

**LIVING IN A GROWN-UP WORLD:
AN EXPLORATION OF THE REALITIES OF YOUNG PEOPLE PROVIDING CARE
AND IMPLICATIONS FOR A CANADIAN CONTEXT**

By
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Living in a grown-up world: An exploration of the realities of young people providing care and implications for a Canadian context.

APPROVED:

A handwritten signature in black ink, appearing to read "Lynda Beveridge". The signature is written in a cursive style with a long horizontal stroke extending to the right.

(Lynda Beveridge, PhD Candidate, RCC, Faculty Advisor)

(Jill Taggart, PhD, RCC, Director of Canadian Education Programs)

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Dedication

I dedicate this capstone project to my wife Lewisa, whose patience and unwavering support made it possible. I also acknowledge my mother, as the incredibly difficult path we have walked has ultimately led to something of great personal meaning to me.

Abstract

A large number of young people provide developmentally inappropriate care to parents or other family members with physical and mental health challenges, which may include substance abuse and stressful life events. Called ‘young carers’, these individuals take on many household tasks and also provide emotional support to the loved ones in their care. The demands of caregiving take both a physical and emotional toll upon young carers, who also face a variety of environmental and psychosocial challenges including low socioeconomic status, social isolation, and poor performance in school. These factors appear to be more acute when young people provide care around mental health conditions. At the same time, the literature identifies benefits from caregiving at a young age, such as enhanced relationships with care recipients and problem-solving skills. In supporting young carers, the literature from the Western English-speaking world provides insight into potential interventions and a course of action for the Canadian context, in which educators play a key role. This paper concludes with a reflection on how interventions identified in the literature may be applied to various levels of the British Columbia public education system and potential obstacles in advancing the status of young carers in Canadian society.

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Chapter 1

Introduction

Children and adolescents naturally assume increased responsibilities in the trajectory of their development. Some of these moments are celebrated rights of passage, in association with specific ages or milestones, and the attainment of coveted privileges: staying home alone, going places unescorted, driving a car, and drinking alcohol are some such examples. Many of the responsibilities of youth, however, are perceived as quite ordinary, lack fanfare, and revolve around the family unit and the home. Indeed, increasing independence and completion of household chores are expected of young people across all cultures. These often garner praise and conform to the accepted view of what constitutes good behaviour. As such, society tends to view responsibility as the hallmark of maturity and a marker of child and youth development. At the same time, however, the Western paradigm views childhood as a sacred time in which children are to be protected and cared for (Becker, 2007; O'Dell, Crafter, de Abreu, & Cline, 2010), and sets limits around acceptable levels of responsibility.

A large number of young people assume caretaking roles within their family unit that are generally accepted to be the domain of mature adults. It is common for young people to participate in household chores, which may include assisting with the care of other family members, especially younger siblings or grandparents. However, this becomes problematic when the provision of care is neither developmentally nor age-appropriate (Becker, 2007; Siskowski, 2006). These individuals, referred to in the literature as *young carers*¹, often face a variety of difficulties with their socioemotional well-being and school experience because of the burden of providing care (Kaiser & Schulze, 2015; Lloyd, 2013; Shifren, 2009).

¹ Italicized words are defined in section at the end of the chapter

Young carers take on a wide array of responsibilities. The vast majority provide company and assist with *instrumental activities* such as grocery shopping, meal preparation, transportation, and paperwork or bill paying. Additionally, a large number of young carers also assist with *activities of daily living*, such as feeding and intimate care tasks such as bathing and toileting (Hunt, Levine, & Naiditch, 2005). Also varied are the reasons for which young people adopt the caregiving role. This may be due to the absence of a parent due to social and economic factors, such as divorce or abandonment and parents who work in far away places (Charles, Stainton, & Marshall, 2008). In such cases, care may not involve physical health conditions, but rather assistance with siblings and/or emotional support for the resident parent. Very often, however, a combination of factors is at play including low socioeconomic status (Hunt et al., 2005). Some examples discussed in the literature include parents' physical ailments or disabilities, as well as their inability to meet the needs of younger children (i.e., caregivers' siblings) without assistance. The literature also indicates that military deployment of a parent can prompt children to assume a caretaking role during periods of absence (Charles, Stainton, & Marshall, 2009; Hooper, Moore & Smith, 2014).

Indeed, many young people provide care not only to a parent but also to a larger family unit (Dearden & Becker, 2004). This may be in fulfillment of expectations around what it means to be a good family member (Chalmers & Synes-Taraba, 2007), and is often in accordance with cultural expectations and a sense of felt obligation towards parents (Dearden & Becker, 2002; Stein, 2009). Regardless of such sociocultural factors, many consider caregiving an obligation with no alternative.

Parental mental health struggles (which, for the purposes of this paper, may include substance abuse and addiction) are also a causal factor in young people providing care,

especially when parent-child roles are reversed (*parentification*) (Abramowitz, 2014; Frank, 2002). Stressful events in the lives of parents such as death and divorce may prompt children to become emotional caretakers. The latter can be particularly difficult if children are situated in the middle of high conflict between parents, as they may feel anxiety and guilt while trying to maintain good relationships with both (Buchanan, Maccoby, & Dornbusch, 1991). A high degree of variability exists in the collective experience of young carers. Although the narratives of these young people share a certain commonality, it is important to note that circumstances are unique to the individual in terms of scope and scale. The volume of care duties and the degree to which these activities disrupt the lives of young carers can be highly variable. Accordingly, the literature examines the activities of young carers on a continuum of care that ranges from commonly accepted chores to ones that are developmentally inappropriate (Frank, 2002). The reasonability of care provided may not be determined by the tasks themselves, but rather by the frequency at which they are performed. For example, it may be perfectly appropriate for a young person to prepare meals on occasion; however, the task of preparing every meal for the family could be perceived as a heavy burden.

Regardless of young carers' motives and feelings about their role, the demands upon them can bring a tremendous amount of stress that negatively influences their psychosocial health. The literature indicates that young carers demonstrate a much higher incidence of anxiety, depression, and antisocial behaviours (Becker, 2007), especially when caregiving focuses on a mental health condition (Grant, Repper, & Nolan, 2008). Also, preoccupation with the home environment often leads to problems at school (Dearden & Becker, 2002; Marsden, 1995), which may have negative consequences upon young carers' future economic well-being (Dearden, Becker, & Aldridge, 2000). Concurrently, the demands of providing care leave little time for

relationships outside the family unit, which hinders the development of friendship skills in childhood and adolescence (Cass, Smyth, Blaxland, & Hamilton, 2009); therefore, it is not surprising that young caregivers are more likely to engage in antisocial behaviours (Siskowski, 2009; Mechling, 2011).

Scholarly inquiry and social policy with respect to young carers are relatively recent phenomena. Society has only begun to examine the impact of this within the last 25 years, despite young people having always occupied caretaking roles (Dearden & Becker, 2002). This is not surprising given that factors associated with the stigma of mental illness such as shame and fear of separation from family often conceal the circumstances of these young people (Becker, 2007). Having originated in the United Kingdom (UK) in the early 1990s, the young carers' movement has since spread across the developed world in varying degrees. Indeed, the UK has been the frontrunner within the Western world in establishing social policy and infrastructure to assist young people who provide care. In other Western nations, this movement has varied in terms of development; in the case of Canada, the early literature suggested that the discourse on young carers had not kept up with the UK, Australia, and the United States (US) (Becker, 2007). Research that is more recent indicates that the young carers' movement is still in its infancy in Canada (Waugh et al., 2015).

Professional interest in the topic of young carers

Often hidden, the realities of young carers and Canada's failure to keep pace with other nations have motivated me to become better informed on this topic. While I have been aware of some young carers during the tenure of my career in education, I now wonder how many of my students hid such circumstances from my view. Perhaps the ones about whom I made assumptions regarding their chronic tardiness or absenteeism were tending to the needs of a

loved one. The ones who fell asleep in class and experienced my disapproval may have been up all night providing care, making their mere arrival at school an achievement. As an educator, I believe that I have a moral obligation to support students in their socioemotional development. In becoming informed on the topic of young people providing care, I hope to be a valuable source of support to students who reveal themselves as young carers.

Research Questions

The narratives of young carers are complex and multi-layered. In order to begin to understand these young people's circumstances, several aspects of the caregiving role must be explored in depth. The key questions that I will unpack in this project are:

1. Who are young carers and what responsibilities does this role entail?
2. What are the psychosocial outcomes of providing care at a young age?
3. Does care recipient mental health differ significantly from physical health in relation to its impact upon young carers?
4. What is the social climate for young carers and how can we support them?
5. What is the status quo for young carers in the Western world and where do we go from here?

Scope of this project

The scope of this project is a review of literature presented in Chapter 2, followed in Chapter 3 by an exploration of the feasibility of interventions for school staff working in the British Columbia public education system. The literature reviewed focuses on published studies that investigate the challenges of caregiving at a young age and how these affect the psychosocial health and school experience of the young people involved. Within this topic, I pay particular attention to mental health issues, as these have a deep personal significance for me –

both as a teacher and trainee school counsellor, and also because of personal experiences outlined later in this chapter. I also examine the existing infrastructure to support young carers in the Western world (with a focus on societies where English is the official language) and the status quo in contemporary Canadian society. Finally, in Chapter 3, I reflect upon how the literature can inform our practice in supporting young carers in schools and implications for social policy in Canada.

While my review of the literature outlined in Chapter 2 focuses on a Western paradigm, it is important to acknowledge that young people providing care surely does exist outside of this context (e.g., Asia, Africa, and the Middle East). However, the distinct sociocultural and socioeconomic factors of these regions place them beyond the scope of this analysis. At the same time, it is equally important to note that the pluralistic nature of contemporary Western society does not permit exploration of the topic through a completely Eurocentric lens.

Personal connection to this topic

On a personal note, I feel compelled to explain the origin of my interest in the subject matter. Following the unexpected and highly contentious dissolution of my parents' marriage when I was 19, I embarked on a prolonged period of providing support to my mother. The eldest of three boys, I felt that I had an obligation to assume this role and to shelter my brothers from the ugliness of our circumstances. Although I was already in my emerging adulthood when I assumed this role, I effectively became a parentified child.

In my story, caregiving ceased when my mother and I decided to sever ties when I was 29. At that point, a decade of providing care under stressful circumstances had taken its toll upon my physical and emotional well-being. My mental health was fragile, as I had begun to experience debilitating anxiety and a sense of hopelessness.

Although I very much needed this reprieve, it also proved cathartic for me as I became consciously aware of how the previous decade had taken its toll on my well-being. While I had been fortunate to finish university, and establish a career (in the banking industry), I felt disconnected from friends and experienced low self-esteem. I also felt a tremendous sense of guilt and failure for being cut-off from my mother.

I ultimately took the necessary steps to heal from my past and create the life I wanted. Yet, I remain acutely aware of the difficulties I faced as a caregiver. I now wonder how I would have fared if I had begun my caregiving journey at an earlier age. Surely, I would have endured an even greater degree of hardship that would have influenced the trajectory of my education and vocation.

Definition of key terms

Activities of daily living (ADLs). Activities of daily living (ADLs; a healthcare term) are the basic self-care tasks that are typically learned in childhood, such as feeding, using the toilet, bathing, dressing, and functional mobility.

Caregiving. Caregiving is the act of providing unpaid assistance with another's physical, emotional, and/or developmental needs. This may be precipitated by, but not limited to, a physical disability, mental disorder, and age.

Emerging adulthood. Emerging adulthood is a construct that extends developmental theory to include the late teens through the twenties, with a focus on the ages of 18-25. This phase is characterized as distinct from both adolescence and adulthood in terms of demographic factors, subjectivity, and identity exploration (Arnett, 2000).

In loco parentis. 'In loco parentis' is a Latin term that means 'in the place of a parent'. This term is often applied to school personnel or individuals in occupations related to the care of

children.

Instrumental activities of daily living (IADLs). Instrumental activities of daily living (IADLs; a healthcare term) are the complex skills required for successful independent living, such as managing finances, transportation, shopping, meal preparation, managing medication, and household chores.

Mental health. Mental health is the condition of one's psychological and emotional well-being. Depression, anxiety disorders, and schizophrenia are examples of mental health conditions. For the purposes of this examination, substance abuse and addiction are treated within the scope of this definition.

Neoliberalism. Neoliberalism is a free-market economic philosophy in which self-interest and competition are guiding principles. In the political sphere, this results in privatization, deregulation, and tax reductions. Examples in the British Columbia public education system are the requirement that school boards maintain a balanced budget and generate revenue as business entities from international students.

Parentification. Parentification is a reversal of roles in the parent-child relationship, in which children provide care to the parent in a manner that maintains homeostasis in the family unit.

Supportive caregivers. Supportive caregivers provide assistance and/or respite to primary caregivers. An example would be children who assist parents in the care of another family member.

