Special feature
Mental health philanthropy

What can philanthropy do to catalyse more attention to, and investment in, mental health and well-being?
Guest Editor
Krystian Seibert
Swinburne University of Technology

Lead article

Does philanthropy have a mental health problem?

Krystian Seibert is an industry fellow at the Centre for Social Impact, Swinburne University of Technology, Melbourne and a policy and regulatory specialist at Philanthropy Australia. He is chair of Mental Health First Aid Australia International, and serves on Alliance magazine’s editorial advisory board.

@kseibert@swin.edu.au
@KSeibertAU

Phanthropy has often shied away from tackling mental health. Do the reasons usually given for this mask a deeper unease among funders?

As a person who is passionate about both philanthropy and mental health and whose work spans both these realms, it was an honour to be given the opportunity to be the guest editor of Alliance magazine’s special feature on mental health philanthropy. Articles like this often highlight facts and figures – these are very important, because numbers and percentages illuminate the importance of an issue and the progress made in addressing it.

Mental health touches the very core of how we relate to ourselves, those around us and the community and world we live in – so it’s important that numbers and percentages don’t inadvertently depersonalise the issue, and that we don’t overlook the relational aspect of the topic and skip straight to a discussion of problems and solutions.

Paul Connolly of social sector consultants, TCC Group writes that ‘effective’ philanthropy involves balancing ‘humanistic’ and ‘technocratic’ approaches and this has particular relevance to mental health. It is a topic that requires a good dose of the heart, as well as the head – passion and expression, as well as objectivity and evidence.

An ongoing cognitive dissonance
Although mental health is, obviously, a ‘health’ issue, it also has certain distinct characteristics. In some ways, because of its nature, it is more tied up in societal dynamics and cultural attitudes and norms than other areas of health, especially those where it is more obvious a person is ‘experiencing’ an illness.

“Mental health touches the very core of how we relate to ourselves, those around us and the community and world we live in.
People experiencing mental illness may not realise they are. Even if they do realise, they may not feel comfortable reaching out to others for fear of the reaction they may get, while those who do seek support from the mental health system may also get let down by it.

Australia, where I live, has come a long way in the last two decades when it comes to awareness about mental health and the support available for people experiencing mental illness. But the mental health system is still far from adequate, and more broadly, the messages given regarding mental health reflect an ongoing cognitive dissonance within society – we say we want to be more supportive of people with mental illness, but they can also be judged or excluded using arbitrary and insensitive generalisations.

If that is the situation in Australia, in other countries, where cultural attitudes have made less progress, it can be even more challenging.

This is starkly illustrated in 2020’s Living in Chains report from Human Rights Watch, which focuses on the practice of shackling people with mental illness. I am Polish Australian, and I can see the role of cultural attitudes from that perspective as well.

As Raj Mariwala and Natasha Mueller point out in their contributions on pages 53 and 56 respectively, globally over a billion people are living with a mental illness and 80 per cent of those live in low- and middle-income countries. On page 50, Rory White and Danielle Kemmer highlight how mental health is the leading cause of disability around the world and contributes to millions of premature deaths every year.

Government funding is still inadequate both within countries and in terms of development assistance, despite efforts to change this. The available data – and it is a bit out of date – also shows that philanthropic funding is, frankly, woeful – with mental health receiving just 0.5 per cent of all philanthropic health spending. When compared against the fact that mental illness accounts for 4.9 per cent of the global burden of disease, it is difficult to summarise it better than in the words of the Funding the Future of Mental Health report from United for Global Mental Health:

![Philanthropic spending for health conditions between 2000 and 2015](Image)

Source: Funding the Future of Mental Health, United for Global Mental Health
As things stand, philanthropic spending on mental health is minuscule and fragmented, and does not reflect the needs of the sector.

This disconnect between societal rhetoric on mental health, the impact of mental illness across the world, and philanthropic action raises a question – does philanthropy have a mental health problem?

In my peer dialogue with Joshua Haynes of the Masawa Fund on page 44, his comment about the reticence he’s seen in the case of family offices in particular, was notable. Could it be that mental health stigma is still so strong that some people may be reluctant to fund mental health because it may lead to uncomfortable questions or unsaid insinuations about motivations for doing so?

While many of us are comfortable to share our own lived experiences, not all of us are.

White and Kemmer highlight some insightful research undertaken in Australia by the Future Generation Group (which uses an innovative approach to grow mental health philanthropy in Australia) and EY. The research found that 85 per cent of philanthropic funders that responded believe Australia is facing a mental health crisis – however, only 28 per cent directly fund mental health themselves. It concluded that they are reluctant to do so for a number of reasons:

- Mental illness is complex and the mental health sector is convoluted
- There is significant duplication across mental health delivery
- Most mental health charities have little profile and their messages are not resonating
- Measuring outcomes is a requirement for funding
- They are not aware of their place in the mental health sector
- There are not enough leaders encouraging other funders to invest in mental health

Some worthwhile recommendations are put forward aimed at addressing these issues. However, there is a sense from the research...
Below: The Masawa Fund – see page 44.

Striking the right balance?
Two issues identified make me wonder whether philanthropy’s lack of focus on mental health could reflect the fact that it isn’t striking the right balance between the humanistic and technocratic approaches I discussed earlier.

First, as Haynes mentions, mental health is relational. As noted, mental illness is less easy to ‘see’ than many other forms of illness, as are the approaches to supporting mental health. Could the strong and continually growing emphasis within philanthropy on demonstrating ‘outcomes’ and ‘impact’ be part of the problem? Mental health is certainly not the only space where this question is relevant – but could philanthropy be focusing too much on wanting to ‘see’ impact, and is therefore not having as much impact?

To illustrate this with a perhaps oversimplified example: it is relatively easy to evaluate the benefits of bed nets as a way of reducing harm from malaria, so much so that estimates for ‘cost per lives saved’ can be derived, of the kind popular within Effective Altruism.

This is not as easy when it comes to mental health. For example, I have the honour of being chair of Mental Health First Aid Australia International. In the two decades since the programme was first devised here in Australia, four million people have been trained around the world, with mental health first aid now being delivered in 24 countries.

Guidelines developed by Mental Health First Aid Australia and used around the world are firmly grounded in evidence. They are also rigorously evaluated, and consistently show the benefits of undertaking mental health first aid training. However, it is hard to track the impact of the training on people experiencing mental illness and determine the effectiveness of support provided by a person with mental health first aid training, so it’s not as easy to assess the benefits as it is in the case of malaria nets.

Of course, there are many different ways to measure outcomes and impact, and the evaluation of mental health first aid reflects that, but I wonder if the complexity that needs to be navigated is acting as a deterrent to philanthropy.

Second, it is certainly true that ‘mental illness is complex and the mental health sector is convoluted’. One quote from the research undertaken by the Future Generation Group, also referenced in the article by White and Kemmer, really stood out to me:

‘There’s not really a coherent story about mental health – you know – causes, research, services, what works, what doesn’t. I don’t think there’s a very coordinated picture.’

