data about the lives of these young people. For example, Becker and Becker (2008) carried out a wide-ranging study into the caring responsibilities of people aged between 16 and 24 years living in England, Scotland and Wales, conducting in-depth interviews, focus groups and a survey of young carers identified as part of carer projects. They also examined the extent of caring among this age group using data from the 2001 Census. Other studies have also used samples of children and young people recruited through carer projects (e.g. Dearden and Becker 2004; Earley et al. 2007; Sahoo and Suar 2010). Much rarer are large-scale random sample surveys of children and young people that measure the extent of caring among this population. While the 2001 Census suggested that around 2% of those aged between 5 and 17 years had caring responsibilities (Becker 2008), one of the main drawbacks with this data source in relation to young carers is that it is not always clear whether the children themselves (especially those in the younger age groups) answer the questions on caring or if an adult answers the questions on their behalf. Therefore, the figure from the Census is very likely to underestimate the true extent of caring among children. The Census has a further drawback as a source of caring data which is that there is limited information on the correlates of caring among these children, many of whom are carrying out tasks usually expected of adults.

There have been some attempts recently to assess the extent of caring among young people of secondary school age. For example, a survey of 4,029 children and young people from 10 secondary schools, carried out by the University of Nottingham on behalf of the BBC (2010), suggested that 8% had caring responsibilities while 10% of 16 year olds responding to the 2010 Young Life and Times (YLT) survey in Northern Ireland said they were carers. Warren (2005, 2007) randomly selected a group of 378 children and young people (the majority aged between 11 and 15 years) from targeted areas such as close to youth clubs and schools within a specific locality and compared their perceptions of what they do to help at home with 15 young people who were known carers. She reported that within her general population group around 10% had considerable caring responsibilities, comparable to and even exceeding those carried out by the known carers in her study.

This paper uses data from a large-scale survey of Primary 7 (P7)-aged children (10 and 11 year olds), Kids' Life and Times (KLT), to look at the extent of caring responsibilities experienced by this age group and at the relationship between caring, educational experiences and academic performance, and children's happiness, health and well-being.

1.1 Caring and Health, Happiness and Quality of Life

The stresses of caring have been found to have a detrimental effect on the health and well-being of both older and younger carers. For example, evidence from surveys with adult carers suggests that, for many, caring is related to poorer general health (Ferguson and Devine 2011) and poorer mental health (Evason 2004). Similar findings have been reported for young carers; Becker and Becker (2008) stated that 'the majority of our sample of 18–24 year old carers identified that caring had an effect on their own health and that they experienced negative health outcomes directly related to caring' (p. 28). Earley et al. (2007), in their focus group research with 17 young carers aged between 10 and 16 years, also found that caring had deleterious effects on health. Participants in the 2007 YLT survey who said they were carers had poorer mental health scores (measured using the General Health Questionnaire (GHQ12) than their counterparts who did not have caring responsibilities, although the difference was not statistically significant. A retrospective study of 66 former young carers carried out by the Children's Society and the Open University School of Health and Social Welfare (BBC 1999) found that 70% of former young carers suffered long-term psychological effects, 40% had mental health problems while 28% said they suffered physical health problems directly related to their caring role. Of the 61 young carers aged between 5 and 16 years (75% of whom were aged between 10 and 15 years) who took part in a survey carried out by Cree (2003) around 60% reported difficulties with sleeping while 34% said they had self-harmed and 36% had thought about suicide. Clearly, then, caring at a young age appears to have detrimental effects on health and well-being although the drawback with previous research is that it either relates to adults and young people, is retrospective or is confined to groups of young carers who are recruited through carer groups. Little is known about the health and well-being of carers in a more general population of younger children and this paper seeks to examine whether there is a relationship between caring and these variables among this cohort of P7s.

