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Original Research Article

Compassion for the caregivers: An Indian perspective on the burnout of caregivers in child care institutions

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Abstract

India has over 23.6 million orphaned and abandoned children (OAC), many residing in child care institutions (CCIs). These children depend on caregivers, who often come from resource-limited backgrounds, impacting their ability to meet the children's emotional, physical, and intellectual needs. A 2018 study by the Ministry of Women and Child Development highlighted a 5% caregiver deficit, with 15% of CCIs exceeding capacity, raising concerns about the quality of care and supervision provided. Caregivers face significant challenges, including mental health issues stemming from the demands of their role.

This study focuses on a capability-building initiative by Udayan Care and Duke University to address these challenges. Capability building emphasises enhancing caregivers' attitudes, knowledge, and skills to better support traumatised children while managing their own wellbeing. Using a quasi-experimental research design, the study evaluates the impact of systemic interventions on caregivers' ability to provide holistic care for OAC. The findings underline the importance of empowering caregivers through training and resources to improve child welfare outcomes in CCIs. This research has significant implications for child welfare practices and policies, both in India and globally.

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Introduction

According to the United Nations Children's Fund (UNICEF), India has 29.6 million orphaned and abandoned children (The Pioneer, 2022). There is also evidence that almost 80% of children living in institutions in India have families who they could be reunified with, if their families were strengthened (Nundy, 2022). In India, 'registration' of child care institutions (CCIs) refers to the mandatory licensing of these facilities under the Juvenile Justice (Care and Protection of Children) Act, 2015. This law requires all institutions housing children in need of care and protection to be officially registered with the state government. Registration is intended to ensure minimum standards of care, accountability, and oversight, and to bring greater uniformity and child-rights-based governance to alternative care settings across the country.

Only about 50% of Indian CCIs have an adequate number of caregivers per child, even though the Juvenile Justice Act, 2015 (JJ At, 2015) mandates a child-staff ratio because individual attention is a basic premise of care (MOSPI, 2018). It leads to two probable outcomes – there is a shortage of caregivers at a system level that makes them a scarce resource, and the caregivers who are currently involved in caring are potentially stretched and overburdened (Ministry of Women and Child Development, 2018). They face an enormous workload while catering to the needs of children at more than the sanctioned capacity, alongside ensuring children's wellbeing and safeguarding them. In either of these scenarios it becomes imperative that caregivers are cared for.

Research context

Caregivers[1] give of themselves in the course of their work with care-seekers. Ideally, they are accessible emotionally, as well as physically and intellectually, in creating meaningful relations with care-receivers. Caregivers thus risk becoming emotionally drained, giving of themselves until they have nothing more to offer to care-receivers. This is known as **job burnout**, defined as

> [a] state of emotional exhaustion, detachment from or depersonalization toward those being served (e.g., children and families), and a lack of a sense of personal accomplishment about one's work. Burnout can be seen as the outgrowth of chronic, ongoing stress and low job satisfaction on the part of those working in emotionally strenuous settings (Maslach & Jackson, 1986).

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[1] A caregiver is someone who provides daily care, protection and supervision of a child. This does not necessarily imply legal responsibility. Where possible, the child should have continuity in who provides their day-to-day care. (UNHCR [2008] Guidelines on Determining the Best Interests of the Child, UNHCR)

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Job burnout engenders a depersonalised emotional withdrawal that undermines the caregiver's personal connections with care-receivers. Given the widespread and detrimental effects of burnout, a valuable endeavour is one that examines and continuously evolves coping mechanisms that stifle the development of burnout in childcare providers. Coping is best viewed as a multidimensional process to deal with the perception of adverse situations such as job-related stress (Lazarus, 1966).

At Udayan *Ghar,* a residential care model under Udayan Care (mentioned in detail thereof), caregivers - referred to as care staff - play a central role in providing day-to-day emotional and physical support to children. Over time, many caregivers report experiencing chronic emotional exhaustion due to the high emotional demands of bonding with children who have experienced trauma, grief, or abandonment. This includes instances of resignations, emotional exhaustion, absenteeism, and psychological distress.

For instance, one caregiver who had been working in a *Ghar* for over five years shared how the cumulative stress of managing behavioural issues, administrative duties, and a lack of personal time led to persistent fatigue and irritability. Eventually, she began experiencing sleep disturbances and showed reduced engagement in team meetings. Another caregiver chose to resign after repeated episodes of stress-related illness, citing a feeling of being ‘constantly overwhelmed and under-supported.’ These examples are indicative of burnout—characterised by emotional exhaustion, depersonalisation, and a reduced sense of personal accomplishment. While some caregivers remain committed despite stress, others experience withdrawal or leave the system altogether, affecting continuity and quality of care for the children. Over the years, three broad types of coping (and inherent strategies) have been proposed (Carver & Scheier, 1999; Folkman & Lazarus, 1980, 1985; Scheier et al., 1989).

