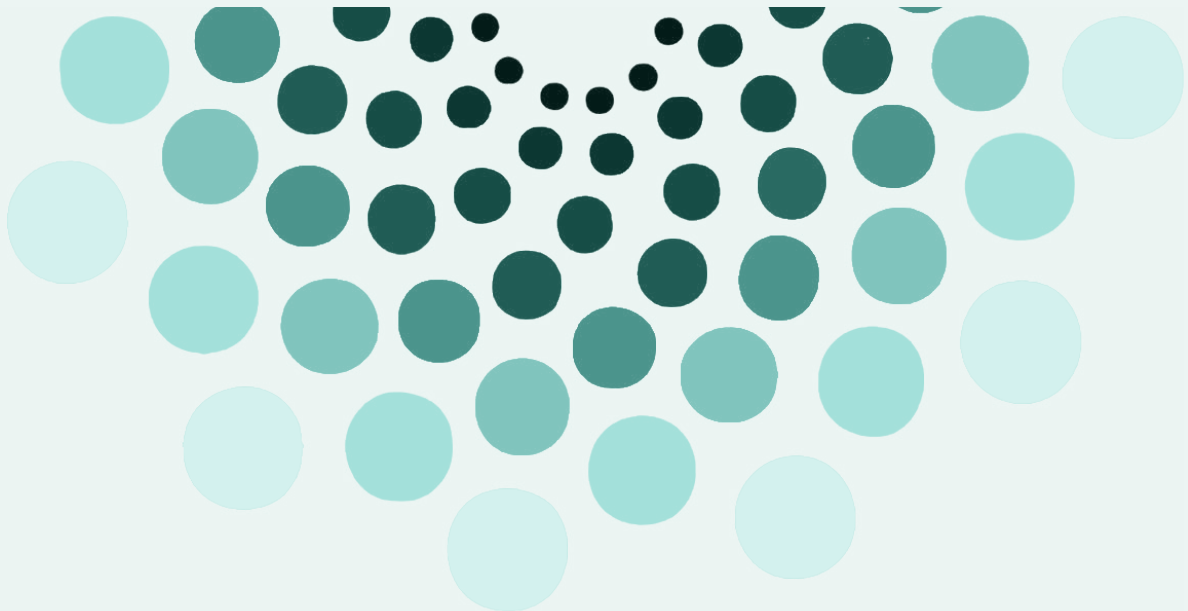


MINDFUL INVESTMENTS: PHILANTHROPY FOR MENTAL HEALTH IN INDIA



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A Report by the Centre for Asian Philanthropy India
April 2024

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ABBREVIATIONS AND ACRONYMS

ABY	Ayushman Bharat Yojana
ASHA	Accredited Social Health Activist
BALM	Banyan Academy of Leadership in Mental Health
BUMHI	Bangalore Urban Mental Health Initiative
CEO	Chief Executive Officer
Cipla	Cipla Foundation
CMH	Community mental health
CMHLP	Centre for Mental Health Law & Policy
DMHP	District Mental Health Programme
GAD-7	Generalized Anxiety Disorder Questionnaire-7
HICs	High-income countries
ILA	Indian Lunacy Act, 1912
IMHO	India Mental Health Observatory
LGBRIMH	Lokpriya Gopinath Bordoloi Regional Institute of Mental Health
LLL Foundation	The Live Love Laugh Foundation
LMICs	Low- and middle-income countries
MHAT	Mental Health Action Trust
MHCA	Mental Healthcare Act, 2017
MHI	Mariwala Health Initiative
NCRB	National Crime Records Bureau
NIMHANS	National Institute of Mental Health and Neurosciences
NMH Policy	National Mental Health Policy, 2014
NMHP	National Mental Health Programme, 1982
NMHS	National Mental Health Survey, 2015-16
NSPS	National Suicide Prevention Strategy, 2022
PHC	Primary health care center
PHQ-9	Patient Health Questionnaire-9
RCT	Randomized controlled trial
RNPF	Rohini Nilekani Philanthropies Foundation
SDG	United Nations' Sustainable Development Goals
UNCRPD	United Nations Convention on the Rights of People with Disabilities
WHO	World Health Organization

ACKNOWLEDGMENTS

India has a vibrant social sector, with philanthropists, nonprofits, social enterprises, and thought leaders collaborating and working relentlessly to address pressing socioeconomic challenges. The vibrancy of this landscape is characterized by its innovations, many homegrown models, and the combined efforts of many stakeholders toward creating change—all of which can provide learnings and guidance for many economies around the world.

The **Centre for Asian Philanthropy India (CAPI)** is a research nonprofit committed to elevating the quantity and quality of philanthropic giving and private investment for social good in all forms throughout the country.

This report is a qualitative exploration of philanthropic endeavors for mental health and wellbeing in India. Mental health remains a significant yet often neglected aspect of public health and socioeconomic change, and philanthropy can play a crucial role in addressing this gap. This report seeks to inform active and future donors about the current state of play, initiatives, and approaches in mental health philanthropy. It also provides recommendations to guide comprehensive efforts in mitigating mental health challenges—a domain that demands urgent and collective action.

We extend our deepest gratitude to our

trustees, **Mr. Jamshyd N. Godrej** and **Mr. S. Ramadorai**, whose generosity, guidance, and unwavering support have made this study possible. We are also very grateful to the 43 individuals across 31 organizations (listed in **Annexure I**) who graciously gave us their valuable time and expertise for this study. Their openness, insights, and perspectives have been instrumental in our research.