The United Nations Convention on the Rights of the Child (UNCRC). The United Nations Convention on the Rights of the Child is an "international agreement setting out the civil, political, economic, social and cultural rights of every child, regardless of their race, religion or

abilities” (“UN Convention on the Rights of the Child [UNCRC.]”, 1989).

Young adult caregivers. Young adult caregivers are individuals between the ages of 18 and 25 who provide care to others who are not their own children. This term is used in the American context, in which the term young carer ceases to apply at age 18.

Young carers. Young carers are children and young people who provide care to family members (who are not their own children) or friends with disabilities, chronic health conditions, mental health challenges, and/or substance abuse problems. They also provide emotional support. For the purposes of this exploration, the term will consider individuals up to the age of 29 as young carers (regardless of lower regional age-ceilings).

Chapter 2

Literature Review

Introduction

As an aspiring school counsellor, I have a strong desire to support young people in navigating the challenges that they face. This is in large part due to challenges I have overcome in my own life. Indeed, my experience as a former young carer has had a profound influence upon not only the trajectory of my career but also my self-concept. While certain aspects of the caregiving role may result in positive outcomes, which I will discuss further on in this paper, it is undeniable that care that exceeds the limits of reasonability has a profoundly detrimental effect upon young people. The school setting is where these challenges are often most evident, as young carers try to balance their education with the demands of life at home. In the following literature review, I examine who young carers are in the Western paradigm and what their role entails. I then explore the psychosocial outcomes of developmentally inappropriate care responsibilities, and seek to delineate the influence of care recipients' physical and mental health upon the well-being of young carers. I conclude with an examination of the sociopolitical conditions regarding young carers in the English-speaking Western world (the UK, Australia, the US, and Canada), as well as recommendations for teachers and a potential course of action for the Canadian context.

Defining the construct of the *young carer*. According to Newman (2002) and Stenner (2014), a universal understanding of what defines “young carers” does not exist. Some base the definition of young carers strictly on the tasks they perform, without consideration for the impact these have upon the life of the young carer. Others view young carers in terms of the restrictions that caregiving places upon the life of the caregiver (Newman). Regardless of such orientations,

it is critically important to note that the term *young carer* describes a very diverse population (Waugh et al., 2015).

Although the young people to whom this label is ascribed may commiserate with one another, they are nevertheless a very heterogeneous group due to their different individual circumstances (Nichols et al., 2013; Oliveira et al., 2015). Not all young carers share the same experience, as the degree of care tasks and the frequency at which they are performed may vary greatly among individuals (Newman, 2002; Stenner, 2014). Cultural norms around caregiving play a significant role in this too, as many groups pass down an ethic of care from generation to generation that is not questioned (Becker, Beyene, Newson, & Mayen, 2003; Pharr, Dodge Francis, Terry, & Clark, 2014). Perceptions of where appropriate care ends and inappropriate care begins may, therefore, be variable (Heyman & Heyman, 2013).

The vast diversity of circumstances hinders a universally accepted understanding of young carers. The United Nations Convention on the Rights of the Child (UNCRC) provides well-defined parameters that can assist in a universal understanding of the topic. It states that all children are entitled to rest, leisure activities, and protection from “performing any work that is likely to be hazardous or to interfere with the child’s education, or to be harmful to the child’s health or physical, mental, spiritual, moral or social development” (The United Nations, 1989, art. 32). Since its adoption in 1989, this international treaty has been ratified by 195 countries (“UN lauds Somalia”, 2015).

Age of young carers. Despite the diverse circumstances among young carers, researchers and policy makers often categorize them by age for administrative purposes (Doutre, Green, & Knight-Elliott, 2013). The UK and the US both define 18 as the age where the label of

young carer no longer applies, whereas Australia does this at age 25 (American Association of Caregiving Youth, 2015). In Canada, where the discourse is in its early stages, the literature suggests that an age-ceiling that includes *emerging adulthood* is preferred. In her Statistics Canada report, Bleakney (2014) extends the age ceiling for young carers to 29, which is the highest age-ceiling discussed in the literature. In his very recent article, Battams (2017) also cites 29 as the age ceiling for young carers in Canada.

Charles et al. (2012) state that “research and experience would have us understand that the needs of young people for ongoing support do not dissolve on the eve of their 18th birthday” (p. 9). Indeed, youth is one of the few circumstances that is universal to young carers; however, the lack of global consensus on age-appropriate care is problematic because it hinders a universal working definition of young carers (Waugh, 2015).

As a result of varying age-ceilings in the Western paradigm, the average age of 12.5 years established by Nagl-Cupal et al. (2014) cannot be generalized to a broader international population. It must be noted, however, that the literature from the US and the UK do not completely disregard caregivers above the age of 18. Levine et al. (2005) undertook the first explorations into the lives of *young adult caregivers*, whom they explain have been largely ignored in the conversation on young people providing care. Becker and Becker (2008) followed suit thereafter with their report on young adult carers in the UK.

Proponents of the lower age-ceiling (18) point out that those above this age have adult legal rights and thus greater autonomy over self-determination, which sets them apart; furthermore, these individuals have a higher likelihood of having their own children and adjusting caregiving priorities accordingly (Becker, 2007; Levine et al., 2005). Advocates of the higher age ceiling cite that, before age 25, many young people have not yet fully transitioned into

adulthood and experience similar challenges to the under-18 age group (Moore, 2005).

In this paper, my inquiry into the condition of young carers considers the broader age range. While I agree that care providers under the age of 18 experience circumstances that are unique to this demographic, I firmly reject the lower age-ceiling in my conceptualization of the construct of who young carers are. This is partly driven by my extensive reading on the subject which indicates that age scale should be considered from a broader perspective, and also because the lower age limit negates my own experiences as a young carer. Although I had already reached legal adulthood when my caring journey began, I experienced a tremendous amount of stress (beyond the norm that all caregivers experience regardless of age) because I had not yet achieved important adult milestones such as; education, self-awareness, and the financial stability that I have now.

Tasks of young carers. In establishing a conceptual definition of young carers, a variety of individual circumstances must be considered. The nature of the illness or disability, the frequency and intensity of care tasks, as well as family structures, all of which can be highly variable factors (Aldridge & Becker, 2003; Dearden & Becker, 1998; Frank, 2002). It is also important to note that illness and physical disabilities may not be a factor in some young carers' lives. For example, children in asylum-seeking families may be relied upon to help adults negotiate language barriers and cope with issues related to cultural differences (Charles, Stainton & Marshall, 2010; Leadbitter, 2006). Additional examples are children of high-conflict divorce who provide emotional support to parents (Buchanan, Maccoby, & Dornbusch, 1991), and those with parents who are absent due to military deployment (Charles, Stainton, & Marshall, 2009; Hooper, Moore, & Smith, 2014).

Dearden and Becker's (1998) collection of case studies highlights the uniqueness of

individual contexts. Some of the young carers interviewed, for example, were responsible for only *instrumental activities of daily living (IADLs)*, such as housecleaning, shopping, meal preparation, transportation to appointments, banking, sibling care, interpreting, and emotional support (Frank, 2002). Others also performed *activities of daily living (ADLs)* in addition to IADLs, such as lifting, physiotherapy, and administration of medication. Warren (2007) points out that the more intimate ADLs (i.e. dressing, bathing, and toileting) are those that most easily distinguish young carers from young people not providing care.

It is important to consider that many children are expected to perform some domestic chores that are considered developmentally appropriate. While the UNCRC provides a broad framework, the criteria for deciding what is not appropriate is ambiguous due to cultural considerations. However, the literature does provide some insight (at least in the Western context). Warren's (2007) study found that those not deemed to be young carers usually spent less than two hours per week in service to the household, which suggests that these tasks did not include assistance with paperwork, banking, and transportation. In the case of young carers, however, household tasks took six hours or more and involved more demanding chores, such as laundry, meal preparation, and grocery shopping.

Warren's (2007) study also found that some had additional support to varying degrees, which eased the burden of care, as in the case of one interviewee who only performed caregiving tasks for her mother when her father and older sibling were at work. This leads me to wonder if caregiving is episodic for some young carers, as in the case of unpredictable chronic health conditions and substance abuse (i.e., relapse). Although caregiving tasks may be performed intermittently, I suspect that the emotional-support aspect of caregiving (which I will explore further on) does not cease during periods of relative stability.

Sociodemographic characteristics of young carers (other than age).

Socioeconomic status. Young carers exist in every economic stratum (Leadbitter, 2006; Nagl-Cupal et al., 2014). Although Nagl-Cupal et al. found no connection between poverty and their sample of Austrian young carers, the literature overwhelmingly suggests that young carers often live in low income families (Becker, 2007; Cass et al., 2009; Ridge, 2011; Siskowski, 2009; Stamatopoulos, 2015; Waugh et al., 2015) and that there are several factors that entrap young carers and their families in cycles of poverty. For example, an inability to work due to illness or disability (which may include addiction or mental health struggles) often results in an inability to pay for private care, and thus may compel children in the household to assume caregiving roles (Nagl-Cupal et al.; Siskowski). Aldridge and Hughes (2016) state that employment and post-secondary education opportunities fall as caregiving demands increase, thus perpetuating economic disadvantage.

Contributing situational variables also impact socioeconomic status. For example, families may lack affordable transportation, especially in rural regions, and incur additional expenses related to the provision of care; increased expenses for heating, laundry, and taxi hire for transportation to medical appointments are some such examples (Frank, 2002). In immigrant families, underemployment is common as parents take multiple entry-level jobs, due to a lack of skills, unrecognized foreign credentials, and deficits in language proficiency (Charles, Stainton, & Marshall, 2010; Rossiter & Rossiter, 2009).

Cultural considerations. Despite the binding terms of the UN Convention on the Rights of the Child, cultural implications are nevertheless a challenging component in the establishment of a universal conceptual definition of the term ‘young carer’. This is due to the lack of consensus across cultures with respect to what constitutes developmentally appropriate and

inappropriate care responsibilities (Waugh et al., 2015). This is further complicated by the fact that young carers often exist in more than one cultural context (e.g., the children of immigrants). Indeed, culture plays a pivotal role when we consider the young carer from an ecological perspective.

Siskowski (2009) states that people outside of the dominant culture are more likely to practice home-based care and are, therefore, less likely to access community supports. This may be attributed to lack of familiarity with available support services and language barriers, as well as conflicting values and experiences from countries of origin (Team, Markovic, & Manderson, 2007; Waugh et al., 2015). According to Merrell et al. (2005), engaging assistance outside of the family (i.e., community resources), may be perceived by some as abandonment of one's relatives.

While Charles et al. (2010a) suggest that young carers from minority backgrounds experience similar concerns to those from the dominant culture, care routines deemed inappropriate from a Western viewpoint may be quite acceptable through other cultural lenses. For example, Eastern cultural norms of filial piety and kin reciprocity may carry embedded expectations around the provision of care (Becker, 2007; Cass et al., 2009; Creado, 2011; Lehman, n.d.; Merrell et al., 2005; Szafran, Torti, Waugh, & Duerksen, 2016). In turn, these may be delegated to younger family members (perhaps by the eldest male in family, according to Confucian tradition) out of a sense of obligation (Levkoff, Levy, & Weitzman, 1999). In her mission to prevent cultural misunderstandings, Lehman (n.d.) provides a synopsis of the generalized cultural values and preferred care practices of several specific cultural groups. Although her extensive and detailed presentation is largely beyond the scope of this analysis, it serves as a reminder that generalizations are problematic due to the vast diversity within groups

in society (Levkoff et al., 1999; Ogbu & Simons, 1998).

It is also important to note that cultural variables in the discourse on caregiving are not limited to ethnic differences alone. According to LeBaron (2003), “Cultural groups may share race, ethnicity, or nationality, but they also arise from cleavages of generation, socioeconomic class, sexual orientation, ability or disability, political and religious affiliation, language, and gender – to name only a few” (¶. 2). Geography is also a significant factor due to the cultural divide that often exists between urban and rural populations (Arnett, 2000; Nurse, 2002). In the rural setting, access to support can be very limited (Carers Australia, 2017; Cass et al., 2009; Shifren, 2009) and carers may be more likely to draw support from neighbours and the local community (Scharlach et al., 2006).

Religious considerations. Just as cultural variables hinder a common understanding of what is developmentally appropriate care, religion also may also play a key role. Indeed, the canons of a particular faith can have a direct bearing upon individuals’ undertaking caregiving roles. Levkoff et al. (1999) found, for example, that some Catholics were compelled to provide care out of religious devotion. In other cases, both circumstances and religious credo are impactful: for instance, Dearden and Becker (2002) report that some Muslims reject cross-gender care, which could have serious implications for families in which the only caregivers deemed suitable are young.