1.2 Caring, School Experiences and Educational Achievement

Previous research which has examined the educational experiences of young carers has suggested that many worried about their schoolwork (Dearden and Becker 2000) and found school an unhappy place because they were bullied (Becker and Becker 2008). Retrospective data gathered from adults who had been young carers suggests that as many as 71% had been bullied physically, verbally or emotionally at school (Bibby and Becker 2000). While bullying at school may not necessarily be directly related to caring, some of the young carers in the Becker and Becker study who were aged 16 and 17 years said they had been bullied 'specifically for being a carer' (2008, p. 30). Young carers aged 10–16 years taking part in focus groups organised and run by Earley et al. (2007) reported being bullied because of their caring role. Similar findings were reported by Warren (2007).

Caring has also been found to have had a detrimental impact on educational attainment (e.g. Becker 2007). Project workers who took part in the Becker and Becker (2008) study expressed their concern about the number of young carers they came into contact with who left school aged 16 years with no educational qualifications, an opinion shared by some of the young adult carers interviewed by the authors. Similarly, analysis of the 2010 YLT survey (ARK 2010) showed that fewer 16 year olds who currently were, or had been,

carers attended grammar[1] schools than their peers who had never been carers (45% and 53% respectively). Taken together, these findings suggest that many young carers do not find school a particularly positive experience and fail to achieve as much as their peers who do not have caring responsibilities. There is a dearth of information on the attitudes of primary school-aged carers towards school, their educational achievements and aspirations, and whether they, too, are more likely to experience bullying than their peers.

In an attempt to contribute to knowledge on caring and its correlates among P7-aged children, this paper examines the extent of caring among this age group and its relationship to health and well-being, school experiences and educational attainment. Specifically, in line with findings from previous research among young carers it is expected that P7 children who are carers, compared with those who are not, will report less happiness at school and with their life in general, more bullying at school, poorer educational aspirations and achievements and poorer health and well-being.

2 Method

The data used for this paper came from the 2011 KLT which is an annual online survey of P7-aged children (10 and 11 years) carried out in schools in Northern Ireland by ARK (a joint initiative between Queen's University Belfast and the University of Ulster). The vast majority of these children will be making the transition to secondary-level education at this age. The overall aim of KLT is to provide a vehicle for children to express their views on a range of policy-relevant issues such as bullying, education and health and well-being.

2.1 Participants

The target population was all P7-age children in Northern Ireland in 2011. Approximately 23,600 P7-age pupils attended 899 primary schools which had P7-age children, including hospital and special schools. In addition, the target population included children in this age group who were being taught at home and those in special educational units due to exclusion from mainstream schools. A total of 292 primary schools participated in the survey representing 32% of all eligible schools, and within these schools, 4,212 children accessed the questionnaire. Twenty children opted out of taking the survey, which means that 4,192 (53% girls and 47% boys) completed the questionnaire. This represents approximately 19% of all P7s in Northern Ireland and around 50% of children within participating schools. While the response rate was lower than had been anticipated, the spread of schools in terms of size, location and free school meals entitlement matched fairly well with figures obtained from the Department of Education in Northern Ireland (DENI) (Lloyd and Devine 2010).

2.2 Fieldwork

The fieldwork for the survey took place from March to April 2011, and two advance letters were sent out to all primary schools in February 2011. The first letter gave information

[1] Children in NI attend either grammar or secondary schools; entry to the former is based on the grade achieved in a test taken at age 11—only those children who sit this test and, in general, achieve a good grade, gain entry to these more academic schools—further details of the implications of getting into a grammar school are provided later in this paper.

about the survey, and explained that the fieldwork would begin in March. The second letter was sent out 2 weeks after the first one along with an instruction document for teachers and parental consent forms. Each school was allocated a unique four-digit identification number that the children used to log on to the survey. Consent for the children to participate in KLT involved three levels. First, the school principal agreed that the school could participate and second, a parent or guardian of each P7 pupil within these schools signed a consent form to say that he or she agreed that the child could take part, and returned this to the school. Finally, at the start of the questionnaire, the child was asked if he or she agreed to take part. The children who participated in the KLT survey were, therefore, those who gave their explicit consent and whose school principals and parents or guardians had already given their permission.

Ethical approval to carry out the survey was obtained from the Ethics Committee located within the School of Sociology, Social Policy and Social Work at Queen's University Belfast.