We hope that this study guides and inspires both new and seasoned philanthropists in making catalytic investments in mental health. Together, we have an opportunity to shape the narrative around mental health and foster a collective responsibility for a healthier, more resilient India.

FOREWORD

I am pleased to share my thoughts on the Centre for Asian Philanthropy India's (CAPI) report, *Mindful Investments: Philanthropy for Mental Health in India*.

This report does an excellent job of mapping out the philanthropic landscape for mental health in India, offering insights into the challenges donors face, and suggesting ways to direct more funding towards mental health initiatives. It stresses the need for collaboration with government efforts and the vital role of community mental health services. CAPI's work inspires a united vision among the public, private, and nonprofit sectors to make mental well-being a key focus of development.

It is also a very timely study. Despite healthcare improvements, mental health in India is still overlooked and underfunded, with mental illness continuing to carry a stigma. Philanthropic and other private sector support can change the scenario and expand access to care.

In my own journey spanning internal medicine, psychiatry, and psychosomatic medicine, I have been deeply committed to the integration of mind and body, drawing on both Eastern and Western philosophies. My experiences have shown me the transformative impact of mental health support that resonates with an individual's cultural and personal context, driving my

passion to advocate for mental health care that is accessible, compassionate, and holistic.

It is heartening to see the momentum over the last few years - philanthropists have increasingly turned their attention to mental health giving. Their efforts could dramatically improve millions of lives, fostering a healthier, more resilient society.

Mental health issues affect everyone, from urban to rural areas, across all ages, genders, and economic classes. We must become more aware, compassionate, and pro-active in providing support where it's most needed. Philanthropy, free from the need for profit, has the power to make a substantial difference. To all philanthropists and organizations working on this cause, your dedication makes a real impact on many lives. Your support is more than financial—it is an investment in our country's future.

Thank you, CAPI and all who contributed to this report. Your work is moving this crucial conversation forward.

Let us keep building upon this foundation of understanding, empathy, and support to strengthen our national approach to mental health.

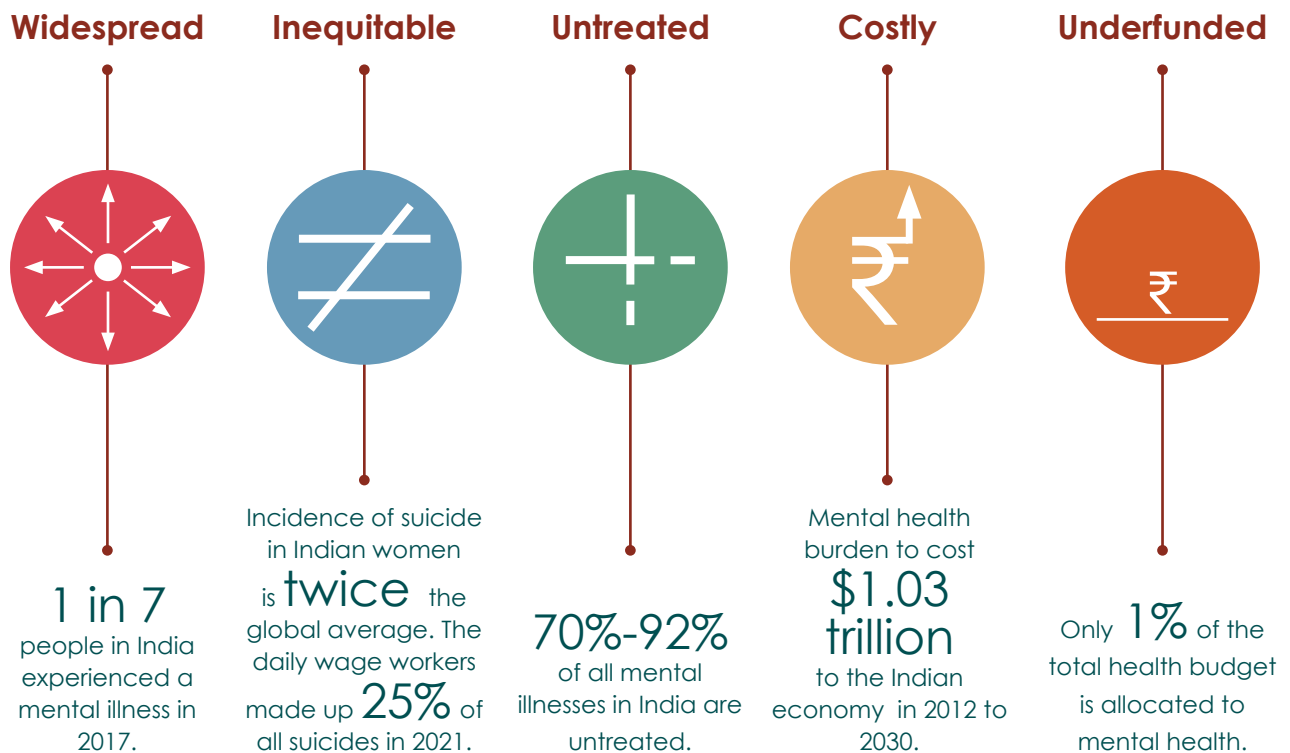
Dr. Shyam Bhat, MD
Chairperson, The Live Love Laugh Foundation

EXECUTIVE SUMMARY

This report, **Mindful Investments: Philanthropy for Mental Health in India**, is an inquiry into Indian philanthropy's response to mental health challenges and identifies key funding approaches. The report also identifies challenges that deter donors from giving in a greater capacity and suggests recommendations and opportunities for donors going forward to meet India's mental health needs.