Practical steps can and should be taken to address this. As White and Kemmer propose, a comprehensive global strategy focusing on mental health is needed, though as they highlight, developing such a strategy is a complex undertaking in itself. But is the lack of a coherent story and the inherent complexity...
of mental illness and the mental health sector really such a barrier? Or is the bigger barrier within philanthropy itself?

Uncomfortable in the chaos
Could it be that philanthropy, again borrowing the words of Haynes, is not ‘Okay in the chaos?’. Perhaps when it comes to mental health, philanthropy isn’t living up to its ideal of being ‘risk capital for change’, as it expects too much certainty?

The tone of this article may seem rather negative but there are of course developments to celebrate – such as changing societal attitudes to mental health and the progress made in reducing stigma in recent decades (even if there is still more work to do). Mental health is now openly spoken about, as is the need to develop systems and responses that are better suited to the needs of those experiencing mental illness – and despite overall low levels of funding, philanthropy is playing an important role, one which it can and must build upon.

In Australia, philanthropy has played a critical role catalysing the development of the Headspace model and leveraging government investment and policy change through the Colonial Foundation’s long-term multi-year support for Orygen, The National Centre of Excellence in Youth Mental Health.

In 2021, one of the world’s largest philanthropic funders, the Wellcome Trust, made a significant strategic shift when it included mental health in its three priority areas.

Hopefully this is the start of a broader shift in philanthropy.

As part of trying to make this shift, introspection could help philanthropy better understand what it needs to change within the sector. It could help avoid externalising – expecting others to change before more funding towards mental health will be allowed to flow.

The reality is that the challenges are likely to come from various directions, and of course philanthropy is comprised of many different organisations, with different approaches, and they will respond in different ways. There is a lot philanthropy can learn from charities and non-profits working in mental health, from experts and those with lived experience – and from organisations within philanthropy that are already funding in this area.

Hopefully this special feature will play a role in shaping this important discussion, and help lead to tangible progress in terms of philanthropy’s role in supporting mental health across the world. ●
Over the next 30 years, therefore, the Trust will help find the next generation of treatments and approaches for mental ill health. This includes supporting the mental health science community to agree common ways to measure mental health outcomes. It also involves enabling connections across the research community, and involving people with experience of mental ill health in all aspects of the work. Current focus areas include anxiety and depression in young people (Wellcome is running a series of Data Prizes, the first of which focuses on young people’s mental health in South Africa and the UK), workplace mental health, transforming the understanding and discussion of mental health and building a global mental health databank. It has also published the *Wellcome Global Monitor 2020: Mental Health*, the largest survey of how people consider and cope with anxiety and depression.

wellcome.org/what-we-do/mental-health

Pears Foundation has funded the new Pears Maudsley Centre for Children and Young People out of its long-standing interest in promoting young people’s social and emotional well-being. It is also a recognition of the importance of intervening in possible mental health problems in the early years and addressing problems before they escalate. Working in consultation with children, parents and the local community, it will bring together leading clinicians, educators and researchers currently operating across multiple buildings. The aim is to create a purpose-built space to increase capacity and collaboration and accelerate shared learning. The Pears Foundation also provides multi-year revenue funding for a range of organisations that deliver mental health services in schools, the community or online. It is also a lead supporter of the Anna Freud Centre’s Closing the Gap strategy to address the gap between children and young people’s need for mental health support and the help available.

tinyurl.com/pears-maudsley-new-centre

Established in 2018, UnitedGMH brings together campaigners, practitioners, researchers, governments and philanthropic funders – such as the Bernard Van Leer and Gates Foundations, the Elton John AIDS Foundation and the Swiss Fondation Botnar – and international bodies like the Red Cross Movement, WHO and the Global Fund to Fight AIDS, TB and Malaria. Able to learn from each other and collaborate on the issue of mental health, it also provides advice and assistance to many of these groups. In 2018, for example, it launched an animation with Aardman and Stephen Fry, along with the report of the Lancet Commission on Global Mental Health and the Sustainable Development Goals at the UK Ministerial Summit on Mental Health. Its key focus areas are rights, financing, systems (strategies and interventions for treatment, prevention and promotion) and education.

unitedgmh.org
The International Alliance of Mental Health Research Funders (IAMHRF) unites funders around the world on a shared set of aims to increase the impact of funding on the basis that current sources are fragmented and inadequate to the size of the task. It stresses the collaborative nature of its projects and on their utility (‘Our projects... focus on what funders need to know and how that knowledge can be put into practice’). These projects include mapping global mental health research and supporting the adoption of common measures. Members come from across the sectoral spectrum and include healthcare supplies company Janssen, Cooper Investors (Australia), the Canadian Institutes of Health Research, the African Academy of Sciences, Wellcome and the Raintree Foundation. In 2020 it produced the global baseline study for mental health research funding, *The Inequities of Mental Health Research Funding*.

iamhrf.org

Mental health problems are a growing public health concern, with anxiety and depression among the leading causes of illness and disability.

StrongMinds provides free, group talk therapy to low-income women and adolescents in Uganda and Zambia. The background to its work is the prevalence of untreated depression among African women – according to statistics on its website, 66 million African women suffer from depression, the vast majority (85 per cent) having no access to treatment. In addition to lifting the burden from the sufferers themselves, the knock-on effects of successful intervention can be considerable, adds the website, in terms of the welfare of the women’s family, education of her children and economic productivity. In addition to its own therapy service, StrongMinds partners with key players to help layer mental health services into existing programmes and is the only organisation offering capacity-building to help other NGOs address mental health issues. It claims to have reached 100,000 women and aims to provide treatment to 300,000 more by 2024.

strongminds.org
LiveLoveLaugh Foundation

Founded in 2015 by actor Deepika Padukone, following her own experience of depression, LiveLoveLaugh (LLL) aims ‘to give hope to every person experiencing stress, anxiety and depression’. The foundation combines knowledge and expertise to create awareness about mental health, reduce the stigma associated with mental illness, and provide credible mental health resources. Its programmes include Frontline Assist which offers free mental health support to India’s front line workers who have experienced great stress during the pandemic, a rural programme (70 per cent of Indians live in rural areas) which provides free psychiatric treatment and rehabilitation to people with mental illness, a youth programme, You Are Not Alone which creates awareness about stress, anxiety and depression among adolescents, teachers and parents and a doctors’ programme to help compensate for the lack of trained mental health specialists in India (the country has about 8,000 psychiatrists to serve a population of 1.3 billion). The programme helps to develop and update standard teaching protocols and modules for evidence-based learning, build a nationwide network of primary care physicians and specialists and continually update them with the latest advancements in the field of mental health.

Set up in 1990, the Graham Boeckh Foundation is named in honour of Graham Boeckh who died at the age of 22 from complications related to schizophrenia. Its aim is to change the mental healthcare system, help save lives and improve outcomes for Canadian families. Activities include transforming youth mental health (it was instrumental in the creation of Integrated Youth Services in Canada), uniting global mental health research funders through its support for the International Alliance for Mental Health Research Funders (see above) and fostering collaboration and the exchange of knowledge.

Above: LiveLoveLaugh founder Deepika Padukone.
#BeKind21 invites participants to practise an act of kindness for themselves and others daily... to build kinder, connected communities that foster mental wellness.