2.3 Instruments

In order to make the questionnaire visually attractive, fun and interesting to complete, the company that designed the Web version used cartoon characters from 'Bang on the door' which are familiar to most P7 children as they appear on merchandise targeted at this age group. In addition to reading the questions on the screen, the children could also listen to the questions spoken by actors (one male and one female). In this way, children who had sight difficulties or who had problems reading could take part in the survey. To sustain interest, the questions were presented in different ways such as faces on a scale, words that could be ticked and text boxes into which the children typed their open-ended responses.

2.4 Questionnaire Content

The 2011 questionnaire consisted of 75 questions and took about 20 min to complete. The survey included items relating to caring responsibilities and this paper will look at responses to the question 'Some children your age have to help look after someone who is sick, disabled or elderly. Is there anyone living with you who you look after or give special help to?' If the child said 'Yes' to this question, then he/she was asked who they looked after (closed-end list of people with an option for 'someone else—write in the box'), followed by 'What kinds of things do you help them with?' This was an open-ended question so the children could write their answers in their own words inside a text box. Each question on the survey had a 'skip' option which the children could use if they did not want to answer it. Full details of the KLT survey method have been reported elsewhere (Lloyd and Devine 2010). The 2011 questionnaire can be viewed at http://www.ark.ac.uk/klt/2011/quest11.pdf.

2.4.1 Health and Well-Being

\Children's health and well-being was assessed using the KIDSCREEN-10 instrument. The KIDSCREEN-10 measures health-related quality of life (HRQoL) from the child's perspective and is designed for use with children aged between 8 and 18 years (The KIDSCREEN Group Europe 2006). The KIDSCREEN-10 was derived from the KIDSCREEN-27 version using Rasch analysis to identify items that represent a global

uni-dimensional latent HRQOL trait (Ravens-Sieberer et al. 2010). The children are asked to respond to the questions in relation to the last week and each has a 5-point response scale which is either 'Not at all, Slightly, Moderately, Very, Extremely' **or** 'Always, Very often, Quite often, Seldom, Never' depending on the wording of the question. These ask: Have you felt fit and well?; Have you felt full of energy?; Have you felt sad?; Have you felt lonely?; Have you had enough time for yourself?; have you been able to do the things that you want to do in your free time?; Have your parent(s) or guardian(s) treated you fairly?; Have you had fun with your friends?; Have you got on well at school?; Have you been able to pay attention? As well as these ten items the KIDSCREEN measure includes an additional question on health, 'In general, how would you say your health is?' with a 5-point response scale 'Excellent, Very good, Good, Fair, Poor'. The KIDSCREEN-10 has been shown to provide a valid measure of a general HRQoL factor in children and adolescents (Ravens-Sieberer et al. 2010). Higher mean scores on the KIDSCREEN-10 indicate better HRQoL. The psychometric properties of the longer version of the KIDSCREEN measure—KIDSCREEN-27—embedded within the 2008 KLT animated online survey have been shown to be robust (Lloyd 2011). The KIDSCREEN-10 data were analysed using the syntax files supplied on the compact disk that accompanied the KIDSCREEN handbook, and the scores that are presented in this paper are the international T-values (The KIDSCREEN Group Europe 2006).

2.4.2 Happiness

The children were asked how happy they were with their life in general: 'Thinking about your life at the moment, how happy are you with your life?' (Responses: Very happy; Quite happy; Neither happy nor unhappy; Quite unhappy; Very unhappy).

2.4.3 School Experiences and Educational Achievement

Respondents to KLT were asked how happy they had been at their school: 'Looking back over the time that you were at this school, would you say you were mostly happy at this school or mostly unhappy?' (Responses: Mostly happy; Mostly unhappy; I can't decide). Bullying was assessed using the following questions: 'In the last 2 months, how often did you get physically bullied at school, for example getting pushed around or threatened or having your belongings stolen?'; 'In the last 2 months, how often did you get bullied in other ways at school such as getting called names, getting left out of games, or having nasty stories spread about you on purpose?' (Responses: A lot; A little; Not at all, Don't know).