One in seven people in India suffers from mental illness. The mental health burden, estimated to produce economic losses of about US\$1.03 trillion between 2012 and 2030, has adverse implications for many of India's developmental goals and aspirations (see **Figure 1**). The massive scale of the mental health crisis means that government resources alone are insufficient to address it; philanthropists and other private sector actors have a critical role in bridging funding gaps and supplementing the government's efforts.

Figure 1 | The state of mental health care in India



Sources: India State-Level Disease Burden Initiative Mental Disorders Collaborators (2020); National Crime Records Bureau (NCRB), 2021; National Mental Health Survey of India, 2015-16 (NHMS); World Health Organization (WHO) (2022); and Centre for Mental Health Law & Policy (CMHLP) Budget Briefs, 2021-24. (Refer to endnotes 9, 12, 26, 34, and 72-76.)

Approximately 70–92% of mental disorders go untreated in India. A severe shortage of mental health medical professionals, such as trained psychiatrists or clinical psychologists, contributes to this large treatment gap on the supply side. On the demand side, stigma, limited awareness, and high treatment costs daunt those who need care or are seeking treatment. The NMHS reports a 10% prevalence rate for common mental disorders—such as anxiety, depression, and substance use—among the Indian population and a 0.8% prevalence rate for severe mental disorders—such as schizophrenia and bipolar disorder.ⁱ This means that common mental disorders affect approximately 12.5 times more people than severe mental disorders. This ratio is similar in many countries.¹

Considering this, the WHO's recommendation is a proportional allocation of mental health services that prioritizes resources toward community models and primary mental health care to treat common mental disorders. It recommends that fewer resources be directed toward specialist care in hospitals or institutions, which primarily treat severe mental disorders. This model could be useful in the Indian context, too.

Evidence shows that common mental disorders can often be managed effectively through self-care, informal community care, and primary care level. In India, nonprofits have successfully piloted and implemented models that utilize trained community workers

and volunteers—known as 'lay counselors'—to deliver mental health care at the village or community level. Impact assessments of these community-level mental health interventions show promise in lowering rates of mental distress among the target community.

While patients with severe mental disorders require intensive attention from qualified professionals in clinics or psychiatric hospitals, their numbers are smaller, and consequently, fewer specialist or tertiary-level facilities are needed. However, India has historically relied on psychiatric institutions and hospitals for treatment because of colonial-era legislation that mandated institutionalization of the mentally ill and entrenched stigma and a dearth of knowledge around mental illness. In recent decades, and particularly with the enactment of the Mental Healthcare Act, 2017, India has pivoted away from institutionalization and closer to the WHO model of bringing care closer to villages, districts, and towns. Despite changes in legislation, the Government of India's budget continues to disproportionately fund institutional care.

Key findings

Historically, mental health has not been a priority for donors in India given the other urgent demands on resource allocation. However, over the past decade, there has been a rise in philanthropy for mental health in India. The issue also garnered attention during

ⁱ We refer to mental illness and mental disorder interchangeably in this report.

COVID-19 due to the collective experience of distress caused by the disease, lockdowns, and loss of livelihoods. This study finds that at present, Indian donors have adopted three types of approaches to funding mental health initiatives:

- Treatment or care for mental illnesses at the **institutional level**. Many donors strategically support either institutions and facilities, such as psychiatric hospitals, clinics and counseling centers, or helplines through telephone, WhatsApp, and other chat/online services. This approach emphasizes treatment through medical professionals at specialized care centers.
- Mental health care at a **community level**, such as in villages and districts. Adopted by fewer donors, this approach is characterized by initiatives where mental health programs are delivered in localized settings—such as at government primary health care centers—through lay counselors from within the community. These are often integrated with other socioeconomic programs and can help connect communities to social entitlements under government schemes.
- **Scientific research, knowledge, and evidence building**. Donors have made significant grants to support studies at reputable institutions, such as the

National Institute of Mental Health and Neurosciences. These studies focus on data collection among an Indian sample population to gather contextualized and nuanced insights.

These approaches are by no means mutually exclusive, and many donors have adopted a mix of the three. Initiatives guided by all these approaches are critical to India as they provide indispensable services and set the stage for future giving and interventions.

Although community models for mental health have demonstrated success—and present as low-cost options that also can reach remote areas of the country—they struggle to gain scale and funding. This can be attributed in part to a lack of amplification of their success, particularly among donors, and in part to the historical inclination toward institutionalization.

Additionally, the wide range of interventions in the mental health sector is accompanied by a similar variance in impact assessment. While experts emphasize the need for a common understanding and consensus in tracking impact outcomes, these are yet to emerge, largely due to the intangible and hard-to-measure qualities of mental health.

There has been a surge in social sector collaborations with the government, particularly in the aftermath of COVID-19. These partnerships extend beyond the health and welfare departments and often involve other departments or ministries such as those

responsible for youth, sports, livelihoods, tribal affairs, and women and child development. This cross-sectoral approach signals a widening commitment to addressing mental health challenges and recognition from the government of the importance of this issue.

Although much progress has been made in the last decade in terms of growing the donor pool and awareness around mental health, critical challenges impede funding for mental health.

Challenges

First, the **widespread stigma deters potential donors** from giving to this cause.

Second, philanthropists struggle to navigate the **complexity of the mental health sector** due to limited data, case studies, and evidence—information that aids decision-making for donors.

Third, **capacity challenges**, both in terms of the limited pool of nonprofits and a shortage of trained professionals, impede the fulfillment of the specific visions or ideas that donors may have.