Instituto Cactus’ mission is to promote mental health in Brazil, with a particular focus on women and adolescents. It was founded in 2020 by Maria Fernanda Resende Quartiero based on her realisation that mental health overlapped with many other social issues in Brazil. This overlap is also reflected in Cactus’ ambition to help achieve seven of the SDGs, among them good health and well-being, gender equality, decent work and economic growth, and peace, justice and strong institutions. This claim is particularly striking given the reticence of the SDGs themselves about mental health and well-being. Projects include partnerships with Instituto Veredas to map the provision of mental health in Brazil and worldwide, particularly for women and young people, and with Impulso – a non-profit that works in collaboration with public authorities to improve the collection and analysis of data on health – to define the chief indicators of mental health and share them with relevant public bodies.

Flourish Australia aims to help people who experience or have experienced mental health problems feel supported and meet their everyday challenges. Programmes include the Resolve Program in partnership with NSW Health and Social Ventures Australia to reduce the chances of readmission for people with a mental health issue who have been hospitalised for an extended period and Primary Care Psychiatric Liaison Service to help general practices provide comprehensive care to people in a primary care setting. Its Young People’s Outreach Program focuses on the everyday needs of 17-25 year olds dealing with mental health issues – from finding accommodation and becoming work-ready to maintaining healthy interests and relationships. Funders include state and federal governments in Australia, as well as charities such as Mission Australia, One Door and WentWest Limited. Like other organisations in this section, it sets great store on including among its staff, stakeholders and members, those with direct experience of mental health problems. Over half of its staff have such experience.
Set up by singer Lady Gaga and her mother, Cynthia Germanotta, in 2012, the foundation is committed to supporting the wellness of young people and working with them to ‘make the world kinder and braver’. Programmes include teen Mental Health First Aid in partnership with the National Council for Mental Wellbeing, and #BeKind21. The first teaches school students about common mental health challenges and what they can do to support their own mental health and those of friends. By late 2020 it covered 180 schools across the US. Launched in 2018, #BeKind21 invites participants to practise an act of kindness for themselves and others daily in order to build kinder, connected communities that foster mental wellness. Partners include Donors Choose, United for Global Mental Health (see above), the National Council for Mental Wellbeing and Starbucks.

bornthisway.foundation

Launched in 2017 by One Mind (formerly the International Mental Health Research Organization), One Mind at Work is a global coalition of organisations committed to the development and implementation of a ‘gold standard for workplace mental health and wellbeing’. With financial support from founding sponsor Janssen Research & Development, LLC, One Mind at Work has more than 60 global employers in diverse sectors including business, medicine, research, education, law enforcement, military and civil society. It has produced a Charter to Transform Workplace Mental Health which commits signatories to a set of best practices that include eliminating stigma, social prejudice and discrimination, adopting a proactive prevention approach and early and effective workplace interventions. It estimates that mental illness will cost global economies $16 trillion by 2030 and that, conversely, ‘every $1 invested in mental health promotion has a $3 to $5 return’.

onemindatwork.org

Founded in 2015, The Friendship Bench (TFB) implements student mental health programmes in secondary and post-secondary schools across Canada with the goal of decreasing the number of suicides and suicide attempts among Canadian students between the ages of 15 and 24. There has been an average 18 per cent increase in students coming forward to talk about their mental health on the 60-plus campuses where the trademark yellow Friendship Bench is installed. The programme works by encouraging peer-to-peer conversations about mental health among students, educating them about the causes of mental illness, building resilience and connecting more students to on-campus and in-community mental health resources. TFB is a not-for-profit organisation run exclusively by volunteers.

thefriendshipbench.org

Above: Lady Gaga.
Peer dialogue

Being OK in the chaos

How can we approach mental health in a different way that recognises its broad impacts across society? How can we more holistically invest in organisations and people, ensuring that the well-being of staff is put front and centre? Guest editor Krystian Seibert talks to Joshua Haynes, founder of mental wellness impact funding platform, Masawa.

Krystian Seibert: It’s a bit of a cliché, but it’s a really timely moment to be exploring this topic given the focus on mental health in recent years, also how the pandemic’s broader impacts have highlighted the importance of mental health and exposed the inadequate focus on the issue especially when compared to other areas. So what got you into the mental health space? Joshua Haynes: I worked in software development and digital innovation. I also was a diplomat in the Obama Administration working at the US agency for international development, and seconded to the Swedish international development agency, working on the nexus of civil society innovation and technology. At some point, I burned out and had a reckoning with my own inner systems, my own childhood trauma. I was raised by a single, alcoholic mother on welfare and had to confront my depression, my anxiety, my issues with food. I quickly realised that I wasn’t the only one experiencing these problems. The flip side is that there are so many approaches, so many opportunities and innovators who are looking to allow people to become more mentally well. However, I saw that there wasn’t any compassionate capital for this work on either the for-profit or the non-profit side, so I decided to use my experience in social impact and systems thinking, and my ability to look beyond surface-level events to work on this capital element. I couldn’t find another impact fund that was doing this in the way I thought was necessary to address a crisis of this scale. That’s when I decided to found Masawa.
KS: That’s fascinating. I’m chair of a mental health charity whose work reaches around the world, and I’m also drawn to it by my own experience of mental illness. I think the mental health space, maybe more than others, draws people in because of their own lived experience. I want to talk about your work in a moment, but I’d like your take on a more general issue. We know that mental illness is a global problem. Over a billion people are living with a mental illness, 80 per cent of them in low- and middle-income countries, but the data that we have shows that the philanthropic funding for that is woeful and that government development assistance is not huge either. Why are funding levels so low? Is there something at the core of philanthropy that is impeding it?

JH: In our work with family offices, we’ve seen that they often don’t want to be associated with mental health-related issues because of the potential public blowback, or because someone in their family has a mental health issue and they’re not ready yet to open up and be vulnerable. I see this both in the philanthropic and in the government space. You mentioned some statistics, and I believe on average, only 2 per cent of health budgets globally goes to mental health. That’s because there’s also a definitional issue. We only think of it as a public health issue, but it goes far beyond that. Mental health is about connection and how we are and relate to each other as people and as a society. It influences our ability to solve the multitude of other pressing global challenges. Further, mental health also has economic consequences, and it has to do with our infrastructure, which I’ll come back to later.

KS: Those examples of reluctance, eg in those family offices you mentioned, is really interesting and does highlight how pervasive mental health stigma can be, and how its impact on funding decisions doesn’t get much attention. I also agree that it’s not just a health issue, it’s about how we live and how we relate to one another. Part of my motivation behind the mental health first aid work that I’m involved with is that mental health is a community responsibility and you can only treat it when the community is educated and given skills, because it’s not just about the health system. I also wonder if there’s a challenge of intangibility. When
someone’s got malaria or cancer, for example, it’s clearer. Whereas, there are people who have a mental illness and don’t even know they’ve got it, or others tell them don’t have it.

JH: This unseen element means the systems aren’t there. You can calculate with malaria or cancer what the economic cost is but you don’t look at the intangible costs of mental health issues – the loss of productivity, the cost of presenteeism when people are at work but can’t do their job. In the UK, for example, five times more money is spent on cancer research than on mental health-related research, but the human and financial costs of the latter, however, are much larger.