The first is **problem-focused** coping, which includes preventative strategies that are executed when the threat of stress is impending (i.e., active coping, planning, suppression of competing activities, restraint coping, seeking instrumental social support). The second is **emotion-focused** coping, involving more responsive strategies that are typically employed to handle stress that has already occurred (i.e., seeking emotional and social support, focusing on venting emotions, positive reinterpretation through growth, acceptance, turning to religion as a source of comfort). The third is **avoidant coping**, a less adaptive method of coping that includes repressing strategies that generally keep an individual from directly addressing the situation (i.e., denial, mental or behavioural disengagement, alcohol/drug use).

Previous research clearly indicates that strategies designed to purposefully change the nature of the stressors, through problem-focused coping, are much more likely to offset, reduce, or even eliminate occupational stress compared to avoidant coping strategies (Folkman & Lazarus, 1980). Generally problem-

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focused ways of coping are used more widely to remove the stressors (Carstensen et al., 2003), while emotion-focused coping methods pertain to short-term distractions and do not really help to increase individuals' social life satisfaction (Rook & Peplau 1982). This finding is consistent across diverse populations and professions (Mann-Feder & Savicki, 2003), including teaching and caregiving (Okabayashi et al., 2008). Emotion-focused strategies include methods such as the focusing and venting of emotions, denial, and positive reinterpretation of events, along with seeking out social support. This encourages avoidance, where the other strategies encourage approach (Roth & Cohen, 1986). Additionally, problem-focused coping, as opposed to emotion-focused coping, is more likely to be employed to diminish work-related stresses (Jenaro et al., 2007; Vitaliano et al., 1990a, b). Perhaps, this is because problem-focused coping consists of active strategies aimed at resolving stress at its source.

Caregivers' burnout and its impact on care receivers (children)

As stated in several studies, caregivers across sectors have reported significantly higher rates of clinical psychiatric disorders, poorer wellbeing, psychological distress, and more depressive symptoms and anxiety than non-caregivers (Butterworth et al., 2010; Kumagai, 2017; Venkatesh et al., 2016). Several studies have examined the factors causing stress for child care providers and its effect on both caregivers' wellbeing and the quality of their care. Chronic job-related stress has been found to be linked to job dissatisfaction (Moriarty et al., 2001), burnout (Goelman & Guo, 1998), and high turnover (Todd & Deery-Schmitt, 1996), as well as being associated with the psychological and physical wellbeing of caregivers (Groeneveld et al., 2012). Assessment of these factors is important, as literature suggests that ongoing stress amongst caregivers ultimately undermines child care quality. This can include low caregiver stimulation, less caregiver sensitivity, and poorer overall care quality in child care homes (de Schipper et al., 2009; Ghazvini & Mullis, 2002). There exists a strong relationship between caregivers' mental health, caregiver/child interactions, and child outcomes, linked to their emotional capacity and ability to deliver quality child care, and thus potentially leading to a probability of disruptive care (Doesum et al., 2005).

The key stressors and triggers for caregivers include stress and burnout, which are determinants of poor mental health, as stated by various studies, alongside low wages, low social support, and poor working conditions (LaMontagne et al., 2007). Despite the generalisability of triggers, stressors and other elements across the caregiver population in different sectors, the exact ways in which these stressors manifest and the strategies thereby required to address these work-related and human-centred determinants of mental health are context-specific (LaMontagne & Keegel, 2012).

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COVID's impact on caregivers

Caregivers experienced negative physical and mental health outcomes as a result of the pandemic. They faced their own COVID-19 exposure risks and increased concerns regarding self-care and health, as well as additional caregiving responsibilities in care homes and catering to care-receivers increased needs, leading to stress. Many caregivers experienced feelings of social isolation, which were exacerbated by social distancing policy measures (Cash & Patel, 2020). The psychological and physical burden of the COVID outbreak on global mental health has been assessed, with the Indian Psychiatry Society revealing in its recent reports that since the start of the lockdown period in March 2020 there has been a significant increase in the number of reported cases of mental illness in India (Loiwal, 2020). While Indian law enforced care and support during the pandemic, especially for children without parental care, and with different needs and vulnerabilities, the essence of the child protection laws also aims to emphasise the importance of caring for caregivers.

Indicators of mental health difficulties related to the workplace, as reported by caregivers during the pandemic, included reduced productivity and job performance; rapid changes in mood, including crying spells, outbursts of anger, poor memory, and changes in communication with co-workers; impaired daily functioning, irritability and restlessness (Government of Karnataka & Department of Psychiatry, NIMHANS, 2020). Some of the reasons highlighted included high intensity caregiving work, limited social interaction, boring daily activities, a high burden of care, and financial and employment concerns (Butterworth et al., 2010; Kumagai, 2017; Venkatesh et al., 2016). All of this was exacerbated during the pandemic.

For instance, at Shreevatsa Child Care Institute in Pune, lockdown restrictions limited the movement of caretakers, leading to increased workloads for those who remained. Caregivers like Shalini Suresh Wadkar adapted by staying at the centre for extended periods to ensure continuous care for the infants, resulting in physical and emotional exhaustion (Bengrut, 2020). The COVID-19 outbreak also resulted in aid reductions and volunteer shortages, exacerbating resource constraints in orphanages. Institutions like Dhanna Bhagat Bridh Ashram faced uphill battles, leading to increased anxiety among caregivers responsible for the wellbeing of orphans (Hindustan Times, 2020).