Educational achievement was measured using the children's responses to questions asking whether they had sat any of the transfer tests and, if so, what grade they had achieved. Unlike other regions of the United Kingdom (UK), most of Northern Ireland has a dual grammar/secondary school system, and the transfer test is used to decide which children are eligible to go to grammar schools. While taking the transfer test is not mandatory, grammar schools in Northern Ireland provide a better education than secondary schools, and the results relating to the percentage of children getting 5 GCSE examinations at Grades A*–C clearly show an advantage for children attending grammar schools (e.g. DENI 2011; Gallagher and Smith 2000). It is not possible to go to a grammar school without sitting the transfer test. In 2009, DENI policy changed to advocate a system that did not operate transfer tests. This was met with extreme opposition from many grammar schools and, as a result, separate tests were developed by two consortia of grammar

schools. One, the Association for Quality Education (AQE) used the Common Entrance Assessment while the other, the Post-Primary Transfer Consortium used a test devised by Granada Learning (GL)—neither of which was regulated by Government. Consequently, the tests became known as AQE and GL. Children who wanted to attend a 'Catholic' grammar school sat the GL test, those who wanted to attend a 'Protestant' grammar school sat the AQE test while some children took both tests.

2.4.4 School-Level Data

DENI provided information on the location of each school defined as either urban or rural, the number of pupils in each school and the percentage of children within the school who were entitled to free school meals. These data were used to assess whether there was any bias in the sample of schools that took part in the survey and to examine the association between caring and school-level data.

2.5 Data Analysis

All analyses were conducted using SPSS Version 18. Chi-squared tests were used to assess the association between the caring variable and health, happiness, bullying and school achievement. Mean scores were calculated for the KIDSCREEN-10 and used as the dependent variable in t-test analyses. As sample sizes are large, which increases the likelihood of finding significant differences, measures of effect size—Cohen's d for mean scores (Cohen 1969), Phi (2 × 2 tables) and Cramer's V—are also presented.

3 Results

Approximately one in eight (12%) P7-aged children said they looked after, or gave special help to, someone who was living with them and there was no gender difference. Just over half (57%) of the children said they helped look after one person, 16% helped look after two people and the rest said they helped to look after three or more people. The person most likely to be looked after was their grandmother (44%), followed by their mother or brother (both 33%), grandfather (27%) and father or sister (both 26%).

The figure for caring among this age-group is higher than the 8% reported by the BBC News survey of secondary school-aged children (BBC 2010). It is also slightly higher than the figure reported for the YLT survey of 16 year olds in Northern Ireland in 2010 (10%). The open-ended question 'what kinds of things do you help them with?' provided useful information on the kinds of tasks children said they carried out for the person/people they helped to look after. In many cases, it was very clear that these children carried out tasks for adults in their lives that might not usually be expected of this age group and some examples are presented below.

The types of tasks children carry out for their mother/father include the following:

When we're out I have to make sure that I have her hand so that she doesn't get unstable and fall over and in the house I would help her when she gets tired. *(P7 girl)*
I help her get up from bed and I give her food as well. *(P7 boy)*
Just day to day things but it can get tough and stressful. *(P7 boy)*
Dressing and going to the loo. *(P7 boy)*
Washing, food, drinks. *(P7 girl)*

Table 1 General health by caring responsibilities in the home

	Help look after someone	
	Yes (%)	No (%)
Excellent	33	37
Very good	39	42
Good	22	17
Fair	5	3
Poor	2	1

The types of tasks children carry out for their grandparents include the following:

Lifting heavy things up and down the stairs and I do most of the cleaning for them. *(P7 girl)*
Well my nannie is disabled so I help her get out her clothes and help her eat her food. *(P7 girl)*
Wheeling the wheelchair, going to the toilet, getting up. *(P7 girl)*
Dinner, drinks, getting out of bed, emptying nanny's bag - can't tell what for). *(P7 girl)*

In some cases, it was more difficult to identify the true extent of caring as some children reported, for example, that they did the housework or went for shopping or helped dress and feed younger siblings. Given that it was not possible to identify whether these children *had* to carry out the tasks because there was no-one else able/available to do them, all the children who said they helped look after someone who was sick, disabled or elderly in their household were deemed to have caring responsibilities and the following analyses examine the relationship between caring and children's health, well-being and happiness.