KS: Coming on to the Masawa Impact Fund, can you explain your approach and what’s different about it?

JH: At Masawa, we’re working to, yes, get capital to those catalysing mental wellness, but also to nurture that capital in order to maximise the internal impact (human thriving inside the organisation) and external impact (human thriving because of the organisation). For us, mental wellness is more than just mental health. We look at the entire spectrum, ranging from innovations that focus on preventing and treating mental illness all the way up to those that enable human flourishing. So, not just being okay, but being really well. That allows us to also invest in things like nutrition, education, urban design and other social determinants of mental wellness.

In the UK... five times more money is spent on cancer research than on mental health-related research, but the human and financial costs of the latter, however, are much larger.

Our Nurture Capital approach is the thesis of the fund. If we work with founders and leaders to maximise their well-being and the well-being of their teams, they can better handle the human issues that lead to failure or poor outcomes; and combined with working on maximising their social impact, we’ll have less ‘failure’, more value creation and more financial and social returns. When I managed large impact funding portfolios for governments, I never once looked at the well-being of the individuals or teams I was providing grants to.

So it’s a two-step approach – investing capital and then nurturing that capital by cultivating human well-being and potential. Interestingly, we found that other funds, family offices, and philanthropists are interested in nurturing their capital, too, but don’t have the expertise in-house, so they’re turning to us.

KS: The ‘nurture capital’ angle is fascinating and again it goes back to the point that mental health is an issue with so many elements to it, and they can be overlooked, even though it doesn’t seem immediately obvious.
JH: At the end of the day, what funders want
to do is minimise risk, and one of those is the
human capital risk. It’s something we always
ignore, especially for those purpose-driven
business leaders in the non-profit and social
enterprise sector whose commitment comes
with the additional weight of wanting to
change the world. We know that founders are
twice as likely to experience depression, three
times as likely to have suicide ideation and
substance abuse disorder. If you aren’t
mitigating those risks, the project is more likely
to fail. In that case, you won’t have the return
or the impact that you’re seeking. On the flip
side, you’re able to maximise your impact –
both social and financial – by treating humans
holistically. Looking at them from this lens also
provides an opportunity for investors and
funders to ensure that there’s a
network around these leaders
that can support them when
they are struggling or failing.
Although I may be biased,
I think that’s a powerful
way to think about
impact.

KS: It would be a really good challenge to
philanthropy, regardless of what cause area
it focuses on, to pay more attention to the
mental health of its grantees. How much
recognition of this are you seeing among
people who aren’t necessarily focused on
mental health?

JH: We tend to be super myopic around our
own topics – ‘I’m focusing on climate change
and that’s all’; ‘You’re doing mental health,
so you’re in this bucket. You’re doing girls’
education, so you’re in that bucket’. There’s
only a small number of future thinkers who
are able to perceive the world from a systems
perspective. Unfortunately, it’s not until there’s
a tragedy, for example, when there’s a suicide
of a founder or a leader of an organisation,
that people start to wake up and see there’s
something they missed – a deeper pattern or
a broken narrative that creates such events.
There are but a few small groups of investors
specifically looking at the well-being of their
investees. And we haven’t seen that on the
philanthropic or social enterprise side, other
than the Wellbeing Project, which is looking at
the well-being of social enterprises specifically.

Another thing is that the de-siloing of
funding to mental health-related issues is
crucial because the researchers aren’t talking
with the advocates, aren’t talking with the
politicians, aren’t talking with the innovators,
the technologists, the funders, the investors.
Something we’re working on in Europe is
creating that conversational space through
events where people can meet and discuss
the common higher goal of creating a
thriving society.

KS: Zeroing in on something you just said
about the relational element – I think there
is this tension in philanthropy between
the relational and the transactional, the
humanistic and the technocratic. Measuring
impact is important, but there can also be
a heavy focus on quantitative measurement
of outcomes. Do you think we may have to
sacrifice some of that for the sake of what
you’re trying to achieve?

JH: Our ability to be okay in the chaos is the
only thing that’s going to be able to allow us to

If we work with founders and
leaders to maximise their
well-being and the well-being
of their teams, they can better
handle the human issues that
lead to failure or poor outcomes.
get out of this quagmire. To say, ‘yes, I have the financial KPIs I want to hit, but there are also the intangible things that I am accountable for’. Philanthropy’s accountability is often to get money out the door – and I know that’s an oversimplification – but where’s the accountability to the actual number of lives improved? Or the depth of that improvement? What happens when the goals aren’t reached? For us as an impact fund, the performance fees that we potentially make on our investments are directly tied to the social outcomes. If we don’t hit those, then we have to forgo up to half of the performance fees and donate them to a non-profit. If we’re only held accountable to the financial aspect then we’re going to put the same type of pressure that the traditional VC world puts on start-ups to pump up valuations, liquidations and exits.

KS: I suppose there are two sides to the impact accountability coin. If a measurement ‘works’, that’s great. But if we’re dealing with things that are intangible, how do you grapple with the challenge of measurement?

JH: The challenge of measurement! The long-term outcome we’re working towards is more people with more mental wellness. We need to find the right measurement that applies to their impact model and will roll up to this larger goal. So it might be the number of people who sustainedly spend less mindless time on their phones or the number of children whose parents report more anxiety coping ability. When looking at the internal impact inside the organisation, we’re able to use our bespoke measurement to assess the wellness of leadership and the overall team.

KS: One last thing I wanted to ask you was the cultural element of mental health. Obviously, it’s seen differently in different places.

JH: I think a lot of it is also how we define mental health. If we think about conditions like schizophrenia, we’re looking from a deficit perspective, whereas we could look at it from an abundance perspective – human well-being, human flourishing. Some organisations are beginning to use terms like resilience. Resilience is important – it allows you to get back up after a setback. And we’re two men talking here, and traditionally men are not great at talking about their own mental health, so framing it as resilience can help with that. In other words, it’s in part a terminology issue that we need to address. Something that we’re testing out is focusing not on mental health per se, but on human wealth. We think of wealth as a money term, but if we look at the etymology of the word, it originally meant happiness and well-being, which could bring about a whole different conversation.

KS: It’s really interesting to hear you reframing it in a positive way. You mentioned the importance of infrastructure earlier. Could you explain its relevance here?

JH: The idea of mental health as infrastructure came from an organisation called Dark Matter Labs, which posited that if we consider and invest in mental health as a form of infrastructure – something that is fundamental to society – it really changes how we value and assess it. So if we’d been investing in mental health as infrastructure over the last 20 to 30 years, for instance, when Covid hit, these issues of loneliness, or lack of self-worth or resilience that are affecting so many people wouldn’t have been as prevalent. The remedy would have been built-in like physical education is in school. Just as roads and transportation systems are the physical infrastructure allowing us to function, mental health would be our psychological infrastructure.
Are you eligible for a FREE digital subscription?

Our mission is to facilitate the exchange of information and ideas among philanthropists, social investors and others working for social change worldwide.