The Udayan Care model and backgrounds of caregivers

Udayan Care, an NGO supporting orphaned and abandoned children in India, developed the 'Udayan *Ghar* Programme' in 1996, which is derived from the idea of 'Sunshine Homes'; a unique group home model, founded on the core concept of 'L.I.F.E.', an acronym for 'Living in Family Environment'. The purpose of these *Ghars* is to nurture OAC (orphaned and abandoned children), including once parentless, abandoned, or abused children in need of protection. Udayan *Ghars*

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house an average of 12 children per home at any given point. The care model consists of: mentor parents — a group of socially committed, civil society members who voluntarily commit themselves for their lifetime to nurture children in care; trained caregivers, who reside with the children 24/7; and certified social workers, mental health care staff, and supervisors, all of whom form the core carer team. The programme focuses on overall development, providing good education, nutritious food, support to develop excellent physical and mental health, and a variety of extra-curricular growth opportunities. The care homes are located in middle-class neighbourhoods, facilitating community participation and interaction. Presently, Udayan Care has 13 *Ghars*, spread across four states in India.

Caregivers are full-time guides and parent-like figures, living in homes with the OAC continually, with breaks to spend time with their families. In their roles they undertake all the physical work needed to raise the children, including that related to hygiene, nutrition, daily routines, etc. Like professionals in other caregiving fields, such as medicine, nursing homes, and special education services, child care institutions' caregiving responsibilities require a level of emotional commitment and regulation that can, over time, become mentally and physically draining. This, combined with the reality of caregivers, in terms of their own background, as well as the fact that they stay away from their families due to their employment, can influence caring styles, work motivation, and interactions with children. From financial needs to broader family obligations most OAC's caregivers, including those at Udayan Care, have entered the field of childcare with narratives, traumas and experiences that are as unique as they are varied (Venkatesh et al., 2016). Each caregiver has an untold story, often bearing the mark of personal struggles and sacrifices. They leave their own families and children behind in the care of another to move far away and care for other children.

Methodology

This study used a quasi–experimental research design as a means to collect and analyse the collected data.

The research and subsequent interventions focused on:

1. Periodic monitoring of the level of burnout for caregivers working with Udayan Care: Udayan Care believes in Maslach's argument that instead of classifying caregivers as 'burned out' or 'not burned out', burnout should be considered along a standardised continuum of low to high (Maslach & Jackson, 1986).
2. Identifying problem-focused coping strategies and gauging their efficacy: adopting a proactive stance, the endeavour of the study was to identify

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problem-focused coping strategies that could work best for caregivers in the Indian context, in terms of mitigating and reducing burnout.

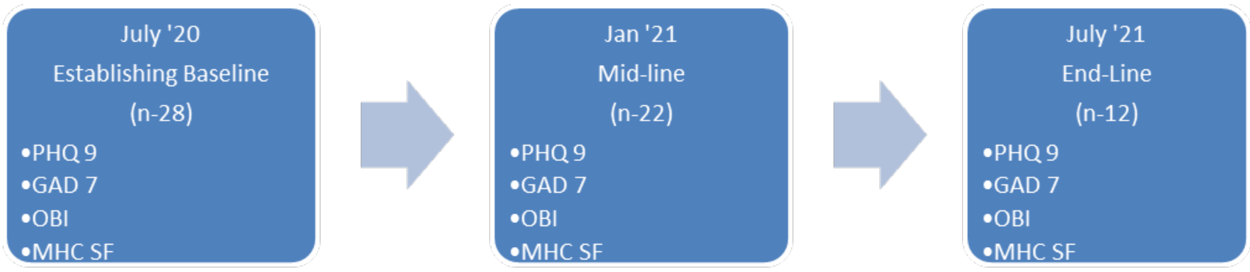
Duration of research

Data collection tools included standard mental health questionnaires (details discussed below), administered three times during the course of the study, in the summer of 2020, winter of 2021, and summer of 2021.

At the start of the study, in summer 2020, all caregivers working with Udayan Care for a period of at least 12 months were included (N=28). Of these 21 were women and seven were men. In the winter of 2021, we had 24 caregivers, which included 16 women and six men –22. In the summer of 2021, 21 participants were included in the study, of which 15 were women and six were men – 21. There were 12 participants who were part of the study across all three data points - seven women and five men. For all results presented herein, analysis using the subset of the total caregiver population interviewed at all three time points is presented first in order to enable within-subject's analysis. Then, analysis for the subset of the overall group at the three time points of summer 2020, winter 2021 and summer 2021 is provided.

Research framework

Figure 1: Research framework



Confidentiality and ethics

This study was conducted by Udayan Care in partnership with Duke University. The project was submitted for ethical approval by the Institutional Review Board at Duke University to the Udayan Care Board which approved the final research design. Information about various measures gathered during the interviews was recorded on paper copies without audio or video recordings and encrypted using *Qualtrics* software, which ensured the protection and reliability of respondents' data, as the certified secure platform for human subject data collection. Access to the account for this software is restricted to the research team, who are bound by confidentiality obligations, with access monitored and audited for compliance.