Finally, **the intangible and subjective nature of outcomes in mental health initiatives** means donors cannot easily see or understand the impact of their giving.

Recommendations

The sheer scale of the mental illness burden means that clinical interventions are not enough. A mindset shift is needed: we need to move away from approaching mental health as simply a health issue and instead view it as a broader developmental issue. Our research has identified some key opportunities for philanthropy to play a strategic role.

- 1 **Donors can champion mental health as a cause worthy of greater support and help to dispel stigma. More donors can speak up about their experiences with mental health and fund convenings, seminars, advocacy, and other avenues. Donors can also collaborate to set up centers of excellence in mental health in different parts of the country to help synthesize existing knowledge and best practices and drive the discourse going forward.**
- 2 **Philanthropy can support overlooked and underfunded programs, such as those that focus on prevention and rehabilitation through the dissemination of educational materials, guidance on self-care programs, anti-stigma campaigns, capacity building of volunteers, early screening of target populations, and so on. Community mental health models have shown promise in delivering care at the village level and present a low-cost, high-return opportunity for donors.**

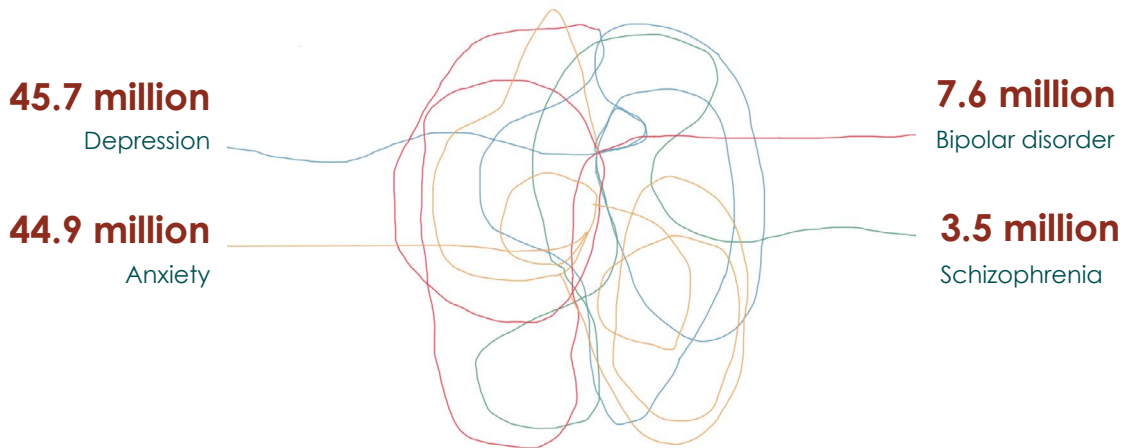
- 3 Philanthropy can fund innovative financing strategies, such as insurance models of 'managed care', and sponsoring competitions with seed capital as prize money. They can support the development of new technology in safe, clinically validated, and ethical ways without the expectation of profits or returns. They can also fund ways of building talent in the sector, such as workshops, courses, and training programs aimed at equipping not only medical professionals but also non-specialists such as teachers, doctors, journalists, police officers, lawyers, and community workers.**

- 4 Donors can support and foster cross-sectoral partnerships that involve joint initiatives, shared resources, and expertise exchanges to leverage the strengths of all sectors. Such collaborations can help promote shared research efforts to better understand mental health issues and their underlying causes. Moreover, they can encourage the dissemination of research findings, data, and best practices to enhance the collective knowledge base and inform evidence-based interventions.**

Philanthropy plays a pivotal role in fostering positive change and progress in the realm of mental health in India. Unlike corporate social responsibility funds that are time-bound or private capital that demands a financial return on investment, philanthropy's flexible nature means it is far better positioned to make a greater impact and create long-lasting change. Moreover, philanthropy can provide the transformative risk capital that innovation, science, and research need.

INTRODUCTION

Figure 2 | A snapshot of mental illnesses in India



Source: India State-Level Disease Burden Initiative Mental Disorders Collaborators (2020). (Refer to endnote 9.)

India is among the fastest-growing economies and is poised to become the third largest in the world.² According to the International Monetary Fund, India is projected to contribute a significant 16% to global growth (as of December 2023).³ Through its stewardship of the Group of 20 (G20), India has also emerged as the voice of the Global South, leading on issues that matter most to developing nations.⁴ Consequently, India's stature has grown remarkably in the last few years.^{5,6,7}

Despite these strides, India has several developmental challenges to overcome, including better access to health and nutrition, mitigating the effects of climate change, and addressing poverty and inequality. While efforts are being made by the government and the private and social sectors to address these, there is one issue that, if left unresolved,

could stymie much of the good work being done in other sectors: safeguarding the mental health of the people of India.

India is witnessing a silent epidemic of mental illnesses.⁸ About 197.3 million Indians experienced a mental illness of varying severity in 2017, representing a widespread and critical challenge for our country (**Figure 2**).⁹

The distress caused by COVID-19 and associated lockdowns escalated mental health challenges.¹⁰ The Indian Psychiatric Society found a 20% increase in the number of people suffering from mental illnesses as compared with pre-pandemic levels, demonstrating the increased levels of stress, anxiety, fear, and depression during the pandemic.¹¹

A high prevalence of mental illness costs the economy. The World Health Organization (WHO) estimates that the burden of mental disorders will cause losses of US\$1.03 trillion to the Indian economy between 2012 and 2030.¹² Further, a report by Deloitte estimates that “poor mental health amongst employees costs Indian employers around US\$14 billion per year due to absenteeism, presenteeism, and attrition.”^{ii,13} Other studies also point to the adverse effects of mental illness, such as reduced productivity, lower labor force participation, decreased tax revenue, and increased welfare expenses.¹⁴

A critical resource and a source of strength for India is its more than 800 million young people. Without adequate mental health care, we risk leaving the potential of this strength unharnessed, as studies find that about 50% of mental health problems are established by the early age of 14 years and 75% by the age of 24.¹⁵ To utilize our demographic dividend, we need to support the mental health of India's young people and children.