Digital subscriptions include:
- Four issues of *Alliance* magazine to read online or download as a pdf
- *Alliance* extra, providing regular updates on developments in the sector
- Unlimited access to the *Alliance* website, including the entire *Alliance* archive
- Free access to all *Alliance* events
- Email updates whenever new content is published

We’re committed to providing an accessible platform for our global audience, which is why we offer free digital subscriptions to readers based in over 140 countries worldwide.

Check if your country is eligible for a free subscription with our interactive map at alliancemagazine.org/free-electronic-subscriptions
Mental health funding still in the shadows

Danielle Kemmer is executive director of IAMHRF and vice president of Graham Boeckh Foundation.
@dkemmer@grahamboeckhfoundation.org
@dkemmer34

Rory White is a research and communication specialist at IAMHRF.
@rory@grahamboeckhfoundation.org
@iamhrf

A global strategy linking the disparate elements of the mental health field is urgently needed if the issue is to get the attention it warrants

In April 2016, the World Bank and WHO co-hosted a landmark event aimed at bringing mental health ‘from the margins to the mainstream of the global development agenda’. At the centre of the event was a report, Out of the Shadows: Making mental health a global development priority – which framed mental health as an urgent global problem requiring substantial philanthropic and governmental investment. The report’s arguments are compelling: mental health is the leading cause of disability around the world contributing to millions of premature deaths every year and an estimated 10 billion days of missed work. These problems can only be addressed – the authors emphasised – with a truly global outlook, given that 80 per cent of people with a mental health condition live in low- and middle-income countries. Many hoped that the Out of the Shadows event would turn the page on decades of underfunding and neglect.

Yet, almost six years later, there is little evidence of change. According to the WHO, governments spend an average of just over 2 per cent of their healthcare budget on mental health – and a recent report by the International Alliance of Mental Health Research Funders (IAMHRF), The Inequities of Mental Health Research Funding, found that funding levels for mental health research have not increased since 2015, with only 2.4 per cent going to researchers in low- and middle-income countries. Meanwhile, as other articles in this special feature point out, mental health philanthropy accounts for an average of just 0.5 per cent of yearly development assistance for health. So why, despite the growing profile of mental health and the strong public health and economic cases for action, have investments not been forthcoming?

No coherent story

Surveys of private funders indicate that there is widespread confusion about how to address the challenge. As an Australian philanthropist put it: ‘There’s not really a coherent story about mental health... causes,
Effective coordination requires development of an overarching strategy, based on evidence and a shared vision with the diverse stakeholders in the sector, from governments to philanthropists, to NGOs having clearly defined roles and responsibilities. Without these components, funders lack the confidence and clarity to invest substantial amounts of money into mental health solutions and research. A poll of private funders revealed that 55 per cent of those who do not invest in mental health would be willing to do so if they were given more clarity on its landscape. Why has the mental health sector failed to coalesce around a concerted global strategy? As we shall see, mental health presents a variety of unique challenges that make the development of such a strategy more difficult – and even more necessary.

**The obstacles to a global strategy**

One of these challenges is the sheer number of determinants that influence mental health which include factors as diverse as income, resilience, trauma and adversity, housing, employment, genetics, stigma, family structure, identity, inequality, health services and social connectedness. The Wellcome Trust sees youth anxiety and depression alone as requiring 27 ‘active ingredients’. This complexity has led the field to fragment into numerous disconnected disciplines with very different conceptualisations of mental health and made it difficult for potential investors to know what to prioritise. Should they start by addressing poverty, developing new drugs, creating more green space in urban areas, or improving children’s social habits?

Moreover, competing characterisations of the case for action on mental health are in circulation, ranging from the so-called ‘treatment gap’ which relies on a biomedical model of mental illness, through the damage to sufferers, to the global economic burden of disease and lost productivity. Other health sectors, such as malaria, have used examples of interventions to great effect in attracting funding but the lack of robust outcome measures in mental health makes it difficult to know for sure whether an intervention has worked. There are over 270 tools for measuring depression alone and even where strong evidence of effective interventions...
does exist, it has been underutilised in making the case for funding. Not only does this deter investment, it also perpetuates the notion that mental health is not a ‘real’ or ‘legitimate’ problem. All in all, there is an urgent need to collaborate on an overarching strategy for mental health that clearly defines priorities, messaging, roles and timelines.

The importance of global collaboration

Moreover, because of the context-dependency of mental health, collaboration and knowledge sharing is urgently needed. An individual’s experience of mental health is deeply influenced by their cultural, social and economic environment and an intervention that works in a metropolitan population in Manhattan may have little impact in a farming community 100 kilometres away, never mind in Mozambique. While isolated examples of local mental health solutions have been successfully adapted, including the Friendship Bench and the Headspace model, implementing and scaling up effective interventions usually requires deep contextual knowledge. This requirement limits the transferability of interventions and has acted as a barrier for overseas impact investment.

Thus, for decades, mental health solutions have been almost exclusively funded and developed in Global North contexts that are not applicable to most people affected by mental ill health. Youth mental health is a case in point: current funding practices neglect 90 per cent of young people living in the Global South, who should be prime candidates for early intervention and prevention. To turn the tide, investment in mental health solutions must be grounded in a deep understanding of local contexts and communities. This level of understanding can only be achieved by building permanent bridges between stakeholders in the Global North and Global South to foster knowledge sharing, equitable partnerships and solidarity.

The role of IAMHRF

This is no easy task. Uniting stakeholders that would not normally work together often requires careful and diplomatic brokering of relationships by a neutral party. In the context of research funding, this role is played by the IAMHRF. Through the careful allocation of resources, research funders have great influence over what is researched and what the research can lead to. The priorities they set can have major consequences on the pace of innovation and the development of improved mental health treatments and care. By connecting research funders around the world and enabling them to share their strategies, the IAMHRF helps them make informed decisions on the funding gaps and inequities that hamper progress globally and, most importantly, creates targeted opportunities for collective impact. In October 2020, a subset of IAMHRF members and academic publishers agreed to mandate a first set of common outcome measures for use in mental health research. This development is testament to the transformative potential of establishing international collaborations to reduce fragmentation in the field.

There are huge challenges facing mental health if it is to emerge from the shadows. An overall strategy is urgently needed. The advancement of international standards for disease categories and tools shows clear promise in guiding the management of mental health problems at a global scale and generating robust evidence – particularly in the context of targeted interventions. And yet, this alone will not move the needle on mental ill health. We cannot hope to improve the mental health of people across the world without an understanding of their cultural and social contexts, and while there is a need for investments that are substantial and multifaceted, these must be embedded in equitable partnerships that allow for local leadership to drive effective implementation and sustainability. We need structures and alliances that can finally unite the mental health sector under an overarching framework that speaks to philanthropists, governments and stakeholder communities alike. Together, we must embrace the principles of solidarity, inclusion and diversity needed to build an effective ecosystem for better mental health.
The care gap

In low- and middle-income countries particularly, the provision of mental health services is inadequate to address the spectrum of mental health issues.

Globally over a billion people are living with a mental disorder and 80 per cent of those live in low- and middle-income countries (LMICs). Other articles in this special feature have noted the treatment gap - the difference between the number of people who need mental health care and those who get treatment - but while the statistic of between 75 and 95 per cent of people in LMICs who are unable to access treatment highlights the magnitude of the problem, it unfortunately frames a limiting narrative and reductionist approach to mental health and related philanthropy.