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Training

Given the pandemic and reliance on virtual meetings, Duke University students with India-based interns collected data following training in the administration of research instruments and application in a culturally appropriate context in individual and group meetings. In 2020, data was collected from caregivers and examined for the aforementioned mental health indicators via virtual interviews.

Measures and tools

Measures used for this study were identified jointly and a combination of tools was deployed, with an intent to determine a comprehensive psychological profile of the caregivers involved (see figure 1).

- Patient Health Questionnaire-9 (PHQ-9) - a nine-item depression scale used to screen for depression and determine depression severity
- General Anxiety Disorder-7 (GAD-7) - used to assess symptoms of general anxiety
- Oldenburg Burnout Inventory (OBI) - used to measure overall burnout via two subscales which measure disengagement and exhaustion
- Mental Health Continuum-Short Form (MHC-SF) - used to gauge overall mental wellbeing with 3 subscales that measured emotional, social, and psychological wellbeing.

Data collection

In 2020, on average four online interviews were conducted per day, with each taking place after gaining informed consent from the caregiver. For caregivers who could not understand English well, interviews were conducted in Hindi by the Indian interns. Interviews took place via a Zoom meeting in the typical environments of caregivers. In winter 2021, the data collection was carried out by India-based interns and sent to the Duke team for data entry, while ensuring confidentiality. In summer 2021, four new Duke team members, along with India-based interns collected data.

Data collection procedures

A combination of the four tools, namely PHQ-9, GAD-7, OBI and MHC-SF, seemed to provide a robust indicator of the overall mental health of the caregivers. Any already available validated Hindi translations were used and checked by Duke and Udayan staff. Any tools requiring new translations were first translated into Hindi by Udayan Care and Indian speakers in the US, translated back into English by separate translators, and compared. Any inconsistencies were re-translated. Language and potential cultural and

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contextual issues with measures and constructs are of particular importance to this work and of particular interest to the team.

Interventions and findings

The findings derived from various tools are presented along the different timelines of data collection, corresponding to the baseline, mid-line, and end-line phases, along with the interventions undertaken in response to these findings. This is followed by a dedicated discussion section that offers an analysis and interpretation of the data across all three stages of the study.

PHQ-9 is a screening tool for depression symptoms, with possible scores ranging from 0 to 27. Its results were interpreted as a possible indicator of the presence and severity of depression symptoms in an individual (Kroenke et al., 2001). The threshold at which an individual is considered to have clinically significant depressive symptoms is a score of greater than five on the PHQ-9. During the summer 2020 baseline survey (N=12), scores suggested that at the start of study three caregivers had minimal depression, six had mild depression, one had moderate depression, and two had severe depression. The five caregivers who scored above four had gender and age distributions that indicated higher depression for female and younger (18-35 years old) caregivers.

There were 12 caregivers who were interviewed during summer 2020, winter 2021, and summer 2021. This sample size is smaller than the other longitudinal samples as some individuals did not complete the PHQ-9. Overall, the average overall PHQ-9 score for these caregivers appeared to decrease as time progressed (Figure 2); these results were consistent, even with stratification by gender. In winter 2020-2021, one caregiver reported severe depression, and in summer 2021, all caregivers from this subsample had mild or minimal depression, with three reporting no depression symptoms.

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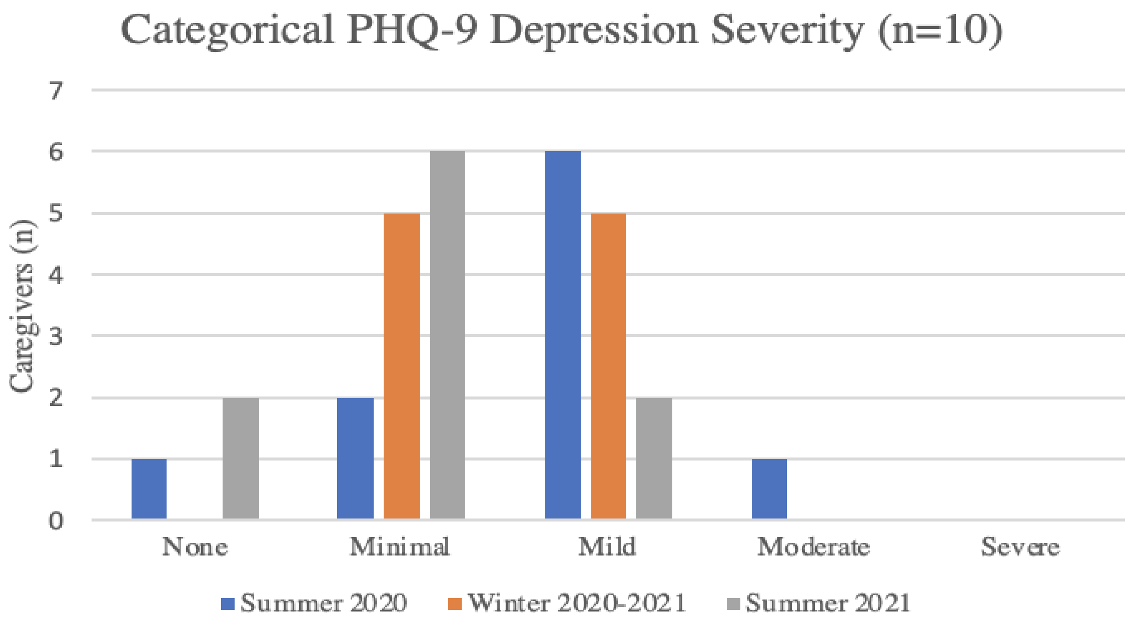
Figure 2: Categorical PHQ-9 depression severity