Legal implications. In Western societies, religious practices can be conceptualized to allow incorporation into law, in terms of individual freedoms, whereas the cultural inheritance of religion (i.e., beliefs) cannot (Jones, 2015). Accordingly, our constitutions not only protect religious freedom but also establish clear standards on what is unacceptable religious practice (e.g., female genital mutilation and denial of medical care on religious grounds). Between these

points, a great deal of individual freedom exists.

Although international law (specifically, the UNCRC) protects the sanctity of childhood, its underpinning premise of basic human rights allows nations a great deal of autonomy in deciding how they will preserve this within their respective (multi)cultural contexts. This leaves the notion of developmentally-appropriate care open to interpretation and thus creates a sliding scale of acceptability in society, which perhaps accounts for the US' failure to ratify the UNCRC.

In the conversation on young carers, the legal systems of Western nations do not generally prescribe which specific care tasks are unacceptable, other than setting a minimum requirement for child-minding in the absence of an adult; the diversity of individual circumstances makes such judgments the domain of social services agencies, who operate on a case-by-case basis. This has significant implications because it may prompt young people to take on developmentally inappropriate roles on the basis that it is their protected right in a democratic society.

Family-related factors.

Family composition. The family structure plays a pivotal role in the circumstances of young carers. For the purposes of this analysis, the nuclear family and grandparents will be considered; it must be noted, however, that young people may provide care to a variety of other significant individuals in their lives (aunts, uncles, friends, etc.). It is also important to consider that young carers often provide care to more than one member of the household (Dearden & Becker, 2004). In examining the influences of family structure, we must consider that this analysis and the literature reviewed places young carers and their families under a Western lens. The extent to which young people's care practices are deemed appropriate varies across cultures

and must not be pigeonholed.

Single vs. two-parent households. Charles, Marshall, and Stainton's (2010b) British Columbia Young Carers Study found that 58.6% of participants lived with both parents; however, the bulk of the literature indicates that young carers are much more likely to live in single-parent households (Abraham & Aldridge, 2010; Becker, Dearden, & Aldridge, 2000; Dearden & Becker, 1998; Cass et al., 2009). The resulting lack of resources makes the connection between young carers and low socioeconomic status unmistakable.

At the same time, the presence of a second parent (or parental figure) in the home does not ensure that young people will not undertake developmentally inappropriate care tasks (Abraham & Aldridge, 2010; Charles et al., 2010b; Aldridge & Becker, 1993). In some cases, the parent who is not a care recipient may reject, or be unable to engage in, the caretaking role (Cass et al., 2009). This may be in favour of paid employment to support the family financially (Dearden & Becker, 2002). Other motives may include physical limitations, or depression and resentment stemming from the stress associated with the other parent's circumstances (Dearden & Becker, 2002; Frank, 1995; The Fatherhood Institute, 2015). Additionally, families may rely upon young people to provide care for siblings because the lone parent is the only wage earner in the household (Cass et al., 2009). The literature also indicates that young people may assume the role of *supportive caregiver*, in which they provide relief to a primary caregiver (Frank, 1995).

Mothers. Many studies identify mothers as the primary recipients of young people's care, especially in the case of single-parent households (Becker et al., 2000; Dearden & Becker, 2004; Abraham & Aldridge, 2010). In the case of separation or divorce, mothers are more likely to maintain custody of children (Mechling, 2011). The literature also indicates that single mothers experience higher rates of poverty and economic disadvantage compared to single

fathers (Kramer, Myhra, Zuicker, & Bauer, 2016).

According to Miller and Lane (1991), children tend to develop closer relationships with mothers compared to fathers. This sheds light on the greater sense of felt obligation towards mothers rather than fathers identified in the literature (Abraham & Stein, 2010; Freeberg & Stein, 1996). Hunt et al. (2005) also found a higher incidence of caregiving for mothers from minority backgrounds, although Freeberg and Stein (2006) state that a sense of obligation towards mothers transcends ethnicity.

Fathers. To date, the literature on fathers as care recipients is very limited and results are varied. This may be attributed to the low incidence of fathers receiving care in relation to other family members, or the data that suggests that young persons' caring for fathers is most often shared with a mature adult (Clay, Connors, Day, Gkiza, and Aldridge, 2016). Dearden and Becker's (2004) national study in the UK identified fathers and step-fathers as care recipients in 14% of cases, while Abraham and Aldridge's (2010) reported a much lower figure of 4%. Dearden and Becker also found that 7% of fathers were single parents, and that fathers were the primary recipients of care in 26% of two-parent households. Cass et al. (2009) report that 23% of care recipients in Australia were fathers, according to the national Survey of Disability, Ageing and Carers 1998. The range in available data may be the result of significantly different sample sizes, as Dearden and Becker's results represent the entire population of the UK.

The impact of fathers' involvement with young carers of mothers has also received limited attention (The Fatherhood Institute, 2015). The literature does suggest that a positive relationship with fathers is a protective factor in the psychosocial adjustment of some young carers, particularly in the case of those whose mothers have serious mental health challenges (Buhl, 2008; The Fatherhood Institute, 2015).

Grandparents. Several researchers have identified a significant population of grandparents receiving care, especially in the (recent) Canadian literature. Using the highest identified age-ceiling for young carers in the literature (29 years), Bleakney (2014) found that grandmothers were the majority care-recipients in Canada in 2012. Like fathers, grandfathers appear to receive little attention in the literature.

Levine et al.'s (2005) finding that the majority of young adult caregivers (i.e., caregivers aged 18 to 25 years) cared for a grandmother suggests that a link exists between the higher age-ceiling and the inclusion of grandparents in the discourse. Notwithstanding, Charles, Stainton, and Marshall (2010a) found that 36.2% of the young carers in their Canadian study, all under the age of 18, provided care for a grandparent; it therefore appears that care for grandparents is not the exclusive domain of the older demographic of young carers.

Although the data is varied, the literature does suggest that the incidence of grandparents receiving care is on the rise. Advances in medicine and technology result in people living longer with chronic illnesses (Cox & Pakenham, 2014), which places increased care demands upon families. Gays (2000) points out the incidence of parents' maintaining their children into adulthood has also increased substantially; the additional financial strain of supporting both the older and younger generation results in a greater requirement to earn, which necessitates children sharing in the care of grandparents. According to Turcotte (2013), the literature refers to these parents as members of the 'sandwich generation'.

It is also important to note that grandparents may be a protective factor for young carers. Academics have studied extensively the phenomenon of grandparents providing general care to their grandchildren; however, very little literature exists that examines their role in supporting grandchildren who provide care to parents. According to Pakenham, Chiu, Bursnall, and Cannon

(2007), social support is critical to positive outcomes for young carers. As they play a pivotal role in providing support to families experiencing difficult times (Dellmann-Jenkins & Blankemeyer, 2009, grandparents' involvement may prove to be an invaluable resource (Robotham, Beecham, Jackson & Penketh, 2010).

Although research suggests that grandparents have the potential to be a protective factor for young carers, the limited and varied literature on the topic suggests that this may not be the reality in Western culture. Tisdall, Kay, Cree & Wallace (2004) report that children in their study who were caring for parents who were HIV-positive received support from grandmothers. However, Aldridge and Becker (1993) found that grandparents provided little support, and Moore and McArthur (2007) reported a participant's account of hostility from her grandparents. These findings may be a result of the exclusion of grandparents' specific needs from the discourse on caregiver support. The UK Parliament's Work and Pensions Committee (2008) acknowledge the role of grandparents as care providers, and recognize that this group has been neglected in the implementation of support infrastructure.

Siblings. Many young carers also look after siblings in their caregiving practice (Abraham & Aldridge, 2010; Dearden & Becker, 2002; Frank, 2002; Leadbitter, 2006; Moore, 2005; O'Dell et al., 2010). This may be due to parents' inability to cope, resulting from their own care needs. In such circumstances, the burden upon young carers increases as they provide care to more than one person (Cass et al., 2009), which Dearden and Becker (2004) found to occur in at least 10% of cases. In other instances, the young carer may provide secondary support to parents in caring for siblings with acute care needs (Cass et al.). Abraham and Aldridge (2010) state that some young carers inherit the role from older siblings who feel compelled to abdicate caregiving responsibilities, presumably for economic reasons (i.e., to

pursue employment). The literature suggests that the shared caregiving experience can reinforce the bond between siblings (Beach, 1997). Other young carers may receive support from siblings living in the home (McDonald, Cumming, & Dew, 2009); in addition to alleviating the burden of care tasks upon one person, this can also serve to build resilience in families (Cass et al, 2009).

According to Dearden and Becker (2004), sibling care among young carers is twice as prevalent in two-parent families. In their national study in the UK, the authors found that almost half of young carers surveyed looked after other children in the home, compared to one quarter of those from lone-parent households. This may be attributed to increased opportunities for economic security in two-parent households, with children taking over care while the parent who is not receiving care earns (Cass et al., 2009; Dearden & Becker, 2002).

Family dynamics. While family composition plays a significant role in the individual circumstances of young carers, so does the way in which the family interacts. Family dynamics are multifaceted and highly impacted by sociocultural contexts previously explored in this literature review, such as culture, geographic location, socioeconomic status, and family composition. Additional factors, such as external events (e.g., death, trauma, unemployment, and homelessness), and previous generations' relationships also play a key role (Miles, 2015).

Individual factors. Individual temperament also influences family dynamics and the decision to undertake the caregiving role (Gays, 2000; Miles, 2015; Shifren, 2009), although the impact of these upon young people providing care is unclear. Lakman (2015) states that no literature exists that explores connections between personality traits and the decision to undertake a caregiving role. However, Cass et al.'s (2009) and McDonald, Cumming, and Dew's (2009) qualitative work does include personal accounts of young carers' reflections upon their motives for so doing: some view themselves as inherently caring, while others find personal

satisfaction in supporting the family.

Parentification. The literature indicates that the reversal of roles between parent and child, or *parentification*, has a negative impact upon the psychosocial well-being of young carers. Jurkovic (1997) provides a concise summary:

Regardless of sex or age, pathologically parentified children at risk of experiencing a variety of emotional, cognitive, and sociofamilial difficulties: loss of childhood, parents, and trust; anger and resentment; stress; guilt and shame; physical and sexual abuse; peer problems; school difficulties; disruption in identity development; conflicts about leaving home; occupational concerns; and personality dysfunction. (p. 51)

At the same time, though, some positive outcomes may result, such as enhanced personal responsibility and competence (Walsh, Shulman, Bar-On, & Tsur, 2006) and sensitivity towards others (Earley & Cushway, 2002).

Abramowitz (2014) explains that parentification takes three distinct forms: expressive, instrumental, and adaptive. Expressive parentification relates to children's provision of emotional support to the family unit, such as acting as a confidant, mediator, or pacifier. Instrumental parentification, on the other hand, refers to functional tasks such as domestic chores and the day-to-day operations of the household. Adaptive parentification occurs when developmentally inappropriate care is viewed as a short-term challenge and other individuals also provide support (Abramowitz, 2014). Further on in this paper, I will unpack the topic of parentification further in the context of caring for loved ones with mental health challenges.

Charles et al. (2012) state that while all parentified children are young carers, the reverse is not necessarily true. Consequently, the topic of parentification cannot be generalized to all young carers. According to the literature, adults who receive care from their children often

maintain their parental status and provide support to the best of their abilities (Aldridge, 2006; Charles et al., 2012). Family circumstances may vary greatly, and Jurkovic (1997) suggests that parent-child role-reversal be considered on a continuum that accounts for individual experiences.

Among parentified young carers, instrumental and expressive parentification are often co-morbid (Abramowitz, 2014; Jurkovic, 1997). Both forms of parentification may also overlap in the lives of young carers, as instrumental behaviours can have an expressive element and vice versa (Jurkovic, 1997). For example, young carers could seek to meet care recipients' emotional needs through their actions, such as preparing favourite meals and taking extra care and attention in certain care-related tasks. At the same time, the literature also indicates that parentification does not ensure poor adjustment (Earley & Cushway, 2002), and that instrumental and expressive parentification can have very positive psychosocial effects upon young carers when caregiving is considered developmentally appropriate (Aldridge, 2006; Beach, 1997; Thirkield, 2001; Thomas et al., 2003). One such example is the case of immigrant children who serve as interpreters for their parents, and thus become confident and helpful citizens (Walsh, Shulman, Bar-On, & Tsur, 2006). In the case of parents battling substance abuse, parentification may provide an element of structure in an otherwise unpredictable childhood (Stenner, 2014; Walker & Lee, 1998).

It is important to note that the concept of parentification is a construct rooted in a Eurocentric dominant culture, and that it often does not pertain to other cultural contexts. Schleicher (2011) states that the Western view was "developed among white, upper-middle class individuals, and set the ideal for all children regardless of their family's level of income or their cultural values" (p. 15). Indeed, some groups place a high value upon kinship and cooperation that could be construed as developmentally inappropriate under the dominant Western lens

(Abramowitz, 2014; Jurkovic, Thirkfield, & Morrell, 2001), while others espouse values of filial responsibility and harmony that legitimize young people's caregiving practices (Pharr et al., 2014; Scharlach et al., 2006).