3.1 Health, Well-Being and Happiness

As Table 1 shows, children who said they looked after someone living with them were less likely to describe their general health as excellent than those who did not look after someone and the difference was statistically significant ($\chi^2 = 14.12$, $df = 4$, $p < 0.01$). However, the strength of the association was weak (Cramer's V = 0.061).[2]

There has been much interest recently in the happiness and well-being of the UK nation with measures of both to be included in general population surveys (ONS 2011). Cognisant of the findings of a recent UNICEF (2007) study, which showed that the UK's children had poorer subjective well-being than those living in many other OECD countries, the ONS is currently consulting on how best to measure happiness and well-being in this population (Hicks et al. 2011). In the absence of an established question, respondents to KLT were asked to rate their own happiness with their life and to complete the KIDSCREEN-10 measure of well-being.

Overall, most children taking part in KLT said they were either 'very happy' (65%) or 'happy' (26%) with their life. This is consistent with the results from previous research on children's happiness reported by Holder and Coleman (2009). The mean KIDSCREEN-10 well-being score was 52.90 which is lower than the Europe-wide score (54.40) reported for

[2] A value of Cramer's V or phi of less than 0.20 is generally considered a weak relationship. Values between 0.20 and 0.49 are considered moderate and values more than 0.50 are considered strong (Acock 2006).

Table 2 Happiness with life and school by caring responsibilities in the home

	Help look after someone	
	Yes (%)	No (%)
Happiness with life in general		
Very happy	57	66
Happy	28	25
Neither happy nor unhappy	11	6
Unhappy	2	2
Very unhappy	2	1
Happiness at primary school		
Mostly happy	76	85
Mostly unhappy	6	3
Can't decide	18	12

children aged 8–11 years in 13 countries[3] but higher than the mean score for 8 to 11 year olds in the UK (47.55) and Ireland (48.92) (Ravens-Sieberer et al. 2010).

P7 boys were slightly more likely than girls to say they were 'very happy' with their life (67% and 64%, respectively) although the difference was not statistically significant. In addition, and consistent with previous research among 8–11 year olds across Europe, there was no statistically significant difference between boys and girls on the KIDSCREEN-10 (Ravens-Sieberer et al. 2010). There were, however, statistically significant differences in happiness and well-being between children who said they looked after someone living in their home and those who did not. Table 2 shows that the former were less likely to say they were 'very happy' with their life than the latter ($\chi^2 = 24.55$, $df = 4$, $p < 0.001$) although the strength of the association was weak (Cramer's V = 0.083). Similarly, children who said they looked after someone who lived with them had significantly poorer well-being reflected in their KIDCREEN-10 mean score of 49.85 compared with 53.45 for children who did not look after someone ($t = 7.72$, $df = 596$, $p < 0.001$). Given the large sample, the effect size was calculated using Cohen's D; this was 0.60, which, by convention, is taken as a medium effect size,[4] suggesting that the statistical significance between psychological wellbeing and caring is not merely an artefact of a large sample size.

3.2 School and Educational Achievement

While P7 boys and girls did not differ significantly in their general happiness, in contrast, boys were significantly less happy than girls at school—a finding which has been constant over the 4 years of the KLT survey (Lloyd et al. 2011). In the 2011 KLT, 87% of girls said they had been 'mostly happy' at their primary school, 3% were 'mostly unhappy' and 10% could not decide. The corresponding figures for boys were 81%, 5% and 15% respectively ($\chi^2 = 27.76$, $df = 2$, $p < 0.001$; Cramer's V = 0.083). Consistent with previous research

[3] The 13 European countries are Austria, France, Germany, Netherlands, Spain, Switzerland, United Kingdom, Czech Republic, Greece, Hungary, Ireland, Poland, and Sweden (The KIDSCREEN Group Europe 2006).