Category	Summer 2020 (N=12)	Winter 2020 (N=12)	Summer 2021 (N=12)
None	0	0	3
Minimal	3	4	5
Mild	6	5	4
Moderate	1	2	0
Severe	2	1	0

Table 1: Overall PHQ-9 level scores

GAD-7 was used specifically to assess symptoms of general anxiety and has possible scores that range from 0 to 21, with a score of 10 or higher indicating a risk of generalised anxiety (Spitzer et al., 2006). There are four categorical levels of general anxiety in the GAD-7 scoring. A summative score of <5 corresponds with minimal anxiety, 5-9 with mild anxiety, 10-14 with moderate anxiety, and >15 with severe anxiety (Spitzer et al., 2006).

GAD-7 at all three time points (n=12) - overall, the average GAD-7 score for these caregivers appeared to decrease as time progressed, regardless of caregiver gender (Table 3).

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GAD-7 - Scores for caregivers interviewed at all interview times				
Time Period	Population	Mean (standard deviation)	IQR (1st quartile, 3rd quartile)	Median
Summer 2020	Overall (n=12)	5.08 (3.87)	4.75 (2.75, 7.50)	3.00
	Female (n=7)	5.00 (3.65)	4 (2.50, 6.50)	3.00
	Male (n=5)	5.20 (4.60)	6 (3.00, 9.00)	3.00
Winter 2020-2021	Overall (n=12)	3.58 (2.47)	2.75 (1.75, 4.50)	3.50
	Female (n=7)	4.00 (2.00)	2 (3.00, 5.00)	4.00
	Male (n=5)	3.00 (3.16)	3 (1.00, 4.00)	2.00
Summer 2021	Overall (n=12)	2.08 (1.68)	3.25 (0.75, 4.00)	2.00
	Female (n=7)	2.43 (1.62)	2.5 (1.50, 4.00)	2.00
	Male (n=5)	1.60 (1.82)	3 (0.00, 3.00)	1.00

Table 2: GAD-7 - Scores for caregivers interviewed across all times

As GAD-7 scores can be categorised into varying levels of anxiety (minimal, mild, moderate, severe), the categorical changes of individual levels of anxiety were also noted between summer 2020 and summer 2021 (Table 2).

Population	**Decrease**	**No change**	**Increase**
Overall (n=12)	5	7 (*7)	0
Female (n=7)	3	4 (*4)	0
Male (n=5)	2	3 (*3)	0

Table 3: Shifts in categorical GAD-7 score for individuals interviewed summer 2020 and summer 2021

Table 3 above shows GAD-7 category change(s), if present, for caregivers who were interviewed at all three time points (n=12), stratified by gender (female n=7; male n=5). The asterisk represents the number of caregivers who experienced no change because they maintained the lowest level of anxiety.

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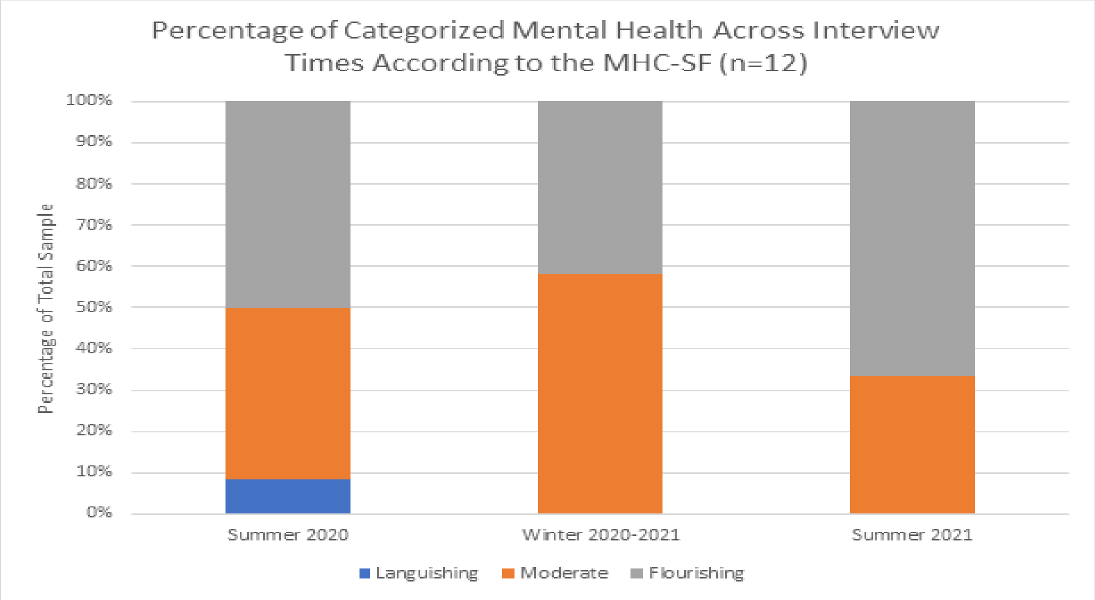
Figure 3: MHC-SF scores of caregivers across interview times



It was found that no individuals experienced a categorical increase in their GAD-7 anxiety scores, and five individuals experienced a decrease in their categorical level of anxiety (Tables 4 & 5). For all those individuals who did not experience a categorical change in their anxiety levels, it was found that this was because they maintained the lowest possible level of anxiety (minimal).