Gender roles. Lee (2010) states that gender may determine which individuals within the family unit assume caregiving roles. Females are socialized to be nurturing (Szafran, Torti, Waugh, & Duerksen, 2016; Ramirez, 2013); accordingly, the literature indicates that they take on a greater caregiving role than males (Dearden & Becker, 1998; Kelley et al., 2007; Lee). Participants in Schleicher's (2011) study, all female, indicated that they provided care so that their fathers did not incur the burden. According to Thirkfield (2001), boys may reject the role of overly responsible child in favour of externalizing behaviours (e.g., drug use, aggression, and crime) that draw attention away from family problems. It is therefore not surprising that girls comprise the majority of young carers (Banks et al., 2002; Dearden & Becker, 1998, 2002; Doran, Drever, & Whitehead, 2003; Schleicher, 2011). Heatherington (1999) reports that girls also appear to be more likely than boys to encounter expressive parentification, although Silverberg Koerner et al.'s (2004) work suggests that rates of incidence may be similar.

Pharr et al. (2014) found that the decision to become a carer among European American young women stems from a sense of personal responsibility rather than cultural expectations; however, the expectation that females adopt caregiving roles is unquestioned in certain cultures (Merrell et al., 2005). According to Pharr et al., this is the case in Asian American, Hispanic American, and African American cultures.

The gender of the care recipient also influences caregiving. Ireland and Pakenham (2010) explain that fathers may be reluctant to accept care based on social expectations of masculinity. The gender of the care recipient may also determine who in the family provides

care. As previously mentioned, certain religions may view cross-gender care as inappropriate, especially in relation to intimate tasks such as toileting and bathing (Dearden & Becker, 2002).

Birth order. Lakman (2015) addresses the lack of literature exploring the role of birth order in assuming the caregiver role. According to Szafran et al. (2016), the eldest child in the household is most likely to assume the greatest caregiving responsibilities. This seems logical, especially in the case of those who provide care for younger siblings (Newman, 2002). The literature also suggests that care responsibilities may be shared when there is more than one adolescent in the household (Cass et al., 2009; Gates & Lackey, 1998). Cass et al. state that younger siblings may gradually take on caregiving responsibilities as they grew older. This may be out of necessity, as older siblings take on the responsibilities of adulthood and are unable to provide the same level of care (Abraham & Aldridge, 2010).

Psychosocial outcomes for young carers

There is no doubt that young people's undertaking of developmentally inappropriate care bears upon their psychosocial well-being. The degree to which this occurs appears to depend largely upon individual circumstances, although Joseph, Becker, Becker, and Regal (2009) did find evidence that suggests that caregiving has a more detrimental effect upon girls than boys. However, the literature also indicates that caregiving at a young age can have a beneficial influence upon development, especially when young carers feel a semblance of control in the process (Tatum & Tucker, 1998). Heyman and Heyman (2013) caution that failure to acknowledge these positive effects is itself a risk factor for negative outcomes, as it pathologizes caregiving.

In the following paragraphs, I explore the literature on both the positive and negative psychosocial outcomes that young carers experience. It is important to consider that the

literature considers such benefits under a Eurocentric lens, as certain cultures have an embedded and unquestioned ethic of care (e.g., African American, Asian American, and Hispanic American) (Pharr et al., 2014).

Positive outcomes. It is natural that young people take action to provide assistance to parents or other loved ones whom they see struggling (Moore, 2005). Young carers may enjoy a close relationship with care recipients and other family members that is enhanced by the caregiving role (Abraham & Aldridge, 2010; Aldridge & Becker, 2003; Charles et al., 2010b). At the same time, the caregiving role may also provide comfort to young people, as it may allow them to have a sense of agency and feel relief with respect to their loved ones' needs (Szafran et al., 2016). The strong bonds that may develop between caregivers and care recipients may be an important protective factor (Doutre et al., 2010; Robotham et al., 2010), provided that expressive parentification is not present. Indeed, supportive relationships between young carers and care recipients (as well as other adults) appear to increase the likelihood of positive outcomes (Charles et al., 2008).

Young carers may also feel a sense of pride and confidence in their abilities (i.e., self-efficacy) from their caregiving role (Doutre et al., 2010; Gays, 2000; Pakenham, Chiu, Bursnall et al., 2007). Doutre et al. report that some young carers derive positive meaning from being viewed as 'brave', 'protective', and 'helpful', which positively reinforces to them the importance of the caregiving role in their self-concept. This appears to be a contributing factor in caregiver resiliency (Skovdal & Andreouli, 2011), which participants in Schleicher's (2011) study identified as a positive outcome. These positive qualities may also enhance the school community, as young carers may be role models for empathy and kindness (Charles et al., 2012).

The requirement of young carers to make frequent decisions also provides opportunities

for identity exploration (Beach, 1997). Young carers who perceive their experience as positive may pursue careers in caring professions, as they have developed applicable skills (Heyman & Heyman, 2013), or be inclined to provide support to friends and loved ones in need (Shifren, 2009). The caregiving experience may also provide increased exposure to the political arena (Heyman & Heyman) and thus spark an activist mindset.

Negative outcomes. Although caregiving at a young age can facilitate growth, an overwhelming account of detrimental impacts pervades the literature (Charles et al., 2008). According to Charles et al. (2012), the likelihood of negative outcomes increases as the age at which caregiving begins decreases. While the vast diversity and variability of individual circumstances make it impossible to generalize outcomes for all young carers, the perceived lack of sanctity in the Western view of childhood is the common denominator (Becker, 2007; O'Dell et al., 2010; Schleicher, 2011). As a result, the negative outcomes associated with developmentally inappropriate caregiving have received a great deal of attention in comparison to positive ones.

Stigma. Stigma often results when the reality of families does not conform to the dominant discourse on children's welfare and the ensuing standards prescribed by the UNCRC. This appears to be the case especially when caregiving revolves around mental illness, intellectual disabilities, and alcohol and drug dependency (Rose & Cohen, 2010). Charles et al. (2012) posit that the inherent difficulty in delineating caregiving from parentification breeds stigma. In contrast, Gates and Lackey (1998) suggest in their study that young carers of cancer patients did not experience shame borne from their circumstances.

Stigmatized young carers face a variety of undesirable social consequences. According to Bolas, Van Wersch, and Flynn (2007), young carers may feel "vulnerable to being misjudged

or rejected” (p. 838). The literature indicates that young carers internalize the unfavourable perceptions of others, which in turn may negatively impact self-esteem (Camp, Finlay, & Lyons, 2002).

Stunted identity development. The stigma and demands of developmentally inappropriate responsibilities and may also have a negative impact upon identity development among young carers. Bolas et al. (2007) indicate that male young carers may perceive their masculinity to be under attack: since boys have not been historically socialized towards caregiving roles as girls have, some may feel conflicted in performing tasks that they view as inherently feminine. Some young caregivers also feel resentment because they perceive that society takes pity upon them, while at the same time condemning care recipients as bad parents (Moore, 2005; Schleicher, 2011). They reject the socially constructed victim identity imposed upon them, as they may in fact be providing care willingly (often within the context of loving relationships).

Social isolation. Many young carers report feeling disconnected from their peers. The demands of caregiving often leave very little time for socializing with friends (Butler & Astbury, 2005; Charles et al., 2012; Frank, 2010; Szafran et al., 2016). Also, when they do have free time, some young carers report being too tired to pursue leisure activities (Banks et al., 2002; Gray, Robinson, & Seddon, 2008). Charles et al. (2011) report that they may develop a ‘pseudo-maturity’ that results from taking charge of difficult situations; while this demeanour serves them well in their caregiving roll, it also isolates them from their peers.

The literature also indicates that stigma is a contributing factor to young carers’ social isolation (Gray et al., 2008; Richardson, Jinks, & Roberts, 2009), as they are often reluctant to invite friends home due to shame and fear of judgement around their loved ones’ conditions

(Becker & Becker, 2008; Frank, 2002; Gays, 1996); this may be especially the case for carers of family members with mental health challenges (Roberts, Bernard, Misca, & Head, 2008), or care recipients who exhibit socially unacceptable or strange behaviours (Abraham & Aldridge, 2010). Friends may also be ignorant to the demands upon young carers, which may result in a lack of sensitivity or bullying with respect to loved ones' conditions (Aldridge & Becker, 1993; Moore, 2005).

Poor social adjustment appears to be a self-perpetuating outcome for young carers, as limited contact with peer groups results in fewer opportunities to develop and practice the critical social skills learned during childhood and adolescence (Charles et al., 2012; Szafran et al.; Tisdall et al., 2004), which may have a profound effect upon future friendships and romantic relationships (Charles et al, 2010b).

Physical well-being. The literature indicates that young carers are generally in poor health (Cass et al, 2009; Doran et al., 2003), and that the demands of the caregiving role take a heavy toll on their physical well-being (Gays, 1996). Sleep deprivation and tiredness from physical exertion are common complaints (Abraham & Aldridge, 2010; Diaz, Siskowski, & Connors, 2007), while Gays reports that muscle strain, fatigue and exhaustion occur frequently. Siskowski (2009) states that back injuries are particularly prevalent; according to the literature, these injuries appear to occur most often in lifting and dressing care recipients (Frank, 2010; Sahoo & Suar, 2009). While Shifren (2009) states that the impact of caregiving upon the immune systems of young carers is not known, the literature also indicates that asthma, colds, hair loss, and ulcers are also consequences of caregiving (Becker & Becker, 2008; Rose & Cohen, 2010).

Self-injurious behaviours (e.g., cutting) stemming from the emotional distress associated

with caregiving may also occur (ADASS, ADCS, & The Children's Society, 2012; Fox, Sparrow, & Webber, 2010; Lakman, 2015; Moore, 2005; Szafran et al., 2016). Cree (2003) reports that 34% of participants in her study had self-harmed, and that girls appear to be at a much higher risk than boys. She also notes that 36% of participants had had suicide ideation; currently, however, there appears to be no published research on rates of completed suicide linked to caregiving at a young age.

The literature also indicates that some young carers have disordered eating habits (Chalmers et al., 2007; Grant et al., 2008; Szafran et al., 2016). Cooklin (2010) reports that they may in fact copy these behaviours from care recipients. Clay, et al. (2016), however, were unable to establish a causal link between developmentally inappropriate care and eating disorders. Alcohol and substance abuse also appear to be a coping mechanism for some young carers (Cree, 2003; Ronicle & Kendall, 2011). While this may not seem surprising in the case of children who provide care for parents with these same issues, as these behaviours may have modeled as typical (Zucker, Ellis, Bingham, & Fitzgerald, 1996), Shifren and Chong (2012) found that non-caregiving emerging adults used alcohol more frequently than their caregiving peers. Some young carers also resort to externalizing behaviours, such as aggression and crime, to distract themselves from the pain they feel (Moore, 2005).

Emotional well-being. While the nature of the caregiving experience is subjective (Bolas et al., 2007) and all children experience anxiety and social challenges in the course of their development (Thomas et al., 2003), it is clear that young carers experience a heightened level of emotional upset (in which the loneliness stemming from the previously explored phenomenon of social isolation is a factor). Thus, as psychological trauma has a direct and undisputed impact upon physical health, it is not surprising that young people providing care experience

somatization (Diaz, Siskowski, & Connors, 2007; Harstone, Bergen, & Sweetgrass, 2010; McClure, 2001). It is also important to note that children of parents who struggle with mental health are much more likely to have the same challenges themselves (Nicholson et al, 2001; Van Loon et al., 2015; Weissman et al., 2016). According to Pakenham et al. (2007), negative outcomes related to mental health are the most broadly researched topic in the conversation on young carers.

Stress and anxiety are perhaps the most commonly identified negative outcome for young people providing care. The literature indicates that the demands of the caregiving role, the instability of loved ones' conditions, and general uncertainty about the future result in a constant state of emotional distress (Charles et al., 2008; Frank, 2002; Butler & Astbury, 2005). A major part of this uncertainty appears to be fear of social services' intervention and subsequent separation from family (Aldridge, 2008; Banks et al., 2002; Hill et al., 2009; Mechling, 2011). While they often demonstrate maturity beyond their years (Thomas et al, 2003), some young people who provide care harbour feelings of resentment (Charles et al., 2012; Frank) and sadness (Banks et al., 2002; Pakenham et al., 2006; Thomas et al., 2003), and are thus prone to emotional outbursts incited by the stress of their circumstances (Ali et al., 2012; Lakman, 2015). According to Shifren and Chong (2012), the sleep deprivation that often accompanies caregiving exacerbates emotional pain. In many cases, prolonged exposure to these conditions leads to depression (Creado, 2011; Charles et al.). According to Gays (2000), young carers may also feel very insecure in the execution of their role and worry about making mistakes or accidentally harming care recipients; this anxiety may be particularly intense with respect to intimate care (Fives, Kennan, Canavan, & Brady, 2013). The literature indicates that stress and anxiety are exacerbated when caring revolves around mental health conditions, which I will unpack further

on in this paper.