Looking ahead, by 2050, our workforce will age, and the elderly are projected to form over 20% of the population. This will increase the care burden and the demand for mental health care for the elderly exponentially.¹⁶ Clearly, we must act now to lay the groundwork for the future.

India's commitment to achieving the United Nations' Sustainable Development Goals (SDGs) is also closely linked with the mental health of our people. SDG 3, which focuses on good health and well-being, is central to mental health, while SDG 4, which aims for quality education and learning environments, is a key determinant of mental well-being. Discrimination and gender-based violence, linked to SDG 5 (gender equality), are risk factors for mental health conditions.^{iii,17,18}

Mental health has historically not been a priority for donors in India given other urgent demands on resource allocation. Only in the last decade has a deeper understanding of the impact of mental illness on other

ⁱⁱ“Presenteeism” in the Deloitte report refers to “attending work while under mental stress and therefore not performing at peak productivity.” (Refer to endnote 13 for further information.)

ⁱⁱⁱ“Mental health intersects with each SDG, illustrating its pervasive influence on global well-being. Poverty (SDG 1) and mental health are entwined in a detrimental cycle, while hunger (SDG 2) and poor nutrition adversely affect cognitive and emotional development, impacting mental health across one's lifespan. Good health and well-being (SDG 3) recognize mental health as integral, emphasizing its role in overall health. Education (SDG 4) is hindered by mental health barriers, and gender inequalities (SDG 5) contribute to mental health risks. Socioeconomic factors affecting water, sanitation, and energy (SDGs 6 and 7) are linked to various mental health conditions. Decent work (SDG 8) is crucial for mental well-being, and innovation (SDG 9) contributes to protective factors. Inequalities (SDG 10) perpetuate discrimination against people with mental health conditions, while urbanization (SDG 11), in tandem with well-planned environments, impacts mental health positively. Responsible consumption (SDG 12) and climate action (SDG 13) are linked to mental health through access to resources and environmental events. Life below water and on land (SDGs 14 and 15) affects mental health through resource availability. Peace (SDG 16) and mental health are also intertwined as conflict poses a major threat. Mental health as a universal concern aligns with the collaborative nature of partnerships (SDG 17), offering valuable insights for the SDG agenda. (Refer to endnote 18 for further information.)

development challenges emerged. The willingness of some donors to speak up has also spurred the funding of mental health initiatives. Furthermore, COVID-19 helped to raise the profile of mental health as a critical issue deserving of attention and resources. Given the magnitude and complexity of the challenge, more philanthropists have stepped up in the past decade or so. However, donors are still adapting to funding interventions in this space.¹⁹

In this context, the Centre for Asian Philanthropy India (CAPI) set out to examine and answer the following questions:

- **What are the funding approaches that donors currently adopt?**
- **What challenges do they face in increasing their support for mental health programs?**
- **Where do opportunities lie for giving more and/or giving better?**
- **How has the government supported the response from the social sector?**

To answer these questions, CAPI interviewed 43 philanthropists, nonprofits, and experts between March and November 2023 via semi-structured conversations. This report contains our insights derived from a qualitative analysis of this primary data, combined with a literature review of India's mental health landscape.

Chapter 1 outlines the concepts of mental health and illness and the various types and stages of interventions needed. In **Chapter 2**, we track the response to mental illness in India through an overview of the government's policy and its implementation, as well as the financing response. Such an account also helps showcase the need for enhanced private-sector support. **Chapter 3** outlines CAPI's key observations regarding the emergence of mental health portfolios among Indian donors, the rise in government collaborations, and the range of impact measurement tools currently at play. It describes the three key approaches adopted by donors. The first is the traditional approach, which provides treatment and care through institutions—mental health care facilities, clinics, hospitals, and research departments in universities—thereby enhancing access to services via specialists. The second is the community-based approach, which funds mental health care in a localized setting and is often integrated with other social programs. The third is a connected strategy that donors have used to support mental health—funding science and research.

Chapter 4 comprises a summary of challenges that donors continue to face, including stigma, lack of a clear path for funding, and difficulties in assessing the impact of their aid and interventions. Finally, **Chapter 5** concludes this report, presenting our thoughts on where opportunities lie for donors to give more along with recommendations on the way forward.

We hope this report can act as a guide and framework for those, particularly from the philanthropic sector, looking to understand the landscape of mental health responses in India. We also hope it can inform and inspire both existing and new donors to enhance the quality and quantity of their giving.