Category	Summer 2020 (N=12)	Winter 2021 (N=12)	Summer 2021 (N=12)
Minimal	7	9	22
Mild	3	3	2
Moderate	2	0	0
Severe	0	0	0

Table 4: Overall GAD categorical scores

Category	Summer 2020 (N=12)	Winter 2021 (N=12)	Summer 2021 (N=12)
Minimal	7	9	12
Mild	3	3	0
Moderate	2	0	0
Severe	0	0	0

Table 5: Details of respondents interviewed across three data points (N=12)

OBI-9 is a 16 question self-report burnout scale for which individuals are asked to rate their answers on a four-point Likert scale from strongly agree (1) to strongly disagree (4) (Bakker et al., 2004). Half of the statements are positively framed while the other half are negatively framed. Those that are negatively

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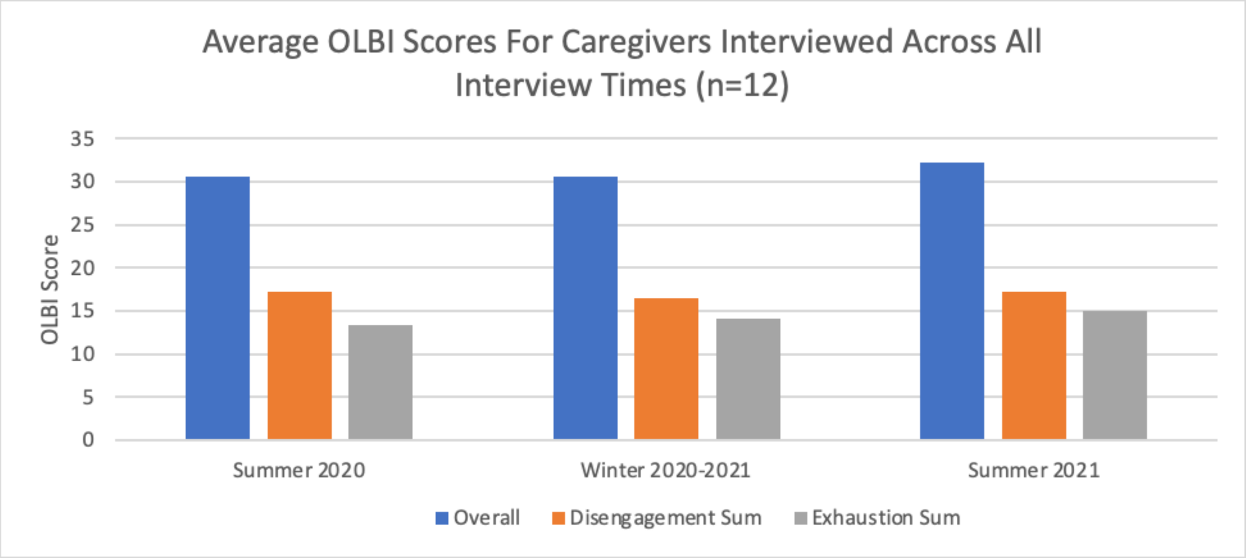
framed are reverse scored, such that higher numbers on the OBI always indicate higher levels of burnout.

In addition to overall burnout, OBI has two subscales which measure disengagement and exhaustion. Exhaustion results from intense and long-term exposure to physical, affective, and cognitive strain relating to one's job (Pereira-Lima & Loureiro, 2015). Disengagement, on the other hand, involves a self-distancing from work and work-related activities/tasks and is frequently accompanied by a reduced willingness to continue working at that job (Pereira-Lima & Loureiro, 2015). The clinical threshold for burnout is defined as an overall score of 44 or more (Leclercq et al., 2021).

With respect to OBI at all time points (n=12), analysis was conducted using data from those caregivers who were interviewed during summer 2020, winter 2020-2021, and summer 2021 (n=12). Overall, the average OBI score, as well as both subscales for these caregivers, appeared to remain the same as time progressed (Figure 4); these results were consistent even when separated by gender.

Figure 4: Average OBI scores (overall, disengagement sum, and exhaustion sum) for caregivers across all three interview times (n=12)



Score	**Summer 2020 N=12**	**Winter 2021 N=12**	**Summer 2021 N=12**
Overall	30.58 (5.07)	30.67 (4.58	32.25 (3.79)
Disengagement	17.17 (4.34)	16.50 (2.71)	17.25 (2.26)
Exhaustion	13.42 (2.78)	14.17 (3.13)	15.00(1.71)

Table 6: OBI mean scores at an overall level

The levels of burnout for all those caregivers interviewed in summer 2021 demonstrates that there were no cases of clinically significant burnout (Table 6).