Education. For many young carers, the responsibilities of home result in little time or energy to devote to school work. Their consequential poor performance is often exacerbated by a high frequency of absenteeism (Dearden & Becker, 2002; Kaiser & Schulze, 2015; Szafran et al., 2016; Waugh et al., 2015) and may lead them to drop out (Charles et al., 2012). Also, young carers are 1.5 more likely to have special education needs (Department of Health, Local Government Association, Association of Adult Social Services, The Children's Society, & Carers Trust, 2014). The literature indicates that when young carers do attend, each of the negative outcomes already discussed (i.e. sleep deprivation, physical and emotional pain, and social isolation) plays out in the school environment, with lack of concentration appearing to be the most common consequence (Charles et al.; Dearden & Becker; Lakman, 2015). Also, the clandestine nature of caregiving may lead to teachers' and peers' having misconceptions about young carers' abilities, attitudes, and work habits (Becker & Becker, 2008; Underdown, 2002). As a result of these factors, young carers' learning and academic performance is often hindered (Charles et al.; Dearden & Becker; Diaz et al., 2007; Siskowski, 2006). According to Frank, Tatum, and Tucker (1999), young carers' school experience may also shape their self-worth and confidence. The degree to which this occurs varies greatly and it is important to note that, like caregiving responsibilities, educational outcomes exist on a continuum and cannot be generalized to all young carers. Dearden and Becker report that some young carers experience no negative consequences in the school setting, and that some exhibit greater resiliency than others in similar circumstances. Nevertheless, the literature indicates that a negative school experience is one of the most profound effects of caregiving at a young age (Cass et al., 2009).

Goal attainment. The UNCRC Articles 28-32 guarantee youth the right to education,

leisure, and individual pursuits; yet the reality of young carers often falls short of these standards. Based on the freedom they enjoy to explore their identities, it is natural that young people experience periods of instability as they transition into adulthood (Wingsiong, 2015). In the throes of their caregiving practice, young carers may not be inclined to contemplate the future (Heyman & Heyman, 2013). Perhaps this is attributed to the chaotic nature of young carers' lives, and their experience in navigating difficult situations as they arise. For some, however, the traditional milestones that come with age (e.g., post-secondary education, career establishment, moving out, and marriage) may provoke intensified anxiety because they feel left behind due to their caregiving roles (Hamilton & Adamson). In this sense, the social isolation that young carers experience can persist into adulthood.

Indeed, the trajectory of young carers' future careers, relationships, and economic well-being is often shaped by their caregiving experience (Dellman-Jenkins & Blankemeyer, 2009). Poor educational outcomes are perhaps the most tangible obstacle for young carers' as they assume age-appropriate adult responsibilities (Barber & Siskowski, 2008; Dearden & Becker, 2002). While caregiving provides them with practical skills (Dearden & Becker, 2000), they are less likely to gain entry to post-secondary education and training and thus have limited options and prospects (Cass et al., 2009). In many cases, young carers end up engaging in employment related to caregiving, in which their experience and skills may serve them well (Dearden & Becker, 2002); they may also seek out these roles because caregiving has been internalized in their identity (Shifren, 2009). Dearden and Becker (2002) caution that, while such work may be meaningful to former young carers, it often pays a low wage and therefore perpetuates economic constraints.

Mental health challenges. In their early work, Dearden and Becker (1998) state that

“over a third of young carers care for someone with mental health problems” (p. 3). While the authors’ choice of words suggests a desire to highlight the impact of psychological conditions, it indicates that the majority of young carers respond to loved ones’ physical limitations and needs. Yet, it seems that the research on young carers is not equally proportionate, as the bulk of the literature appears to focus on the more prevalent incidence of caring around physical conditions (Schleicher, 2011). Perhaps this is because the effects of parental mental health upon caregivers may evolve over a long period of time and are thus more difficult to perceive. According to Gray et al. (2008), more comprehensive inquiry into the impact of caregiving around mental health is required, which could then facilitate the advancement of social policy (Doran et al., 2003).

In the following paragraphs, I examine how supporting a person with mental health challenges may differ from caregiving related to physical illness or disability. As a former young carer of a parent with severe depression, this topic resonates deeply with me and forms the basis of my inquiry into the mental-health side of caregiving. In my analysis in the following paragraphs, I delineate mental health from physical health; however, it is critically important to keep in mind that care recipients may require support in both areas (Charles et al., 2012). As mentioned previously, parentification that occurs as a result of divorce and substance abuse is treated as a mental health issue.

Emotional support. The literature indicates that emotional support is the backbone of caring for a person with mental health challenges (Aldridge, 2006; Gays, 2000; Schleicher, 2011), whereas care for physical conditions appears to be more task-oriented. Practical examples of emotional support include lending an empathetic ear, calming and re-orienting loved ones in agitated states, and acting as a buffer between the care recipient and other family

members (Schleicher). In their 2004 study, Dearden and Becker stated that 82% of the young carers they surveyed provided emotional support and that this figure had increased substantially since 1997. The authors do not specifically state that the prevalence of young people providing support for psychological struggles had increased, nor can we assume that all recipients of emotional support had significant mental health challenges; however, their work suggests that mental health had acquired a more prominent position in the dialogue since their original research (1998).

According to Aldridge (2006), young carers supporting people in their mental health provide ‘critical crisis support’; this may be in addition to many of the instrumental activities of daily living that carers of people with physical illness or disabilities perform. The author thus infers that mental health conditions are more volatile and place greater demands upon caregivers when compared to physical health, which Charles et al. (2012) echo in their later work. Also, given that conditions such as schizophrenia, bipolar disorder, and major depression are known to run in families (Abraham & Stein, 2013; Barkmann, Romer, Watson, & Schulte-Markwort, 2007), young carers may be coming into their own mental health crises.

Parentification and psychopathology. The literature indicates that parentification plays a major role in the lives of young carers supporting parents with mental health issues. Abraham and Stein (2013) point out that the bulk of the literature on parent-child role-reversal focuses on addiction and divorce as causal factors, and that researchers have not extensively studied the impact of mental health struggles. Nevertheless, in the context of young carers, the limited literature that does exist indicates that expressive parentification is much higher among those who provide care to a parent with psychopathology (Abraham & Stein, 2013; Van Loon et al., 2015). It is important to note, as I mentioned earlier in this paper, that role-reversal exists on a

continuum and is not a foregone conclusion for all young carers. However, the reverse is true in that all parentified young people are indeed young carers (Charles et al., 2012).

The literature on parentification suggests that it is a dangerous phenomenon that steals childhoods and interrupts development. Yet, the desire to care for a loved one is natural, as is the desire to please one's parent (López de Victoria, 2008). While the Western view pathologizes parent-child role reversal, Charles et al. (2012) advise that "there is typically mutuality and reciprocity in at least some of the parent-child relationship" (p. 8). According to Göpfert, Webster, and Seeman (2004), young people have the right to take action in the form of care when they are worried about their parents. It is the degree to which parentification occurs that appears to be the critical factor (Aeyelts, Marshall, Charles, & Young, 2016).

Psychosocial outcomes of parentification. The literature indicates that adolescent children of parents with a serious mental health condition demonstrate higher levels of both internalizing and externalizing negative behaviours (Mowbray, et al., 2006). However, longitudinal studies suggest that role-reversal in the parent-child dyad results in internalizing behaviours rather than outwardly directed ones (Abramowitz, 2014; Van Loon et al., 2015). Perhaps this is due to parentified children's pseudo-maturity, or the lack of time and energy for the consequences of acting out. In turning their feelings inward, they may experience depression, suicidal ideation, shame, guilt, loneliness, and psychosomatic complaints that begin in childhood and persist in adulthood (Schier et al., 2015).

According to López de Victoria (2008), parentified young carers (and former ones) may have a love-hate relationship with their parents and feelings of unexplainable anger towards significant others and their own children. Research suggests that young carers cope better with the reversal of roles if the presenting mental health issues have always been present, while those

that witness a decline experience a sense of loss that may result in internalizing behaviours (Schleicher, 2011). López de Victoria also reports that parent-child role reversal may lead to attachment difficulties in adulthood, thus resulting in challenges connecting with family and friends as well maintaining intimate relationships. Abramowitz (2014) attributes such struggles to unmet needs in childhood, which is congruent with Wingsiong's (2015) observation of decreased warmth in the parent-child relationship.

Intervention and supports for young carers. Although the discourse on young people providing care is a relatively recent phenomenon (Dearden & Becker, 2002), young carers in Western society have begun to emerge from the shadows in increasing numbers since the 1990s. The UK, where the research-base has its roots, has proven to be a world leader in scholarly inquiry, social policy, and support infrastructure for young carers. Other Western nations have followed suit to varying degrees, which I will discuss later on in this paper. Despite society's progress in supporting this vulnerable group, many young people providing care nevertheless remain hidden (Abraham & Aldridge, 2010; Banks et al., 2002; Charles et al., 2012; Kaiser & Schulze, 2015; Szafran et al., 2016), due to reasons such as shame, perceived failure, fear of separation, and a lack of awareness of available supports (Moore & McArthur, 2007).

The literature indicates that early intervention and prevention is also of key importance in supporting young carers (Abramowitz, 2014; ADASS et al., 2012; Department of Health et al., 2014; Schleicher, 2011), which seems obvious. In their later study, Moore and McArthur (2007) found that young carers' most wanted respite and the opportunity to do 'normal' things. Aldridge (2006) reported in a previous study that the voices of young carers had been largely absent from the dialogue on interventions and support up to that point, which suggests that the protected view of childhood and the tendency to pathologize young people's caregiving (and

parental disability) play a dominant role in formulating social policy. This begs the key questions ‘What should this look like?’ and ‘Who gets to decide what is best?’. In the following paragraphs, I will examine the literature on various policies and contextual models of intervention and support for young carers; then, I will explore how English-speaking Western nations compare with one another in this regard.

The sociopolitical context

Legislative and community supports from a historical global perspective. In the last twenty years, society’s awareness of the plight of young carers has increased dramatically. In the UK and Australia, the efforts of lobbyists and young carers’ initiatives have indeed made a significant impact upon the social landscape through legislation that recognizes the rights of caregivers (Becker, 2007). While they lag behind the UK and Australia, Canada and the US are making progress in this area (Aldridge, 2008; Waugh et al., 2015). In examining what works, it is apparent that the successful advancement of the social agenda in relation to young carers depends on a symbiotic relationship between governments and community organizations. When legislation establishes clear definitions of caregivers and their rights, support organizations are in a more secure position to procure funding via government and charitable donations; in turn, they are better able to fulfill their mandates and thus drive further research, social policy, and development (Waugh et al.). It is clear from the literature that some nations are more advanced than others in their support of young carers, and that these serve as an example to which lesser developed ones may aspire (Charles et al., 2012).

The numerous studies conducted by the UK-based Young Carers Research Group of Aldridge, Dearden, and (formerly) Becker, constitute the research foundation from which the discourse on young carers in the Western world has evolved (Becker, 2007). It is important to

note that many other developed nations (i.e., European countries) also pay attention to the realities of young people providing care (Aldridge, 2008) and draw upon this foundational work. In order to understand the sociopolitical context of young carers, an examination of regional differences from a historical perspective is helpful. Becker's (2007) typology of *advanced*, *intermediate*, *preliminary*, and *emerging* nations proves useful for this purpose. In the following paragraphs, I examine the evolution of young carers movements and the current discourse in four developed English-speaking Western nations (the UK, Australia, the US, and Canada) in relation to legislation/social policy and community-based agencies that provide support.

The UK. After a long political history of health care reform, the UK has become world renowned for its support of young carers in society (Diaz et al., 2007; Charles et al., 2012). Within Becker's (2007) typology, it is the only nation to hold *advanced* status (Stamatopoulos, 2015). In 1990, Britain began to transition under the Thatcher government's National Health Service and Community Care Act to a *neoliberal* model of community care (now called social care), which saw the deinstitutionalization of many people with physical and mental disabilities and the transfer of support responsibilities to local health authorities and community agencies (Greener, 2009; Lloyd, Webb, & Singh, 1994; Waugh et al., 2015). For both ideological and economic reasons that are beyond the scope of this paper, the government became in effect an enabler of care rather than a provider (Kim, 2008). As many individuals with care needs were once again able to live in their homes, the number of family members who became informal carers increased dramatically within a short period of time.