CHAPTER 1

UNDERSTANDING MENTAL HEALTH

The World Health Organization (WHO) defines mental health as “a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well, work well, and contribute to their community. *It is an integral component of health and wellbeing that underpins our individual and collective abilities to make decisions, build relationships, and shape the world we live in* [emphasis added].”²⁰ This definition encompasses aspects of learning and social interaction as well as health. The WHO also defines a mental disorder as “a clinically significant disturbance in an individual’s cognition, emotional regulation, or behavior. It is usually associated with distress or impairment in important areas of functioning.”²¹

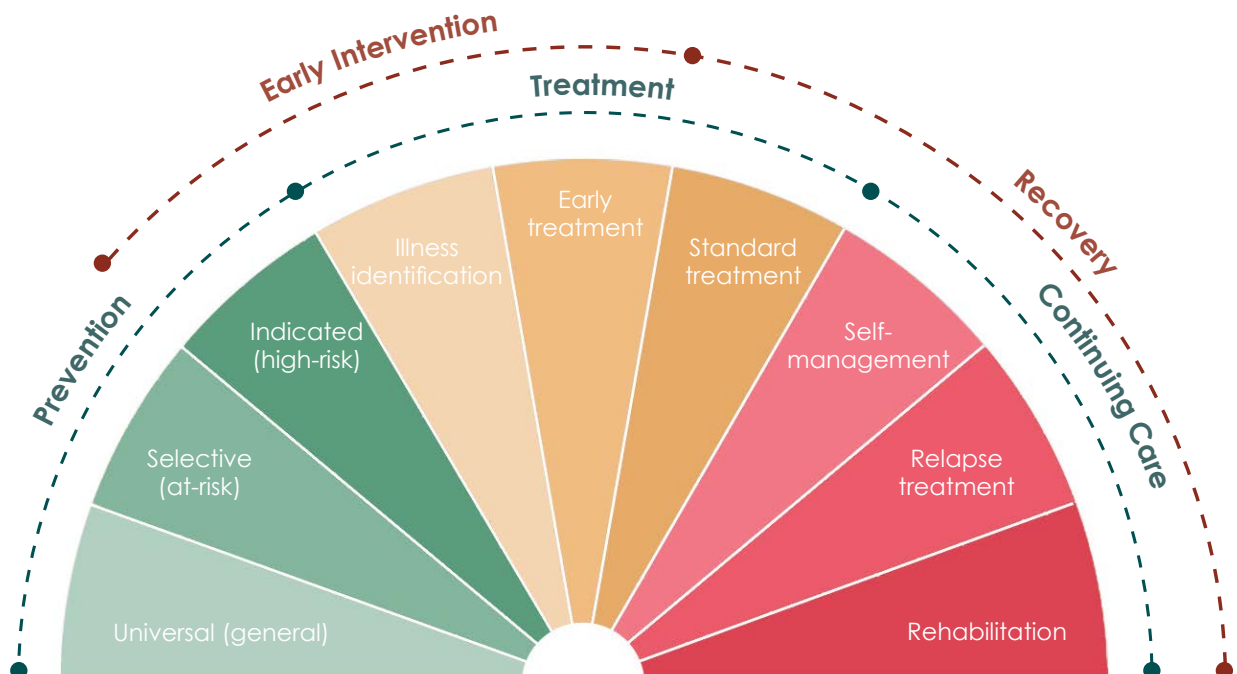
Mental health disorders are often invisible due to their nonphysical nature; they are heavily stigmatized in India and many places around the world. Moreover, mental illnesses often do not adhere to a linear path. These aspects make them challenging to detect, understand, and address.

Mental illness is influenced by multiple factors. Structural determinants, such as socioeconomic status, family dynamics, gender-based violence, discrimination due to caste and other identities, traumatic experiences, substance use, and societal pressures, all contribute to conditions of poor mental health.²² Mental health and poverty are correlated, as the former has a real impact on whether a person can find and hold down a job, make a living, attend school, or fully

participate in social situations.²³ Poverty in turn leads to poor mental health. Consider the example of daily-wage workers—a segment that constituted a quarter of the deaths by suicide in India in 2021.²⁴ This economically vulnerable group has consistently had the highest rates of suicide rates in India: according to the National Crime Records Bureau (NCRB), daily wage workers' suicides increased from a share of 12% to 26% of all suicides between 2014 and 2021. Low wages and precarious job conditions are the primary drivers of poor mental health conditions in this segment.^{25,26}

Mental health occurs on a spectrum. Good or bad mental health is not a fixed state; rather, it is a dynamic human experience that varies over time and across situations. At one end, individuals may experience good mental health, characterized by positive emotions, effective coping mechanisms, and the ability to manage life's challenges. On the other end of the spectrum, individuals may experience varied degrees of mental challenges, such as anxiety, depression, bipolar disorder, and schizophrenia. People may experience stress, mild anxiety, or periods of low moods without needing clinical diagnosis or interventions.

Figure 3 | Spectrum: wellness, illness, and rehabilitation



Source: Mrazek and Haggerty (1994). (Refer to endnote 27.)

Mental health can fluctuate, and people may move along the spectrum at different times in their lives, with recurring disorders or multiple periods of poor mental health.

A range of interventions is necessary to support good mental health. The large spectrum of mental health conditions requires a range of interventions that can address different stages and conditions. Interventions are usually categorized as prevention, treatment, and rehabilitation (or continuing care) **(Figure 3)**.