Fragmented services
In 2017, close to 200 million people in India were living with mental health conditions and while the country is home to 18 per cent of the global population, it accounts for 24-37 per cent of global suicides. Thus, it comes as no surprise that South Asia, and India in particular, is one of the major recipients of philanthropic funds for mental health. However, such a starting point is insufficient when it comes to designing services and policies to address access and the provision of better mental health. For example, the absence of mental health care at a primary or even secondary level means that someone living in rural India may have to travel long distances and speak certain languages to even access treatment. Current specialist-led vertical mental health programmes in India are organised on a service-led approach in which users are forced to come to the district level tertiary care, where services are fragmented and don’t typically go beyond purely pharmaceutical interventions. Such a biomedical and individual approach has also insidiously rendered mental health invisible as a global challenge and a development issue.

Inadequate response by the state
Despite the high incidence of mental health problems and their links to poverty and homelessness, the focus of the state has been on a ‘medical’ model that is largely institution-based. Despite the calls for increased funding, no state government of India has spent even 80 per cent of the funds allocated to it under the District Mental Health

Raj Mariwala is director of the Mariwala Health Institute. rm@mariwalabhealthinitiative.org @mariwalabheath

Below: A prevention of sexual harassment workshop held by MHI partner organisation Anubhuti Trust.

SPECIAL FEATURE: MENTAL HEALTH PHILANTHROPY
Programme in the last six years, largely because of the lack of capacity and technical knowledge and a marked lack of monitoring and evaluation. While provisions for review exist in recent policies and laws such as National Mental Health Policy (NMHP, 2014) and Mental Healthcare Act (MHCA, 2017), they remain on paper.

The nexus of mental health and poverty
Especially in LMIC contexts, poor mental health is both a cause and a consequence of poverty, compromised education, gender inequality, physical ill health and violence. To adequately address mental health in LMIC contexts like India we need to foreground mental health as a rights-based issue, not just in terms of widespread rights abuses of persons with mental illness, but also in the barriers they face in access to education, employment and exercising civil and political rights.

There is a vicious cycle of poverty associated with mental illness in India. The poor are significantly more likely to experience mental health problems and conversely those with mental health problems are more likely to slide into poverty. While research shows that mental illness is linked to higher rates of unemployment and shorter employment spells, it also shows that being unemployed for a significant period impacts a person’s mental health.

According to the National Mental Health Survey of India (2016), mental health issues were significantly higher in households with low income, poor education and limited employment, so it is vital not only to provide mental health services but also links to services that support shelter and social inclusion. Thus, in LMICs, understanding the ‘care gap’ is imperative for philanthropy - recognising that mental health is squarely a development and inclusion issue that requires a psychosocial, multisectoral and community-based approach.¹

A major barrier to increased philanthropy is the Foreign Contribution Regulation Act (1976) which means that many promising community-based mental health organisations are unable to accept foreign funding. Domestic philanthropy in mental health has been very limited. For many years, Tata Trusts was the only philanthropic organisation supporting mental health. Indian philanthropic funding has not only been limited but also has largely focused on institutional reforms in mental hospitals, intellectual disability and rehabilitation of...
persons with mental illness. Despite organisations such as the Azim Premji Foundation and Mariwala Health Initiative (MHI) currently funding mental health, there is a dire need to fund community-based, psychosocial mental health non-profits, as well as carry out advocacy and capacity building with central and state governments of India to utilise budgets and implement the MHCA and the NMHP.

MHI and its partners
These concerns are at the root of MHI’s outlook as a grantmaking and advocacy organisation working on mental health in India. Due to our focus on accessible and appropriate mental health services and support for marginalised communities, we partner with organisations and programmes that foreground community-based mental health support that goes beyond a symptom-reduction approach and works towards social inclusion via multiple pathways and referral linkages.

One such programme is the Atmiyata programme run by Centre for Mental Health Law and Policy (CMHLP). Operating in over 530 villages in Mehsana Gujarat and serving around 20,000 individuals a year, local leaders are trained to provide support and counselling as well as make referrals to the public health system, legal aid, shelter homes and livelihood services. As the local leaders are part of the community, there is a high level of intervention by individuals who are part of the social fabric of the place, share the living circumstances of persons needing care, and are able to communicate about mental health using context-specific and accessible language.

In addition, MHI partners with the iCALL helpline which is staffed by psychologists and offers free counselling in nine languages. This combination of quality, affordability and access (geographic and linguistic) allows for scalability. For example, between April 2020 and March 2021, iCALL received 22,575 calls (a 35 per cent increase over the previous year) and 12,658 emails (52 per cent increase over the previous year). While iCALL’s direct counselling services cannot cater to the mental health needs of the entire country, MHI’s funding supports iCALL to work with stakeholders such as the government to train and help build government helpline capacity, such as Counsellors of Women’s helpline in seven states, Umang Helpline (for varied government services) and more.

Finally, it is imperative to strengthen the base of mental health advocacy in India and MHI has been working with funders to support mental health through various means such as Alliance For Suicide Prevention, or by supporting programmes to train lawyers, judges and government machinery on the MHCA.

Thus, the initiatives we tend to support are those with a strong focus on community-based grassroots interventions, where services and support are provided not just by experts, but also by trained individuals from within the community. In addition to foregrounding community voices and participation, this approach also acknowledges how systemic barriers and forms of marginalisation specific to their context affect an individual’s well-being. When considering mental health philanthropy in India the principles that are important to remember are: any ‘expert intervention’ or mental health practice should be situated alongside peer groups, networks and communities and that technology cannot be relied upon exclusively, but used when appropriate to scale services. Finally, to tackle the gaps in mental health in India we cannot sidestep the need to address social, economic and institutional exclusion that contributes to psychosocial distress – which means widening the ambit beyond mental health services to intersectional work with issues such as food insecurity, provision of social safety nets and labour rights.

Poor mental health is both a cause and a consequence of poverty, compromised education, gender inequality, physical ill health and violence.

1 The urgency is underlined by a 2021 study by Azim Premji University that found that 230 million Indians were pushed into poverty after one year of Covid-19 leading to widespread unemployment, loss of income, food insecurity and homelessness.
Now it’s getting exciting!

Although it is seldom highlighted by the SDGs, good mental health is fundamental to many of the most significant challenges we face. There are positive signs that funders are catching on to this.

Many philanthropists currently funding mental health services around the world do so for deeply personal reasons, having experienced poor mental health ourselves or having cared for family and friends through trauma and illness. In my own case, my father suffered from bipolar disorder and depression and committed suicide when I was only 17; this is not a memory that ever fades. It has shaped the way I look at life and has driven me to turn my pain into the passion, energy and strength I need to be part of the positive changes that I want to see in the world.

It has become very clear to me, both from watching those closest to me struggle and from my own mental health issues, that our mental health can either empower us to, or derail us from, living our best lives. And the more I understand about this sector, the more I realise that caring for mental health is the foundation for success not only in our own lives, but also for creating a kinder, more sustainable and productive society.