Although it reunited family members, community care legislation ultimately added a heavy burden to many young people's lives. Furthermore, the National Health Service and Community Care Act's provision of assessments for caregivers only applied to adults, and young

carers' welfare remained the domain of children's social services (Becker et al., 2000). The Carers (Recognition and Services) Act of 1995 remedied this gap, and granted all caregivers the right to an assessment of their circumstances and corresponding needs through local service providers (Becker et al.; Charles et al., 2012; Keefe, 2011); however, this statute placed the onus upon caregivers and required them to provide evidence that caregiving was regular and substantial (Carers Trust, 2015). Reiterating these rights, the Children and Families Act of 2014 now stipulates that local authorities must provide carer assessments based on the appearance of need; this legislation does not require young carers to be proactive in requesting assessments nor able to demonstrate a minimum burden of care (Carers Trust).

The UK has a long history of recognizing adult caregivers (who acquire this status at age 18). In the 1970s, the House of Lords introduced the Invalid Care Allowance (now called the Carer's Allowance), a non-contributory social benefit currently for people providing care under specific conditions (Carers UK, 2014). Since the 1990s, British society has come very far in recognizing the difficult circumstances of young carers. For example, young carers aged 16 or older may now qualify for the Carer's Allowance (currently £62.10 weekly) if certain criteria are met (Government Digital Service, 2017). As a result of increased awareness about young people providing care, services for this population in the UK have increased exponentially over the past two decades (Newman, 2002). Some of these are administered by agencies that advocate for all caregivers regardless of age, such as The Carers Trust, while others are specifically geared towards youth and may fall under the umbrella of child welfare (Becker, 2007). Crossroads for Carers, The Children's Society, Barnardo's, and Carers UK are some of the larger organizations dedicated to supporting young carers (Frank, 2002). These support agencies facilitate connections with young carers and leisure activities, counselling, education about community

resources, and assistance in making decisions related to the caregiving role (Grant et al., 2008) and often offer comprehensive online support.

Australia. Australia occupies an intermediate position in the global context of the young carers' movement (Becker, 2007; Leu & Becker, 2015). As such, there exists "some awareness in society, a small research base, partial rights in some regions, a small but developing body of professional guidance, and some dedicated services and interventions nationwide" (Becker, p. 26). Although the country has a significantly different sociopolitical landscape than the UK (Noble-Carr, 2002), the literature indicates that the realities of young carers in both nations bear a striking similarity. In Australia, the young carers' movement began not long after the British one, in the mid-1990s (Becker). In 2001, Noble-Carr led the nation's first extensive study on this population, which indicated the need for support infrastructure similar to that in the UK. Currently, there are many non-profit young carers' projects operating in Australia that mirror the British context (Becker).

Perhaps the most significant difference between the British and Australian contexts, apart from the latter's higher age ceiling, lies in the legal status of young carers in society. Becker (2007) reports that some Australian States and Territories grant partial rights to young carers; however, information on these in the literature is sparse; in relation to the national context of the time, he stated that "young carers in Australia to date have no specific legal rights to recognition, assessments or to support services" (p. 20). The subsequent Carers Recognition Act 2010 acknowledges the challenges of young carers and their fundamental human rights as consumers of social services. However, instead of defining carers' specific legal entitlements, the Act provides a list of social justice protocols that public service agencies must observe, such as meaningful consultation with carers and operational and human resources policies that reflect an

awareness of their needs (Australia, Department of Social Services, 2016). Also, the Act itself states that it does not create legally enforceable rights or duties and that failure to comply is not grounds for challenging decisions (Carer Recognition Act 2010).

The US. The status quo in the US places the nation in a preliminary position within Becker's (2007) typology (Leu & Becker, 2015). This means that there is "little public or specialist awareness and recognition of young carers, a limited research base, no specific legal rights, and few (if any) dedicated services or interventions at national or local levels" (Becker, p. 26). The author suggests that this lack of local research on the topic of young caregivers (as they are called in the US) has hindered the development of social policy and infrastructure for this population. Champlain (2012) echoes this message in her call for further domestic research and increased social awareness of young carers. To date, the National Alliance of Caregiving (NAC)'s 2005 report has been the only large-scale US research effort; this report, however, considers young carers as one small sub-topic in the general conversation on caregiving as does most of the other existing American literature (Champlain). Hunt et al. (2005) provide an analysis of the NAC survey in relation to young carers exclusively.

The results of the NAC report, which has become the cornerstone of the American literature, reflect similar realities for young carers in the US as in the UK and Australia. The report indicates that there were at least 1.3 million American young carers between the ages of 8 and 18 (in 3.2% of households), and that this figure was likely understated by a wide margin due to the hidden nature of caregiving (Hunt et al., 2005; Serres, 2016). According to Bookend Caregivers (2017), experts estimate the current number of young carers in the US to be six times the 2005 figure. The NAC study also provides the data for Levine et al.'s (2005) study on caregiving in emerging adulthood (i.e., ages 18 to 25), which indicates that a significant number

of young men in this age range undertake care responsibilities and suggests that existing support infrastructure does not reflect this demographic.

An analysis of the literature reveals that the US does not extend any special provisions to young caregivers. Several non-governmental organizations (NGOs) provide services that are indirect and support specific conditions (Charles et al., 2009). NGOs that support caregivers, such as the National Alliance for Caregiving and the Caregiver Action Network, provide information/resources and reaffirm basic human rights. While they do support young carers, these organizations operate in the broader context of family caregiving and are not dedicated exclusively to the younger demographic; a possible disadvantage to this is a lack of specialized attention to the challenges of children, such as navigating the school and social services systems. Government support is also exclusionary. For example, the National Caregiver Support Program awards grants to state and territory governments to support caregivers; yet, its funding formula is based on the state's population over the age of 70 and carers must be above the age of 18 to apply (Champlain, 2012; US Department of Health and Human Services, 2016).

Canada. Like the US, Canada is in the preliminary stage of Becker's (2007) typology (Stamatopoulos, 2015). Although the literature indicates that the Canadian discourse on young carers began in the early 2000s, the information about this population is relatively scarce in comparison to the other nations discussed in this paper. Turcotte (2013) and Bleakney (2014) indicate in their respective Statistics Canada census reports that 8 million Canadians aged 15 to 24 years (i.e. 28% of the population above age 15) provided care to a loved one; however, these figures do not account for younger children who are caregivers. Although Charles et al. estimate that the number of Canadian young carers is proportionate to other nations in relation to total population (2008), Canada has no official data on the number of its young carers below the age

of 15 (Bednar et al., 2013). As young carers are a largely invisible population in Canada (Charles et al.), the omissions in Turcotte's and Bleakney's reports are problematic because they engender a lack of awareness in society that hinders the development of support infrastructure (Szafran et al., 2016; Waugh et al., 2015). To remedy this, Szafran et al. call for a national survey to determine the prevalence of young carers in Canada and raise awareness as a platform for social policy.

Stimulated by the discourse in the UK and Australia, Canada's domestic research base has grown significantly in recent years (Charles et al., 2008, 2009, 2010a, 2010b, 2012; Stamatopoulos, 2015; Toporas, 2003), which sets the stage for the development of policy and social services for young carers. The literature indicates a clear need for these: in their British Columbia Young Carers Study, Charles et al. (2010a) report that 12% of the secondary students they surveyed (ranging in age from 12-17 years) had been providers of care. This information is very impactful for me, as it suggests a high probability of many young carers in my own professional environment (a Metro Vancouver secondary school). My knowledge that the students I support may bear a heavy burden of care has motivated me to become informed on what supports are currently available to them in society.

Organized supports for young carers in Canada are limited. Currently, only three organizations dedicated to young carers are in existence in this country (Stamatopoulos, 2015). Based on the experiences and observations of care professionals, The Young Carers Initiative: Powerhouse Project evolved from a collaboration that began in 2003 between 14 community support agencies operating in the Niagara region; this program provides respite, counselling, life skills training, support groups, and social events for young carers and their families (Powerhouse Project, 2017). Hospice Toronto also initiated a similar program on a smaller scale and in an

urban setting in 2009, in the Greater Toronto Area (Stamatopoulos; Hospice Toronto, n.d.). The one other community agency that offers such services is based in the Cowichan Valley on Vancouver Island; this organization is unique in that it also offers specialized services tailored to the needs of local First Nations communities and involves young carers in social justice initiatives that promote awareness (Cowichan Valley Family Caregivers Support Society, 2015; Stamatopoulos). Although these NGOs provide valuable services and support, the general approach to young carers in Canadian society is responsive rather than proactive. Stamatopoulos states, “the range of dedicated young carer services in Canada remain either assistance or mitigation-based, with none operating at a preventative level” (p. 185). Another obvious shortcoming is the narrow geographic scope in which each of these organizations operates. With two of the three agencies located in close proximity in Southern Ontario, the majority of provinces do not have universal supports for young carers; in these areas, support for young people providing care is disorder-specific (Charles et al, 2009). The provincial Alzheimer and Schizophrenia Societies are such examples. The literature out of Quebec indicates a similar reality for Francophone young carers (Weiss, 2014).

Delivery of support. The aforementioned stigma and fear of separation from loved ones serves to keep young carers hidden in society. We know, however, from the literature that it is critically important that awareness of this population be increased in order to advance policy and support services. In order to bring young carers out of the shadows, it is critical that all service providers support them in a dignified way that includes their voices and aligns to their wishes. In the following paragraphs, I examine some important considerations from the literature for the delivery of optimum support from the perspective of an educator. It must be noted that the role of various other support personnel, such as health care professionals and social workers, is also

integral to supporting young carers, but beyond the scope of this paper.

'Whole family' approaches. The literature suggests that 'whole family' approaches show the greatest potential for successful intervention in remedying difficulties and building family resiliency (Department of Health et al., 2014; Charles et al., 2012; Ronicle & Kendall, 2011). These address the needs of all family members, instead of just those in the caregiver-care recipient dyad. Historically, interventions that focus upon child welfare have tended to portray families as a source of difficulty (Allen & Petr, 1998), which leads to resentment and mistrust. Within a holistic family-centred approach, no one particular person is the centre of attention. Examples of interventions within this model are varied and, among other things, may include: access to professional and community supports for both adults and young carers in areas such as physical health, effective parenting, substance abuse, mental health concerns, emotional support, activities outside the home, and financial matters; assistance for youth in the transition to adult-oriented support services; the bringing of families together; engagement of family members collectively in positive pursuits; and volunteer mentors for general support (Ronicle & Kendall). Holistic models such as this may also serve to open dialogue within the family unit, which creates awareness (a protective factor) and may lead to positive changes in the family dynamic. At the same time, critics of family-centred approaches express concern that the specific needs of children may be overlooked in considering the needs of the family as a whole (Allen & Petr).

In this holistic approach, which has gained traction in UK social policy in recent years (Ronicle & Kendall, 2011), the focus on the needs of the family rather than those of the individual keeps a strength-based perspective at the forefront of care, rather than pathologizing individual circumstances (Walter & Petr, 2000). It also assists in maintaining a balance in service delivery, as the needs of all are addressed. Service delivery models that focus on the

individual often fall short in this area (Cass et al., 2009; Newman, 2002). For example, activists within the disabilities movement believe that supports exclusively aimed at young carers cast parents' conditions in a negative light and thereby marginalize persons with disabilities (Banks et al., 2001; Newman). They argue that the young carers movement would not exist if the needs of persons with disabilities were properly acknowledged (Aldridge & Becker, 2009). On the other hand, some young carers believe that the best way for society to support them is to provide direct support to their care recipients, especially in intimate care, mobility and transport, and ensuring safety (Moore & McArthur, 2007). While such practices provide welcome respite that may allow young people to participate in the normal activities of people their age, they focus on care recipients' physical and mental health and fail to address the emotional needs of young carers. In this regard, support infrastructure for young carers in the school and community settings is vital and will be discussed later on in this paper.

Multi-agency collaboration. The literature indicates that multidisciplinary support compliments the whole family approach and vice versa (Scott, 2005). However, there appears to be a lack of interagency collaboration in the mission to support young carers (Moore & McArthur, 2006). The Mental Health Commission (2006) states that shared expertise and collaboration between service providers can "ensure that all 'bio-psycho-social-cultural' components of intervention and care are delivered" (p. 13) and help to maintain continuity of care; at the same time, a family-centered approach can form the basis of a shared vision between agencies (Walter & Petr, 2000). According to King and Meyer (2006), a model in which support services are integrated into a cohesive unit within a specific geographical area is optimal because it provides coordinated care; this results in a more seamless and streamlined experience for clients in their interactions with different service providers and more efficient use of resources.

In the Canadian context, progress in multi-agency collaboration has been slow. According to the Advisory Panel on Healthcare Innovation's 2015 report, this is due to poor integration between funding mechanisms and provincial health services, and a lack of dedicated personnel to drive innovation within the Canadian health care system (Naylor et al., 2015). Although best practices for building interagency collaboration and cooperation are beyond the scope of this paper, it is important that individuals who support young carers be mindful of the power of holistic and collaborative models of service delivery.