[4] By convention, a small effect size is taken as 0.2, a medium effect size is 0.5 and a large effect size is taken as 0.8.

findings on the attitudes of young carers towards school, children taking part in KLT who said they looked after someone were less likely than their counterparts who did not to say they were 'mostly happy' at their primary school (76% and 85%, respectively—$\chi^2 = 26.14$, $df = 4$, $p < 0.001$; Cramer's V = 0.082).

Previous qualitative research has reported a link between caring and bullying (Bibby and Becker 2000; Earley et al. 2007) and this study found that P7-aged children who had caring responsibilities were more likely than their peers who did not to say they had been bullied at school. As Table 3 shows, one-third of children who said they looked after someone at home had been bullied physically in the 2 months before the survey ($\chi^2 = 101.20$, $df = 2$, $p < 0.001$; Cramers's V = 0.17) while 49% had been bullied in other ways ($\chi^2 = 765.69$, $df = 2$, $p < 0.001$; Cramer's V = 0.15). The corresponding figures for children who did not look after someone at home were 16% and 31%, respectively. These results support previous research findings and suggest that many children who are carers may not be finding school as enjoyable and rewarding an experience as their peers who are not carers.

At the present time, sitting the transfer test is the only way children in Northern Ireland can enter the grammar school system and the better their performance in the test the more likely they are to get into a highly academic grammar school. Clear evidence exists that this, in turn, increases the probability that they will acquire 5 or more GCSE passes at grades A*–C, 2 or more A levels at grades A*–E and continue into further and higher education (DENI 2011). Table 4 shows that children who were carers were significantly

Table 3 Bullied physically and in other ways by caring responsibilities in the home

	Physically bullied		Bullied in other ways	
	Carer	Not a carer	Carer	Not a carer
A lot	8	2	13	5
A little	25	14	36	26
Not at all	60	79	44	62

Table 4 Sat transfer test(s) by caring responsibilities in the home

	Help look after someone	
	Yes (%)	No (%)
Sat transfer test(s)		
Yes	56	67
No	44	33
Grade in AQE or GL test(s)		
A or equivalent (top grade)	22	34
B1 or equivalent	15	16
B2 or equivalent	16	16
C1/C2 or equivalent	12	15
D or equivalent (bottom grade)	17	10
Don't want to say	19	9
Would like to go to university		
Yes	61	71
No	15	10
Don't know	23	19

less likely to have sat the transfer test ($\chi^2 = 17.96$, $df = 1$, $p < 0.001$; Phi = 0.070) and, of those who did sit the test, to have achieved the highest grade ($\chi^2 = 33.05$, $df = 5$, $p < 0.001$; Cramer's V = 0.13). Fewer children who said they were carers than those who were not said they would like to go on to university when they finish compulsory education ($\chi^2 = 19.81$, $df = 2$, $p < 0.001$; Cramer's V = 0.072).

4 Discussion

The results from this research suggest that, like those reported by Warren (2007), many children identified through a large-scale survey of P7s carry out a range of tasks, some of them very personal, for adults in their lives and that the responsibilities they assume go beyond what would normally be expected of this age group. The findings indicate that caring undertaken by the children responding to KLT is associated with somewhat poorer self-reported health, well-being and happiness with life overall. They also show that children who are carers experience more bullying and are less happy at school, and that they tend to have poorer educational outcomes when compared with children who are not carers. Overall, the findings provide support for previous research, using both qualitative and quantitative methods, with children and young people who are carers as well as retrospective findings from studies with adults who were carers at a young age (e.g. BBC 1999; Becker and Becker 2008; Cree 2003; Earley et al. 2007).

Children who said they cared for someone were less likely than their peers who did not to say they were 'very happy' with their life. They also had significantly poorer well-being reflected in their KIDCREEN-10 mean score, although it is notable that their overall mean score is higher than the scores reported for a sample of 8–11 year olds in both the UK and Ireland. Analysis of the individual questions which make up the KIDSCREEN-10 measure suggests that the most significant differences between the two groups of children—those who care for someone and those who do not—relates to the former experiencing more feelings of sadness, loneliness, not having enough time for themselves and not being able to do the things they want to do in their free time. This is perhaps unsurprising given the caring responsibilities they are undertaking.