In recent research that I carried out with United for Global Mental Health and Arabella Advisors, we found that mental health cuts across at least 12 of the 17 UN Sustainable Development Goals (SDGs), interwoven as both cause and symptom. Recent research by United for Global Mental Health has shown, for example, how integrating mental health and psychosocial services into HIV and TB programmes could avoid up to one million HIV infections and 14 million TB cases by 2030. According to research by Imperial College London and the Grantham Institute, when temperatures rise, so do the cases of death by suicide and hospitalisations for mental health conditions (roughly a 1 per cent increase in the number of suicides for each one-degree rise in local temperature).

In short, wherever humans are at the heart of the problem and wherever we need individuals and communities to adapt and change the way they do things, we also need mental strength and mental health services to be part of the solution.

It is, therefore, exciting to see the transition that is now happening within mental health philanthropy. With mental health brought to the forefront by the extraordinary measures taken in response to the Covid-19 pandemic, individual and corporate philanthropists are...
beginning to focus not just on tackling mental illness as an important goal in itself, but also on the extraordinary power that integrating mental health services has on improving the outcomes for other SDGs.

Recent examples of integration include The Global Fund and the Clinton Health Access Initiative, both of which are starting to use mental health services as one of the tools to reduce HIV and TB infections in response to the research cited earlier.

Fashion design house, kate spade new york, has a vision to ‘put mental health at the heart of women’s empowerment’ through its social impact work and giving; the Bernard Van Leer Foundation is integrating mental health into maternal health care; and Zoom and Peloton have recognised the importance of funding mental health programmes as part of tackling racism and discrimination. Recent research from Imperial College London outlines the relationship between the climate crisis and mental health, and the significant opportunities that arise from combining mental health and environmental efforts.

These developments are all important because, despite the systemic importance of mental health, the financing gap is so severe that of the billion people around the world currently experiencing mental ill health, more than 80 per cent are without any form of quality, affordable care. The low level of funding both from public (despite the agreement of a global comprehensive mental action plan in 2013) and philanthropic sources has been documented in other articles in this special feature.

Supporting, researching and encouraging this new momentum in mental health philanthropy has, therefore, become a key priority for me as an existing funder. With this in mind, we set up Kokoro: a not-for-profit to inspire greater understanding among leaders on how mental health affects our society, economy and planet – both in terms of the risk and damage that comes with poor mental health and, conversely, the benefits of creativity, energy, empathy and perspective that come with positive mental health.

In partnership with Nexus Global, Kokoro hosts the Future Mental Health Collective, a global peer-to-peer network for those who include mental health services in their philanthropic giving. Even in a short time, we have seen how valuable it is for this community to have each other to learn from and to lean on – funders themselves can feel overwhelmed by the global need for mental health services, which far outstrips what any single one of us can provide.

Mental health is undoubtedly complex... but it’s also deeply human. I lose count of how many meetings I attend where the personal stories I hear give me goose bumps. As funders of mental health, we share an energy and a drive that is visceral and powerful. Our hope is that by combining forces and taking collaboration to new levels, we can accelerate our learning from other sectors, countries and specialisms; we can make the systemic links that are needed across the SDGs; and we can catalyse action well beyond our own individual reach. If you want to get involved, we’d love to hear from you!

For more information on the Future Mental Health Collective, email collective@kokorochange.com
Strengthening young people’s mental well-being

Adolescence can be a critical time for mental health, especially in challenging circumstances. Funders who work with young people – on any issue – can help.

At EMpower, we partner with organisations in emerging market countries to enable marginalised young people to transform their lives and communities. In 2016, we shifted our strategy in South Africa to support programmes that focused on adolescent mental health and resilience. Why? Because although 65 per cent of the young people with whom our partners worked managed to get jobs after graduation, only 35 per cent remained in employment six months later. We learned that fostering better mental health, helping build communities of care and strengthening organisational capacity are fundamental to achieving the goals our grantee partners sought for young people.

Mental health problems often begin during adolescence. In South Africa and other challenging environments, a mix of poverty, violence and intergenerational trauma lead to high levels of unaddressed psychological distress. The young people with whom our partners work live in households that are below the national poverty line and are regularly exposed to high levels of violence and volatility. Young women in South Africa face among the highest levels of gender-based violence in the world, which has increased during the Covid-19 pandemic. One partner found that youth in their programme had experienced eight traumatic events each year in the years 2016, 2017 and 2018 (compared to the UK/US average of 4.8 per lifetime). Compounded over time, these events compromise young people’s ability to focus on learning, make healthy decisions and engage positively with others.

Theodoros Chronopoulos is senior programme officer at EMpower, Africa and Russia.
@tchronopoulos@empowerweb.org
@EMpowerweb

Deborah Diedericks is a programme officer at EMpower.
@ddiedericks@empowerweb.org

Eva Roca is a consultant at EMpower.
@eroca@empowerweb.org
@EvaRoca

Below: EMpower partner organisation Khululeka Grief Support specialises in grief and mental health support for at-risk children and adolescents.
EMpower’s work in South Africa focuses on supporting partners who work directly with young people and, where needed, with their caregivers. We have seen that, even in challenging circumstances, grantee partners have found ways to support the mental health and resilience of young people. For example, one organisation developed a community monitoring programme featuring regular socially-distanced home visits to ensure girls remained safe from violence.

Given continuing stigma and other barriers around discussing or seeking care for mental health needs, innovative approaches are often required. Such programmes employ methods that promote young people’s self-awareness; forge connections; develop the ability to self-regulate; focus on what they can control and help them take purposeful action. These strategies are not only beneficial in themselves, they also improve young people’s educational, health and livelihoods outcomes.

In 2021, we commissioned a listening exercise including grantee partners and young female programme participants to understand whether young people’s mental health needs are served by current approaches, to document existing and emerging best practices and identify capacity strengthening needs. The girls and young women (aged 10-24) told us they feel unsafe, often overwhelmed, struggle to meet basic needs and were facing additional challenges as a result of Covid. One said, ‘I feel like it is my responsibility to make sure that everyone in my family is taken care of. I cannot just focus on myself because my family will drown in their stuff.’

During this exercise, evidence emerged that some approaches are both highly valued by the young people and successful. These include: a) creating safe spaces to help young people explore their experiences, and learn to recognise, express and manage their emotions; b) exposure to unfamiliar situations in which young people are forced to face fears and practise different responses to stress; c) having mentors who come from their own community and are able to forge relationships on the basis of shared power; d) having access to mental health professionals in the partner organisation and in the public health system. These strategies are engaging, relatively low-cost and effective, yet many young people also have needs that go beyond the ability of our partners and require expert intervention and treatment.

It is critical for foundations that fund work with young people to recognise how fundamental mental health is to achieving other goals.

Above: United Through Sports utilises the power of sport to help improve education outcomes, raise sexual health awareness, promote gender equality and build life skills.
Shifting the frame

Vani Jain is executive director of the Daymark Foundation, Canada. 
@vani@daymarkfoundation.ca
@DaymarkFdn

Philanthropy needs to move away from targeted support for a few to mental health for all

When I started at Toronto’s Centre for Addiction and Mental Health in 2006, mental health was an unfamiliar term. To most, mental illness was something that happened to ‘other people’.