School-based supports. In collaboration with parents and the community, schools maintain a high level of social responsibility in the promotion of mental health for young people (British Columbia Special Education Branch, 2016; Health Service Executive and Department of Health, 2013; Robotham, et al., 2010). However, a very limited body of research exists on the role of schools in supporting young carers (Robotham et al.) despite the literature indicating that young carers' needs may be most easily perceived in the school setting (Dearden & Becker, 2002; Robotham et al.). Indeed, teachers play a critical role in identifying young people who provide care. Educational psychologists, school counsellors, school nurses, and office staff also support young carers; in addition, they may be able to provide valuable mentorship and training to other support professionals in pursuit of a coordinated care model (Department of Health, Carers Trust, The Children's Society, & Department for Education, 2016.; Doutre et al., 2013).

Schools have tremendous potential to support identified young carers, yet they very often underserve this population. The literature indicates that teachers, counsellors, administrators, and support staff can implement a variety of practical strategies to assist students who bear caregiving responsibilities; yet, according to Hill et al. (2009), the majority of teachers they surveyed were unaware of any official protocols for young carers in their schools; perhaps the

hidden nature of young carers contributes to this. The authors also state that those who were aware felt that effective support was lacking. A critical first step in remedying this is to ensure that all staff are familiar with the plight of young people who provide care through informative professional development initiatives and digital resources (Carers Australia, 2017; National Educational Psychological Service et al., 2013; Underdown, 2002). Stamatopoulos (2015) and Underdown also recommend that each school have at least one champion of young carers to whom other staff can refer. Ideally, anyone in this role would help broaden awareness and provide mentorship rather than act as an individual contributor.

In terms of supporting young carers at the classroom level, a variety of relatively simple protocols may prove helpful to both school staff and caregiving students. For example, allowing young carers to leave school without question (provided standard safety measures are in place) and access to a mobile phone during the school day can assist in managing anxiety around care recipients' well-being (Hill et al., 2009). It should be no surprise that flexibility in the delivery of curriculum and evaluation of learning outcomes also aids in mitigating young carers' stress and poor performance in school; this could include strategies such as reduced amounts of homework and negotiation of deadlines, as well as lunchtime tutorial sessions (Abraham & Aldridge, 2010; Hill et al.). In working with students collectively, teachers can raise awareness of caregiving in society and thereby combat related stigma (Hill et al.); this can be achieved through the use of age-appropriate curriculum, print and digital media, and guest speakers. In so doing, however, it is imperative that teachers demonstrate sensitivity towards the individual circumstances of identified young carers within such groups and respect their privacy.

At the broader school level, the literature suggests registration protocols that encourage families to be open about students' caregiving responsibilities, which could include an

affirmation of core values of inclusion and diversity (Hill et al.); of course, many families may not provide disclosure due to the aforementioned hidden nature of young people providing care. If families are willing to take this risk, schools can proactively put supports in place, such as connecting young carers with appropriate personnel for counselling and academic support, as well as school-based young carers' groups to facilitate supportive social connections (Waugh et al., 2012). Hill et al. also suggest that collaborative planning within the school-based team and at the district-level could also take place; this process could include care assessments conducted by school personnel (Morrow, 2005), with the possibility of a formalized individualized support plan (similar to an Individualized Education Plan) for each identified young carer. At first glance, it may appear difficult for schools to take a whole family approach due to the child-centric mandate of education systems; however, schools may be able to implement supports for the siblings of young carers on a proactive basis and also collaborate with external agencies that may be better equipped to take a holistic approach.

It goes without question that school personnel have a moral, ethical, and professional obligation to treat all students with dignity and respect. In the case of young carers, this entails particular attention to confidentiality as many prefer to remain anonymous (Bolas et al., 2007; Eley, 2004). Indeed, it is possible to create a general awareness of caregiving without singling out individual caregivers. Yet, according to Eley, some young carers who desire privacy also express frustration that their teachers are unaware of their circumstances. It is therefore critical that they have a voice in their school support plan. By listening to young carers and valuing their agency and skills, support professionals can encourage young carers to advocate for themselves and others (Grant et al., 2008).

Summary of literature

In analyzing the impact of developmentally inappropriate caregiving upon young people, a variety of factors are at play. Young carers may support loved ones to varying degrees with physical assistance, emotional support, or both. The body of literature on young carers, and this paper, consider this from a Western perspective that views youth as a sacred time for growth and development that is enshrined in international law. This delineation is challenging because the cultural and religious backgrounds of young carers may obscure a universal understanding of this construct. Regional differences also play a significant role. The UK is the world leader on social policy for young carers, and Australia is not far behind. In the US and Canada, the national dialogue on young carers is in its infancy. Also, the different age-ceilings used in each of these countries complicates a common understanding of young carers in the Western world. The analysis in this paper considers the Canadian age-ceiling of 29 years, while other Western nations use the significantly lower age-ceilings of 18 and 25 years.

Despite regional distinctions and the vast diversity of circumstances under which young people undertake developmentally inappropriate care, certain demographic trends are evident across the board. The research indicates that many young carers support mothers who are lone parents, as well as siblings, and that many experience low socioeconomic status. In some two-parent households, the parent who does not receive care often does not provide it either, and delegates this responsibility to children. The literature also indicates that fathers experience a much lower incidence of receiving care, while grandparents appear to be receiving progressively more. Regardless of the aforementioned variables, the literature indicates that young people who provide developmentally inappropriate care, according to the Western view, struggle in several aspects of their lives. Young carers report physical, emotional, and social challenges that stem

from the caregiving role; yet, these circumstances are often hidden due to the stigma associated with developmentally inappropriate care responsibilities. The literature indicates that care for a parent in poor mental health takes a greater toll, especially when children are parentified. In school, academic performance and the development of healthy social skills are often hindered, which may lead to relationship and career struggles in adulthood. At the same time, however, the literature reports certain benefits associated with being a young carer, such as enhanced relationships with care recipients and praise from family members.

In supporting young carers, the literature indicates that this is best achieved in the context of the support for the whole family. This approach does not pathologize the caregiving role, nor does it marginalize persons with disabilities, and considers the needs of all family members. Multiagency collaboration is also important in delivering optimum support to young carers and their families. In the school setting, the flexibility of teachers around demonstration of learning, deadlines, and allowing students access to the home environment are key; the provision of basic necessities such as breakfast and a place to rest may also have a positive effect. As an educator, I believe that I have a moral and ethical duty to support the young carers that I encounter in my professional world. The literature outlined in this chapter has provided me with a wealth of information regarding the realities of young people who provide care, and professional practice considerations from other parts of the Western world. In Chapter 3, I offer insights for how this awareness might be actioned here in the British Columbia school system, and specifically how I may adjust my practice as a teacher and future school counsellor to best support young carers.

Chapter 3

Implications for Practice in British Columbia

Introduction

As an educator and soon-to-be counsellor in Metro Vancouver, the topic of young carers in the Canadian school setting is of particular interest and relevance to me. The literature suggests a variety of practical strategies for supporting these vulnerable students from a multidisciplinary perspective; yet, I am also aware that the realities of the education system within which I work pose constraints not captured in the research. I presume this is same in other domains that support young carers, such as social services and health care. I also know that bridging the gap between theory and practice requires action, and that effecting positive change can begin with me. In the following paragraphs, I examine potential approaches to young carers at various levels of the British Columbia public education system and consider the feasibility of potential supports identified in the literature. As much of this analysis is anecdotal, based on my own experiences in this setting, I must note that I am mindful of my biases in relation to the current sociopolitical environment in British Columbia.

For the purposes of delineating the hierarchy of the provincial education system in which I work, I apply a UNESCO construct that consists of four levels of educational planning and management: the institutional level, which is the school setting; the micro-level, which represents the school district; the meso-level, which represents the provincial context; and the macro-level, which represents the national state of affairs (UNESCO, 1991).

The institutional level. I believe that school is the front line where attention to young carers is most critical. School staff who are aware of issues in caregiving and the potential impact of this function can play a key role in minimizing young carers' stress at school. As

discussed previously in this paper, teacher flexibility in relation to absenteeism, assignment deadlines, test taking, and access to care recipients plays a pivotal role. However, to embrace such practices requires cultural and environmental conditions that are absent from the literature on young carers. Reflecting upon my own practice, I believe that I am inherently flexible to the diverse needs of my students. Yet, this is not the practice of all teachers, and I see how varying philosophical orientations among colleagues could support or impede young carers' academic performance. Indeed, some teachers have very rigid expectations that stem from their own ecological backgrounds and are beyond the scope of this analysis. In my experience, some individuals tend to be closed-minded and dismissive towards new pedagogies and belong to an old guard of teachers who have not embraced the winds of change. Knowing what I do now, I believe that such inflexibility serves to compound young carers' stress; it also alienates this group, and encourages them to remain hidden. On a hopeful note, this is not indicative of the majority of teachers with whom I have worked. In the forthcoming paragraphs, I will explore the institutional level from both a classroom and a school-wide perspective.

In the classroom. In relation to my own classroom (and future counselling office), I would employ strategies to build relationships with students. First and foremost, I would try to connect with young carers and their families in order to demonstrate my commitment to supporting them and to establish trust. I would take care to use language that does not portray me as judgmental, and encourage an open line of communication between home and school. I would also try to engage young carers in collaborating with me and others in drafting a support plan tailored to their unique circumstances; this would be a working document that evolves from a process of meaningful consultation between young carers, their parents, and teachers. Other staff members with whom these young carers interact could also take part, provided all parties

are willing to participate in this process. In terms of immediate interventions, I would also employ some simple measures. For students who are severely sleep deprived, I would provide a quiet and comfortable place for them to take short rests. I would also maintain a supply of nutritious snacks on hand for those whose responsibilities do not allow time for breakfast. If the number of young carers were small, I would likely do this at my own expense (as many teachers do). If a greater need were evident, I would seek guidance from my principal for the establishment of a school-wide initiative; this may involve making funding requests to charitable organizations such as Breakfast Club of Canada (www.breakfastclubcanada.org), Breakfast for Learning (www.breakfastforlearning.ca), and COBS Bread End of Day Giving (www.cobsbread.com/cobs-cares/end-of-day-giving). I would also encourage identified young carers to participate in a lunchtime group, which would involve facilitated discussions of topics related to caregiving from a strength-based perspective. Ideally, this group would meet once per week and the school would provide participants with lunch.

At the broader level of the classroom, I would seek to raise the awareness of all students of young carers in society using age-appropriate resources. In elementary and middle school classrooms, this content could be incorporated into language arts and health education curriculum; Marchetta's (2007) book *Saving Francesca*, a story about a teenage girl caring for her mother who suffers from acute depression, would be an excellent resource to use for this. In the high school environment, homeroom class would also be an ideal forum to explore the topic of caregiving. Teachers must exercise care so that young carers do not feel pitied or marginalized by such efforts on the part of teachers, even if their anonymity is protected. To mitigate this, I would discretely check in with students whom I know may be personally impacted by this content and negotiate an appropriate course of action with them (and possibly in

consultation with their families).

Within the school. A variety of supports can also be implemented at the school-wide level to support young carers. For this to be successful, a healthy school culture is key; this requires a positive working relationship among staff members and effective school leadership. I have been fortunate to work in schools with generally cohesive staffs that embrace collaboration and a shared vision. For the purposes of this analysis, a healthy school culture of this nature is assumed.

In promoting supports for young carers at school-wide level, I would begin with professional development initiatives to raise awareness among colleagues. In so doing, I would seek collaboration from other staff members who may share my interest in the subject and then approach the school's Professional Development Committee. Alternatively, we could explore the topic of young carers in staff meetings or in-service workshops (if there were an appetite for this). In a high school setting, I would also lobby for the offering of Social Justice 12, and urge the teacher (if it were not I who taught the course) to include caregiving in the curriculum (British Columbia Ministry of Education, 2008; Fives et al., 2013). Another potential means of promoting awareness of young carers is through initiatives organized by students. For example, the Leadership 12 class at Gleneagle Secondary School in Coquitlam, B.C. hosts the annual Talk to Me symposium on mental health issues, to raise funds for the Mood Disorders Association of British Columbia; open to the school and the community, this very popular event would be an ideal venue to discuss the realities of young carers. Another successful example of student-led initiatives is the result of a partnership between School District 79 (Cowichan Valley) and the Cowichan Young Carers Program: through leadership and social justice work in promoting awareness of caregivers in schools, students are able to earn high school credit (Stamatopoulos,

2015).