Consistent with previous findings using qualitative research methods (e.g. Bibby and Becker 2000; Earley et al. 2007) children taking part in KLT who said they looked after someone were less likely than their counterparts who did not to say they were 'mostly happy' at their primary school and to report that they have experienced bullying (both physically and in other ways). They were also less likely to have taken the transfer tests and, of those who did, to achieve the highest grade which would enable them to gain entry to the grammar school system in Northern Ireland which is associated with better academic outcomes in later life. Perhaps reflecting this, children who are caring for someone have lower expectations of attending university than their counterparts who are not carers. Taken together, these results support previous research with young carers and suggest that many children who are carers may not be finding school as enjoyable and rewarding an experience as their peers who are not carers (e.g. Becker 2007; Becker and Becker 2008; Dearden and Becker 2000).

4.1 Limitations

While the findings from this survey contribute to, and offer support for, previous research in relation to the health, well-being and educational achievement of young carers there are, nevertheless, limitations that suggest some caution in their interpretation. Firstly, while all

P7 children are invited to take part in KLT, the response rate was fairly low and the children who took part were those whose school principals and parents gave their consent. While very little personal data about the children was collected by the survey that could be used to assess bias in the sample, the characteristics of the schools that participated did not differ markedly from those that did not take part, at least in terms of school size, location (urban/rural) and number of children in receipt of free school meals. Furthermore, none of these variables were statistically significantly related to caring.

Secondly, while it was clear from many of the open-ended responses to the question on the kinds of things they help with that some children carry out a range of personal tasks for people living with them, it was not possible to tell how much of the responsibility these children have to bear alone and how much support they get from others. Also, it may be that some children were interpreting the question on caring in a broader sense and this is borne out to an extent by the fact that, when asked what tasks they carried out, the responses included 'Washing dishes', 'Helping with homework and getting ready for school' and 'Feed and play with my baby brother'. This means that the figure of 12% who said they helped someone living with them could be an overestimation; and, while it does not differ substantially from the percentage reported by Warren (2005) for a clustered sample of young people aged between 11 and 15 years, it may also help explain the weak associations between some of the variables reported in this research. However, because it was not possible to identify whether the children who said they carried out these tasks were doing so because there was no one else in the household able to do them, it was important that those who said they had to help look after someone were included in the analyses. Future KLT survey questions need to be designed in conjunction with young carers to ensure that the children understand fully the concept being measured. It would also be useful to give young carers responding to KLT the questionnaires designed by Joseph et al. (2009)—the MACA-YC18 and the PANOC-YC20—to provide a more meaningful assessment of caring and its outcomes among this age group.

4.2 Conclusions

Notwithstanding these limitations, this research represents an attempt to assess the extent and nature of caring among P7 children from their own perspective. The findings support previous research and suggest that caring at this young age could have a deleterious effect on children's health, happiness and well-being and have implications for their long-term educational outcomes.

While it is not possible to know how many of the children taking part in KLT have support from family members, caring organisations or statutory agencies it is very likely that many do not and may not know how to go about seeking help. Given that the findings from this survey, and from earlier research, suggest that some children who are carers are experiencing bullying and unhappiness at school and poor educational outcomes it would seem prudent for teachers to discuss the issue of caring in the classroom in a general and supportive way so that young carers feel able to confide in them and seek support if they need it. While cross-sectional data on young carers from surveys such as KLT are informative and useful, they cannot tell us anything about the longer term consequences of caring. Some of these young people are caring for long periods of time and it is only through longitudinal research, starting at an early age, that the real implications of taking on this role will be identified.

Conflict of interest The authors declare that they have no conflict of interest.

Ethical standards This study has been approved by the Ethics Committee located in the School of Sociology, Social Policy and Social Work and the work has been undertaken in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki. This information is included in the Method section of the manuscript. All persons taking part in the survey gave their informed consent prior to their inclusion in the study. Any information that might disclose the identity of the participants has been omitted.

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