- Prevention involves proactive measures aimed at reducing the risk of developing a mental disorder.** It could include education, sensitization, and awareness around mental health and the promotion of a healthy lifestyle. Guidance on stress and relationship management, and information on the importance of physical activity, self care, and the risks of substance (ab)use are other measures needed for effective prevention. In addition, individual self-care and support from family and friends are central to the prevention of mental illnesses.²⁸ Preventive strategies and interventions are particularly important in children and young people, as this is when a majority of mental illnesses are likely to develop.²⁹
- Treatment focuses on providing care (medical and otherwise) to individuals experiencing a mental health disorder.** Options for treatment can include medication, electroconvulsive therapy, and psychological therapeutic interventions, including psychotherapy, psychosocial counseling, expressive art, and movement-based therapies. The goal is to provide effective and evidence based treatments that alleviate symptoms and improve overall mental well-being.³⁰ Treatment for mental illness is not necessarily the same as a cure. Some people experience poor mental health throughout their lives, either consistently or in recurring periods. Some mental illnesses may not have a permanent cure.³¹
- Rehabilitation is a critical part of mental health interventions, particularly for those who have experienced severe or prolonged mental illness.** It focuses on improving the quality of life and preventing the recurrence of the disease. Accordingly, it not only addresses symptoms but can also focus on improving an individual's vocational or skills training and social integration or provide ongoing therapeutic support to help them regain independence and improve their quality of life.^{32,33}

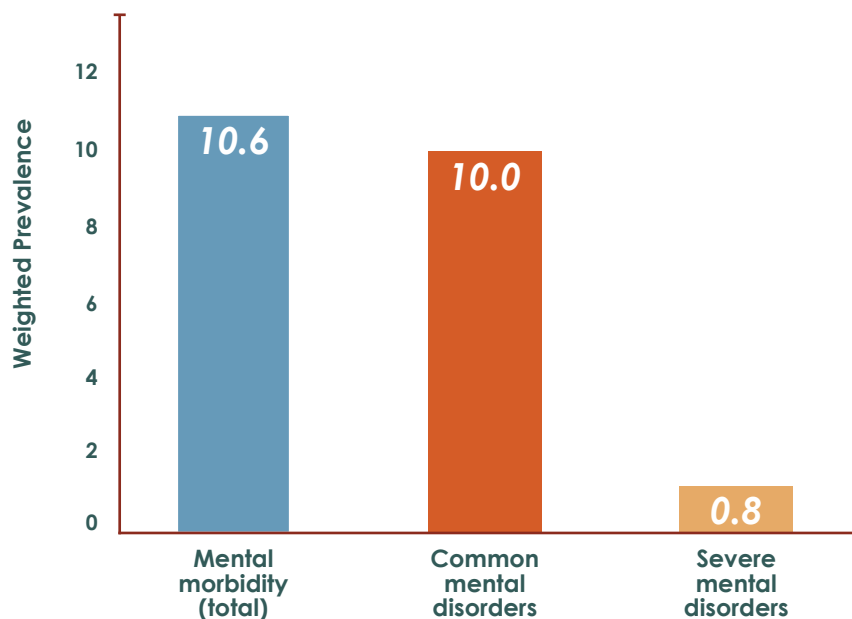
^{iv} The total percentage of those with mental illness differs based on the study being referenced. The difference in the data points between various studies could be attributed to differences in the data set, sample population size, and methodology.

DISTRIBUTION OF MENTAL ILLNESS IN INDIA

In India, common mental disorders such as depression, anxiety, and substance use disorders are a significant burden affecting nearly 10% of the Indian population, as per the *National Mental Health Survey of India, 2015-16 (NMHS): Mental Health Systems*.^{iv,34} The share of people with severe mental disorders, such as schizophrenia and bipolar affective disorder, and those needing hospitalization is much smaller—only 0.8% of the population (Figure 4).³⁵

The WHO offers a framework to address the needs of this pattern of distribution of mental illness that occurs across the world. The WHO recommends that countries adopt an array of mental health care services with a certain distribution of resources for each. The service organization pyramid (see Figure 5) outlines the varying levels and quantum of care/resources needed to service a population at large.

Figure 4 | Prevalence of common and severe mental disorders^v

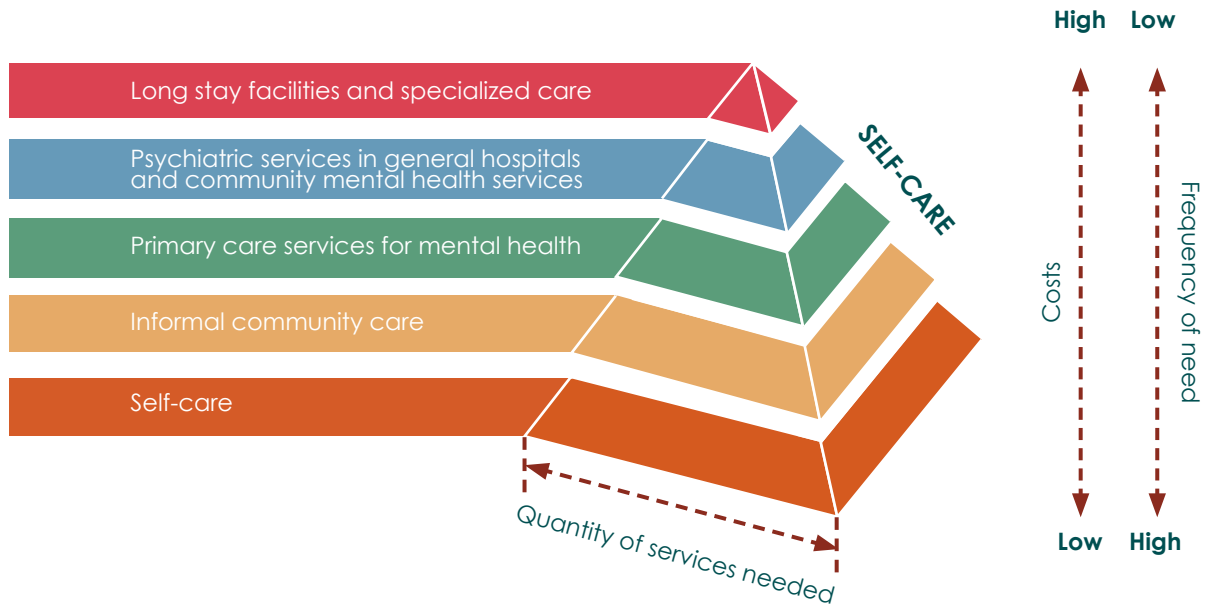


Source: National Mental Health Survey of India, 2015-2016. (Refer to endnote 34.)