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Sample size in this instance is n=21 as there were 21 caregivers in summer 2021 that fully completed the OBI survey.

MHC-SF - General mental wellbeing was assessed for caregivers using the mental health continuum - short form. This measure contains three sub-scores: emotional, social, and psychological wellbeing. The summative, overall wellbeing score ranges from 0 to 70. Subscale scores range from 0 to 15 for the emotional (hedonic) wellbeing, from 0 to 25 for social wellbeing, and from 0 to 30 for psychological wellbeing. There are also categorical levels of mental health based on caregiver responses to certain questions. Flourishing mental health is defined by reporting ≥ one of three hedonic signs and ≥ six of 11 eudemonic signs (social and psychological subscales combined) experienced 'every day' or 'five to six times a week.'

Moderate mental health is defined by meeting flourishing requirements but having an individual emotional, social, or psychological score below six, 10, or 12 respectively. All other scores are classified as languishing mental health. Higher scores indicate greater levels of positive wellbeing (Keyes, 2009). Analysis was conducted with respect to those caregivers who were interviewed during summer 2020, winter 2020-2021, and summer 2021 (n=12). Overall, categorical levels of mental wellbeing appeared to increase as time progressed (Figure 10); these results were consistent across gender.

Score	**Summer 2020 (N=28)**	**Winter 2021 (N=22)**	**Summer 2021 (N=21)**
Cumulative	44.03 (12.76)	45.27 (11.42)	49.14 (13.31)
Emotional	9.64	10	10.76)
Social	14.67	15.22	15.57
Psychological	19.71	20.04	22.81

Table 7: MHC-SF scores for caregivers

First Intervention Point - The EMO AID (emotional aid) program was the first intervention used, which was designed to focus on self-care, equipping participants with supplies to create a personalised first aid box for their emotional wellbeing. Specific emphasis was put on becoming aware of emotions, regulating negative responses, and enhancing positive feelings. This program ran between September and December 2020.

Second Intervention Point - As a precursor to the second intervention of role appreciation and skill building, expansive round tables were facilitated with caregivers to determine the contours and exact focus this second intervention should take. Role appreciation and skill building was designed to focus on deepening the understanding of caregivers' roles and building skills around the evolving context of child care homes in India. The intervention was delivered

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through training workshops, specifically emphasising empathising with children and handling them with compassion, appreciating the role of caregivers in the Udayan Care model, inducting new children, identifying and handling significant events, classifying visitors and working with them, and this program ran between March and June 2021. Considering the focus on skills, pre- and post-intervention tests were conducted. Designed as a simple nine-question instrument, this test was focused equally on the knowledge and skill elements of the caregiver role.

Statement	**Pre-test**	**Post- test**
Knowledge about type of children that come in care	64%	95%
Knowledge about authorities through which a child comes into care	59%	86%
Skills to work effectively with children in care	64%	73%
Awareness about their roles and responsibilities from a legal perspective as well as from being a go-to person for the child	64%	100%
Ability to identify the different types of visitors	73%	73%
Gauging standard protocols to be followed when someone arrives or leaves	45%	86%
Level of conceptualisation of participants of their role when a new child enters care	73%	86%
Knowledge of a significant event	73%	100%
Understanding of roles and responsibilities when a significant event occurs	68%	91%

Table 8: Statements pre-test and post-test

Discussion

Baseline data

Bringing the results of PHQ-9, GAD-7 and OBI together suggested that: The majority of caregivers (n=16) had scores that fell above the minimal depression range. There were low levels of average anxiety, but a majority of caregivers (n=15) indicated mild or moderate anxiety. With respect to burnout, there were moderate levels of average overall burnout, but a wide distribution of overall burnout scores, suggesting that some individuals may still be experiencing severe levels of burnout, despite the group as a whole experiencing moderate levels. We found that gender, age, and time spent working in Udayan *Ghars* all provided insights into the state of the individual. Females generally tended to have a higher frequency and severity of depression and anxiety. Moreover, they

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also had higher burnout scores and lower overall mental wellbeing scores. Individuals in early adulthood in this sample tended towards having higher depression, anxiety, and burnout scores, as well as lower mental wellbeing scores. We observed that caregivers' depression, anxiety, burnout and MHC-SF scores varied considerably across length of employment.

The MHC-SF indicated moderate to high levels of average overall mental wellbeing, despite there being individuals in these groups who fell under low/languishing mental wellbeing. One intriguing possibility was that mental health scores followed a pattern in which we saw a decrease in score in the first year, possibly related to relief from previous life circumstances, an increase in scores the following year or two, related to mounting pressure from work, and then ideally a clear or gradual reduction in scores as length of time in Udayan Care increased, due to the stability and support structures in place.