Fast-forward to today. One in four Canadians over 18 and one in three young people have symptoms of depression, anxiety or post-traumatic stress disorder. One in 10 Canadians has had suicidal thoughts – up 400 per cent from pre-Covid times. Even pre-pandemic, we had realised that nearly half of all Canadians will experience a mental disorder by the age of 40.

Rather than a binary definition of mental health (either ‘normal’ or mentally ill), we are reaching a better understanding of the fluidity of mental health along a spectrum, and that none of us is immune.

What does this mean for philanthropy? In my view, we must shift our framing from targeted mental health support for a few to mental health for all.

Scaled approaches are key
Small investments into niche programmes are no longer enough. As demand for mental health care increases, philanthropy has an important role in investing in innovative approaches that can respond to mass need. For example, Bell Let’s Talk, RBC Foundation, the Rossy Family Foundation and Health Canada together invested in the creation of national mental health standards to inform the practices of post-secondary institutions across the country.

We must think – and invest – systemically
More on-the-ground mental health services are not the only solution. Philanthropy should look at all aspects of the system – for example, research into more effective models of care, advocacy and awareness-raising efforts, and structures that enable enhanced collaboration between stakeholders. In the Daymark Foundation’s first year of funding in perinatal mental health, our six funded projects each focused on a different systemic leverage point.

We need to go upstream
A sole focus on people currently experiencing a serious mental illness is short-term thinking. Philanthropy needs to look at all aspects of the stepped-care model, which starts with universal mental health promotion, followed by preventative approaches for those at high risk, and treatment for sufferers. When I worked at McConnell Foundation, our school-based mental health efforts included social and emotional learning (SEL), through which we learn to recognise and manage emotions, care about others, make good decisions, behave ethically and responsibly, develop positive relationships and avoid negative behaviours. SEL in schools provides a strong foundation for positive mental health throughout life.

Government and philanthropy should work together
In a publicly-funded health system like Canada’s, foundations and individual philanthropists should consider their unique contribution and complementary role to government. For example, the Graham Boeckh Foundation (GBF) has been instrumental in bringing the Integrated Youth Service model to Canada. Rather than funding these hubs alone, GBF catalysed the model through pilots and research, then worked with government to scale them in each province.

We must take a health equity lens
Not everyone experiences mental health the same way. We need to consider the unique needs of groups such as Black, Indigenous, LGBTQ++ and women, to name a few. Learning about, designing and evaluating interventions for equity-seeking groups is an important role for philanthropy. For example, the Movember Foundation has played an important role in raising the profile of, and funding programmes for, the unique mental health needs of boys and men.

It is still a stretch to say that we have eliminated stigma around mental health. That’s why it is vital for people to speak out, like Gillian Stein of the Henry’s Foundation recently did when she shared her experience with bipolar disorder. But as our understanding of mental health becomes more common and holistic, our approach to addressing the issue will have to change – and philanthropy has a big role in enabling that to happen.
£100 million to spend on mental health...

What would you do with the money?  
Alastair Campbell, British broadcaster and mental health campaigner, has a few ideas  
@campbellclaret

One hundred million pounds is a significant amount of money in the world of mental health, but the need is even greater. So where would I start?

My first thought is that the money would be well spent on the Maytree Respite Centre (maytree.org.uk), a charity of which I am patron. It is a sanctuary for the suicidal, the only one of its kind in the country, in North London, where people at risk of suicide can get respite and support. It has without doubt saved lives, and there ought to be such places in every part of the country. Though given property prices in some parts of Britain, even £100 million would not get us far.

Perhaps the better approach is to break this down into four areas, and suggest a programme of work across each: education and prevention; innovative intervention and young people; reducing inequalities; and research.

On education and prevention, among the many bad things the current UK government has done, cutting its support for the Time to Change (time-to-change.org.uk) anti-stigma campaign is high up my list. The campaign showed that it is possible to change public attitudes and behaviours, which encourages more people to seek help and removes the stigma.

We may be in a better place than we were, but people are still rejected or ejected from jobs because of a mental health condition, even one that is in the past. You will still find people who think that depression or anxiety are somehow lifestyle choices, and that all you need to do is ‘pull yourself together’. Changing attitudes takes time. Cutting the support for the charities working together on the Time to Change campaign was a retrograde step. Philanthropy could step in.
Part of this educative programme is about helping people to understand better the many things we can do to manage our own mental health, and support the mental health of others. Over time, a more preventive approach will save lives and save money.

In the second area, innovative intervention and young people, there are two things to recognise – a rising need for mental health support for young people; and a crisis in many parts of the UK when it comes to Child and Adolescent Mental Health Services (CAMHS). It is shocking given how wealthy we are as a country, and how proud of the NHS, that only around one in three young people actually get the help they need.

There are some really good examples of work taking place locally, but which are scaleable. Mind (mind.org.uk), one of the biggest and best mental health charities, of which I am an ambassador, runs an Active Monitoring project in Wales, which gives people access to support in dealing with anxiety, depression, self-esteem, stress, anger management, loneliness and grief. It would be wonderful if that could be extended across the whole of the UK.

Mind also runs Get Set to Go, which helps people find the form of activity that’s right for them to be able to enjoy the physical, social and mental benefits of being active. It is funded by Sport England, the National Lottery, and Mind’s On Your Side partnership with the English Football League. Again, the preventive theme is to the fore. These partnerships are vital, and philanthropy can be the glue that binds them together. Mind is also pioneering an innovative digital project for young people in schools with the Anna Freud Centre.

When it comes to reducing inequalities, if there is one thing we have learned from the pandemic, it is that when inequalities exist, they are often exacerbated by crisis. Poorer people, and people from black and ethnic minority backgrounds, were harder hit. So it is in the mental health field and because mental health does not get the same commitment from government as physical health, it is much harder for people without money to get the support they need. Again, there are already some great projects, such as Bayo (bayo.ubele.org), which is run by and for the black community. And, again, it is a programme that can easily be scaled up.

Finally, but perhaps as important as anything else, is research. One of my main motives for campaigning and fundraising in this area is that my brother Donald had schizophrenia. When he was diagnosed in the 1970s, I remember reading that on average, people with this horrible disease may live up to 20 years less than others. My Dad was 82 when he died, Donald was 62. Bang on.

The treatments have barely changed and while the medication helped Donald live a pretty good life, the effect of four decades on powerful anti-psychotics meant that when it came to fighting ‘ordinary’ illness later in life, he was a lot weaker than the rest of us. No significant new treatments in the mental health space have been developed for 30 years. Compare the speed with which a new vaccine for Covid was developed.

Mental health care is still hugely underfunded compared to physical health... philanthropists could make important change happen by identifying and investing in the best bets for future research into treatments and prevention.

Mental health care is still hugely underfunded compared to physical health, despite a commitment in the NHS Constitution to parity. Philanthropists could really make important change happen by identifying and investing in the best bets for future research into treatments and prevention. There is a readymade charity to support in this too, namely MQ (mqmentalhealth.org), which is doing some great work researching the causes, treatments and prevention of mental illness.

Across the board, mental health has been significantly underinvested for decades. The need is urgent. But so are the opportunities, on short, medium and long-term bases which could transform the lives of so many people.