The micro-level. In the school district where I work, there is tremendous potential for district-level supports for young carers. The local Teachers Association's social justice committee could be an ideal platform to present this issue. I could also apply to host workshops at our semi-annual district 'Focus Days', which draw in hundreds of educators. I could also consult our district's Counselling and Behaviour Support Coordinator and Mental Health Inclusion Support Team to discuss opportunities to host in-service workshops and explore the topic at our counsellors' semi-annual round-table discussions. These sessions are very valuable as they facilitate dialogue and the sharing of ideas and experiences. Once momentum begins around supports for young carers in our schools, we could host a 'town-hall' style meeting with an invited panel of support professionals from various external agencies. For example, we could bring social workers, health care workers, counsellors, teachers, administrators, non-profit agency staff, and young carers together to discuss their mandates and the challenges they face, with a view to strengthening interagency connections. I also believe that there are many informal opportunities to support young carers at a district-wide level. For example, I recently met another school counsellor who serves on a committee to understand and remedy poor attendance; when she casually asked me the topic of my capstone project, she immediately identified schools where my research into the topic of young carers could be impactful. I advised her that I would be very interested in any opportunity to share my knowledge and provide support.

The meso-level. Support for young carers at the provincial level entails an activist role in the preservation of human rights. Currently, the British Columbia Teachers' Federation's (BCTF) Committee for Action on Social Justice (CASJ) advocates via sub-committees for

environmental justice, the status of women, the LGBTQ+ community, peace and global education, and the eradication of poverty and racism; the 24 committee members are classroom teachers who serve 3-year terms on a voluntary basis (BCTF, 2017a). I believe that the topic of young carers would easily align to the CASJ mandate, provided that initiatives at the institutional and micro-levels have gained traction. The BCTF could also educate the public on young carers through its website and social media channels, and include the topic in external campaigns in collaboration with other organizations (BCTF, 2017b). Another viable means of raising awareness of young carers is to engage pre-service teachers on the topic. Champions of young carers could accomplish this by giving presentations to education classes and professional programs at local post-secondary institutions, which attract students from a wide geographic area, or by engaging student teachers on an individual basis within the school environment. Beyond the educational setting, advocates for young carers could lobby the provincial government for legislative change. An example of this is Manitoba's passing the Caregiver Recognition Act in 2010, which requires a biennial report on the status of care providers in the province (Canadian Caregiver Coalition, 2015).

The macro-level. In order to effect change at the national level, such that Canada may catch up with countries like the UK and Australia, we must raise awareness in society so that the topic becomes enshrined in human rights legislation and engrained in the Canadian cultural landscape. The Canadian Caregiver Coalition (2015) states that "human rights is [sic] an underutilized, yet powerful approach when it comes to caregiving policies in Canada" (p. 1). While legislative change is generally the work of lobbyists and politicians, I strongly believe that activism at the lower levels (e.g., in the public education system) is a necessary pre-cursor. As the vast majority of social services are the provinces' domain, it is probable that such campaigns

would occur at the provincial level of government. However, the possibility exists that young carers or, more likely, their advocates will bring legal challenges to the Supreme Court of Canada as complaints of violations of human rights, after having exhausted all legal measures at the provincial level. Philanthropy and the continued advocacy of NGOs is also necessary, such as that of the Canadian Caregiver Coalition and the Vanier Institute of the Family (www.vanierinstitute.ca), as there is great regional disparity in organized support for young carers in Canada. Scholarly inquiry into the topic of young carers is also essential, particularly in comparison to other nations, and the recent body of Canadian literature is encouraging.

Obstacles

Institutional-Level obstacles. It would be naïve to say that implementation of the aforementioned strategies is easy. A number of potential difficulties exist at each level of the UNESCO framework (UNESCO, 1991). At the classroom and school-wide levels, the negotiation of boundaries is perhaps the greatest challenge. First and foremost, although our profession may require us at times to act *in loco parentis*, school personnel must be mindful of becoming too emotionally attached to young carers in school, which may be particularly difficult in the more acute cases (i.e., those of parentified children). In contrast, some teachers may lack empathy or be unwilling to incorporate suggested interventions into their practice. For example, I have known colleagues who maintain a zero-tolerance policy on cellular phones in the classroom, regardless of extenuating circumstances. When educators do accommodate students, it is important that they have a sense of what is reasonable and what is not. Overuse of suggested strategies could prove counterproductive, as this may detract from addressing the root cause of young carers' difficulties; keeping these boundaries in check will help to ensure that referrals to external supports, such as social services and community agencies, are timely. In working with

parents and family members, it is important to maintain boundaries around the frequency and content of conversations, as the role of school staff is to provide an education and not to unofficially act as social workers; this is challenging because no definitive universal boundary exists in this regard. In running school-wide initiatives such as breakfast programs, an important consideration is feasibility in terms of the time commitment and staffing required. For an in-school support group, younger children would require parent permission; this may be difficult to obtain given the private nature of caregiving in many families. Ground rules around confidentiality must also be clear and enforced in order to preserve participants' dignity. Another important consideration is the extent to which activism and teachers' personal agendas in the classroom are ethical. Teachers who are passionate about particular issues often share these with their students, but they must exercise caution to avoid placing their own needs before those of their students.

Micro-Level obstacles. A potential barrier to supporting young carers at the micro-level is a lack of consensus on the importance of the topic. Some schools may have a large number of identified young carers, while others may appear to have few. Consequently, the conversation at the school-district level may be eclipsed by other issues deemed to be more pressing. I believe this is also a matter of individuals' impact and influence in advancing the dialogue, as the efficacy of professional development workshops depends highly upon dynamic and engaging presentation skills rather than simply content (Franckowiak, 2016). In my experience, educators are very discriminating consumers in this regard, which Franckowiak attributes to their need to feel respected.

Compassion fatigue and feelings of disengagement are also barriers, both at the micro-level and in the classroom. According to Froese-Germain (2014), "Teachers are experiencing

increased demands of rapid and extensive changes, increased expectations for accountability, and decreased supports provided to and for students” (p. 3). While school professionals certainly care about the well-being of their students, they may not have the capacity to take an active role in advancing the status of young carers in society. Franckowiak (2016) advises that that the success of professional development depends highly on appropriate timing, and this seems to be increasingly difficult to coordinate in the current sociopolitical climate in British Columbia. If educators were able to have rich and meaningful dialogue on the topic of young carers in their schools, no guarantee of progress would exist. School counsellors, for example, report that mental health concerns in schools are more acute and that allocated counselling time and outside resources have reduced (School District 42 Secondary School Counsellors, 2016). While I believe that the majority of school professionals do the very best they can for their students, the current state of affairs in public education in British Columbia is not optimal for initiating new initiatives in social justice.

Meso-Level obstacles. At the provincial level, the greatest barrier in moving the conversation on young carers forward appears to be a lack of awareness of the issue in the context of human rights. Many believe that neoliberal politics are to blame (Poole, 2007; Ross, 2010). Unlike Manitoba and Nova Scotia, no legislation specifically addresses the rights of caregivers in British Columbia and the other Canadian provinces (Canadian Centre for Elder Law & The British Columbia Law Institute, 2010; National Seniors Strategy, n.d.). Consequently, young caregivers in this province may only rely upon the basic tenets of the Human Rights Code of British Columbia (1973) and the Canadian Human Rights Act (1977), as well as international treaties such as the UNCRC and the United Nations Universal Declaration of Human Rights (1948). Brodsky and Day (2014) argue that the abolition of the BC Human

Rights Commission in 2002 was a major setback for human rights in the province because there is no longer a government organization that educates or does prevention work in human rights violations; the mandate of the BC Human Rights Tribunal (which replaced the Human Rights Commission) is to rule upon charges brought forth by complainants, and is thus responsive rather than proactive. Therefore, changes in human rights policy in British Columbia are often the direct result of case law that puts the onus upon complainants to pursue justice (Canadian Centre for Elder Law & The British Columbia Law Institute).

Educators cannot rely on stakeholders from other government sectors to effect social change for young carers. Although the health care sector advocates for caregivers, young carers play a minor role in the dialogue. For example, Doctors of BC (2016) has demonstrated a recent effort to promote awareness of the realities of caregiving by registering as the sole lobby group in British Columbia to champion this cause (Office of the Registrar of Lobbyists for British Columbia, 2017), in conjunction with its policy paper *Circle of Care: Supporting Family Caregivers in BC*; media coverage upon the release of this paper also served to bring the topic to light, at least momentarily (Ellis, 2016). However, while the Doctors of BC literature does make a brief reference to young carers, it focuses primarily on financial and social supports for adult caregivers and provides no indication of collaboration with other agencies that support child welfare, such as the Ministry of Children and Family Development, the Ministry of Education, the BCTF, and the Cowichan Valley Family Caregivers Support Society. It therefore seems that the call to action must come from the organizations in which the impact of caregiving at a young age is most felt. This is problematic in the context of the British Columbia public education system, due to the longstanding acrimonious relationship between the BCTF and the provincial government (Poole, 2007; Slinn, 2011; Thornicroft, 2015). Proponents of neoliberalism would

also argue that the topic has not gained momentum because society has not made it a priority.

Macro-Level obstacles. As the government agencies involved in supporting young carers (i.e., health care, public education, and child welfare) are the responsibility of the province, the advancement of the status of young carers in society is essentially a matter of human rights and Canadian culture. Progress in the national discourse on caregiving does occur when legal challenges escalate to through the mechanisms of the justice system to the Supreme Court of Canada; however, such progress is most often attributed to adult caregivers who have the means and the voice to challenge what they perceive to be violations of their human rights. The vast majority of young carers do not have this agency. Canada's Chief Justice Beverley McLachlin acknowledges that many citizens are denied access to the courts, especially in civil complaints, due to stretched resources in the justice system and prohibitive legal fees (Bailey, 2012). Regionalism in Canadian society is also a factor (Nurse, 2002), as some geographic areas have policies for caregivers and provide better social support for young carers. There is no question that driving social change at the national level requires a tremendous commitment that many are unable to make. It is not logical that we could expect individuals who struggle with the burden of caregiving to find the time to take a leadership role in social justice campaigns; this is especially true for young carers, as the majority of them remain hidden in society. Consequently, advocacy at the national level depends largely upon the activism of individuals in cooperation with professional associations, labour unions, and NGOs. This has its own inherent challenges in the form of organizational politics and bureaucracy (Narayana, 1992), which is beyond the scope of this paper.

Conclusion

Over the last 25 years, a wealth of literature has explored in depth the impact of

caregiving upon young people's lives. The literature also indicates that the conversation on young carers will continue into the future, especially given the disparities between the UK, Australian, and North American contexts. Although the vast majority of this research has thus far been qualitative due to methodological and sampling challenges (Nagl-Cupal, 2014), Schleicher (2011) reports that there has been a recent call for more quantitative evidence. While the literature sheds light on the realities of young carers and provides practical suggestions for educators, social workers, and health professionals, research incorporating efficacy measures of identified best practices is limited to a few studies (Ronicle & Kendall, 2011; Scottish Government, 2017).

The Canadian discourse on caregiving is gaining momentum and recent progress has been made in raising awareness of this social justice issue. The recently released 2017 Federal Budget includes expanded tax credits and benefit payments to caregivers (CARP, 2017). While these changes represent headway in advancing the status of caregivers in Canadian society, they do not provide relief for young carers. I suspect that this is largely due to the hidden nature of this segment of society and its lack of a collective voice. Yet, I am optimistic that social progress in relation to the status young carers is forthcoming. Fortunately, there are community agencies that support young carers in Canada with great success. However, only three such organizations are dedicated exclusively to young carers and they exist in very regional contexts. The literature indicates that this low number is due to differences in perceived needs and the lack of a unified vision among service providers (Waugh et al., 2012). This challenge must be resolved in order to provide services and support to all young carers in Canada.

In terms of my own commitment to supporting young carers, I will most certainly apply the fruits of my research to practice. I am fully committed to supporting not only the young

carer but also the whole family, to the extent that my role as a teacher and school counsellor permits. I am also eager to share my knowledge on the subject with my colleagues, as the role they play is perhaps the most significant in the public education system in terms of the day-to-day lives of young carers. In this regard, I am hopeful that my understanding of the realities of young people providing care will allow me to make a difference not only within my school community, but also within my school district. In practical terms, I doubt that I will become an advocate for young carers at the provincial and national levels, as this does not match my temperament nor my ambitions. Yet, I fully support those who are willing and able to take the cause of young carers to higher levels.

In terms of my own experience as a former young carer, my inquiry into this topic has been very enlightening and therapeutic. I believe that I have a clear understanding of the realities that these young people face; yet, at the same time, I know that every situation is unique and that my experience does not mirror that of all young carers. Since I began writing this paper approximately six months ago, I have been forced to revisit how caregiving has impacted my own life. A few months ago, my mother suffered a stroke and I briefly reconnected with her after a 16-year period of estrangement. I came to realize that, although I have healed and am relatively resilient, repetition of the dysfunctional dynamics of the past were inevitable. Fortunately, my understanding of mental health and the caregiving role have provided me with a sense of peace. It is my wish that my learnings in this journey can translate to support for other young carers.

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