Mid-line data

There was a very slight (1 to 1.5) mean score improvement in depression, anxiety and overall wellbeing, and a very slight increase in burnout, pre-/post-intervention (between testing in June 2020 and in Jan 2021). This result in no way suggested that the intervention was not effective; it only indicated that there isn't evidence that gains made after the intervention were large across the whole sample, or were retained across three to five months, as measured by the PHQ-9, GAD-7, MHC-SF, and OBI. However, there were a subset of caregivers who showed substantial clinical improvement across all four mental health categories.

In addition to the strengthening of knowledge and skills, a feeling of being a community which was learning together also enabled the participants. One of the participants stated, 'I will leave no stone unturned to make all the kids successful so that they are able to reach great heights.' They added, 'I have worked with many different spaces, but the life lessons and values I have learnt from the children in Udayan Ghar are helping shape my worldview.'

Another advantage of these sessions was the ability to engage in dialogue. For instance, punishment and shouting at children has been a common disciplining practice in the country. To get an idea about participants' views on corporal punishment and yelling at children, the caregivers were asked, 'Do you feel that under certain circumstances it becomes important to shout at children to make them understand their mistakes?' Pre-training assessment divulged that 68% of caregivers concurred that it is okay to shout at children under certain circumstances. The training effect is visible in the fact that in post-training assessment the percentage of people who agreed that shouting at and spanking children is okay dropped by 27%.

End-line data

Tool	**Score Range**	**Base-line score**	**Mid-line Score**	**End-line Score**
GAD	0 – 21	5.0	3.5	2.0
PHQ 9 (n-10)	0 – 27	7.3	6.4	3.2
MHC SF	0 – 70	47.7	48.1	47.7
OBI	16 – 64	30.5	30.6	32.2

Table 9: Overall scores across the survey for 12 participants who had valid data points across the three touch points. (N-12, 5 Men, 7 Women)

Investigation and conversation with these 12 participants indicated that while short-term interventions may not show a visible result, sustained interventions support caregivers to manage their overall anxiety and depression levels.

Conclusions

The issue of burnout among caregivers in child care institutions (CCIs) is a critical requiring more focused attention. In this study, the emotional, psychological, and structural tensions that caregivers work under have been brought to light, particularly in environments characterised by overdemand, under provision, and a high emotional investment in the health of vulnerable children. The caregivers act as containers for children's pain, trauma, and an underperforming system, sometimes at the cost of their own emotional health. There is a need for proactive and continued investment in the emotional development of caregivers, to enable them to better support orphaned and abandoned children (OAC). Despite the constraints discussed herein, there is hope for the future. It is significant that India has been witnessing a growing awareness of the importance of high-quality child care services and the wellbeing of caregivers. Government policies, like the Juvenile Justice (Care and Protection of Children) Act of 2015, and its *Model Guidelines for Foster Care* created in 2016, increasingly emphasise the rights and overall development of children, and the critical role of caregivers in the system. The Ministry of Women and Child Development has also made progress in the 'Child Protection Services' scheme, previously called ICPS, which aims to strengthen the capacities of child care institutions (CCIs) and personnel through the implementation of training programs around stress management and child psychology.

There has also been expansion in non-state led initiatives aimed at caregiver wellbeing. Organisations like Miracle Foundation India and Udayan Care have brought in practices like reflective supervision, formal emotional support meetings, and professional development for CCI staff. These initiatives reflect increasing recognition that the quality of care children receive is central to caring for the caregiver. Interestingly, the inclusion of mental health professionals and psychosocial support networks in CCIs is gradually picking up pace. A few states have experimented with the inclusion of counsellors at child welfare centres as a

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step towards addressing the emotional burden faced by both workers and children. Concurrently, training initiatives that use trauma-informed and attachment-based methods are gaining traction, equipping caregivers with the ability to respond with more empathy and strength.

These positive shifts are uneven and must be integrated fully in the nation. This also requires support through a shift in cultural attitudes—beyond thinking of caregiving as administrative or vocational, to recognising its relational, emotionally textured nature, which is essential to a child's healing process. This is not merely a matter of policy and funding shifts, but also close attunement to the lived reality of caregivers, many of whom remain invisible in the child protection system.

As India develops its child care resources, it is important to incorporate the welfare of caregivers as not just a moral imperative but a strategic necessity for child development. A supported and compassionate caregiver could be a life-changing force in the lives of many of the country's most vulnerable children.

Limitations and future research

The research was consciously designed as a ‘pilot study’, to be administered to the caregiver pool working in Udayan Care for a period of at least 12 months. This resulted in a statistically small sample size, which reduced further through factors like attrition. Considering Udayan Care mostly runs girls’ homes, the caregivers also tend to be women. Initial data indicates that gender nuances do factor into anxiety, depression and overall mental health. Going forward, our intent is for the study design to be replicated with a larger group working with not-for-profits across the country, with both genders equitably represented.

With three data points, the study has generated rich information providing useful insights into the anxiety, depression, burnout, and overall mental health of caregivers. Being able to monitor these across a longer timeframe would definitely provide richer insights into those mental health triggers for caregivers which are ecosystem driven.

The challenge of the short-term employment mindset that caregivers typically operate within may not be a limitation that can be addressed completely, but broad basing the research to caregivers across various organisations in India may help to rectify this issue to a certain extent.

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