^v Mental morbidity is defined by the International Statistical Classification of Diseases, Tenth Revision Diagnostic Criteria for Research (ICD-10 DCR) as the presence of mental health disorders or conditions that affect a person's thoughts, emotions, and behaviors. It indicates the extent to which individuals may experience psychological distress or impairment in their mental well-being. Essentially, mental morbidity is a broad term used to describe various mental health problems or illnesses that can impact a person's overall mental functioning.

Weighted Prevalence is a statistical measure that adjusts prevalence rates by assigning different weights to individual observations, considering factors such as age, gender, or socioeconomic status to provide a more representative estimate of a condition within a population. This helps to ensure that the prevalence estimates reflect the overall distribution of the condition in the entire population more accurately while considering the specific contributions of various subgroups. (Refer to endnote 34 for further information.)

Figure 5 | WHO's service organization pyramid for the optimal mix of services for mental health



Source: WHO (2009). (Refer to endnote 36.)

Common mental disorders, as the name suggests, occur in a significantly larger share of the population and, therefore, form the base of the pyramid depicted in **Figure 5**; their mitigation requires a proportionately greater share of services or resources. Common disorders, although greater in frequency, often can be treated without medical specialists, through self-care, community care interventions, and other initiatives that can be integrated into primary healthcare settings.

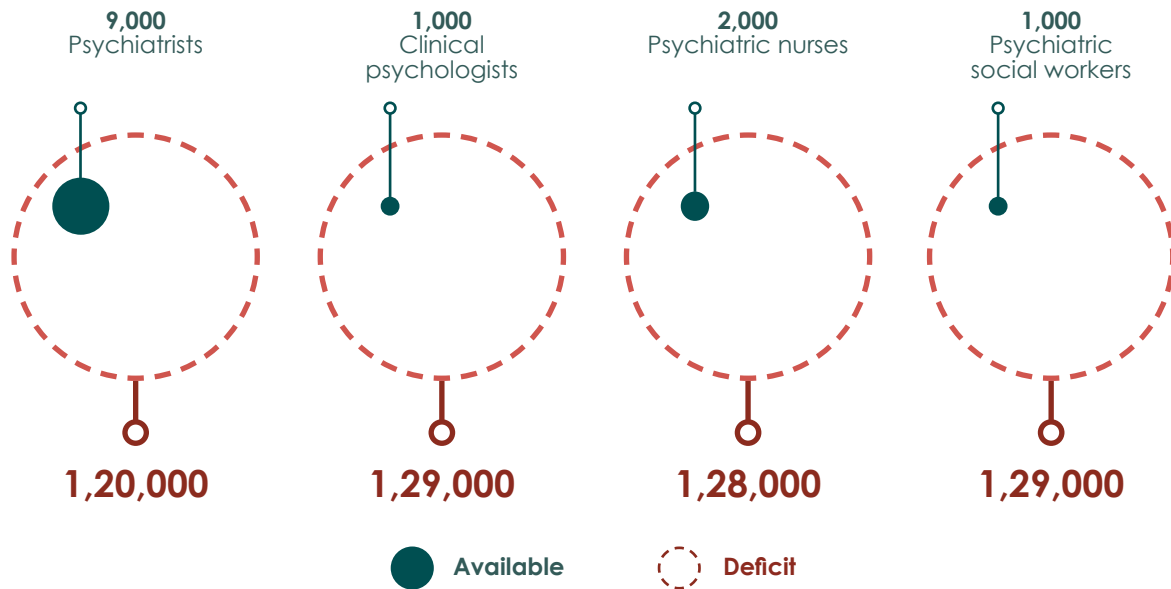
Persons with severe mental disorders require treatment by specialists and at facilities such as hospitals. However, this is a small fraction of individuals—0.8% of India's population as seen in **Figure 4**—and requires far fewer services.

While the WHO model is a general one, it can be applied in the Indian context as well and offers a solution to one of India's key

constraints: a woefully inadequate supply of trained mental health professionals.

SUPPLY AND DEMAND OF MENTAL HEALTH CARE IN INDIA

India has a severe shortage of mental health professionals (see **Figure 6**), with only two mental health workers and 0.75 psychiatrists available per 100,000 people—a much lower number compared to the global average of three per 100,000.³⁷ Given the dearth of mental health professionals, it is not surprising that to the extent there is coverage, mental health care is more accessible to those with resources, although even they find it challenging to obtain. Dr Manoj Kumar, Founder, Mental Health Action Trust, a Kerala-based nonprofit said, “In India, people from well-to-do families also struggle to get support for their mental health, while the struggle is much worse for people from underserved

Figure 6 | Availability and deficit of medical specialists

Source: Indian Journal of Psychiatry (2019). (Refer to endnotes 37 and 38.)

backgrounds. Even the private sector has not been able to meet the demands of mental health care in the country.”

On the demand side, a lack of knowledge about mental illnesses and persistent stigma deter individuals from seeking care. Those who do seek care are impeded by the

shortage of mental health professionals, limited support from their caregivers, and high costs of treatment.³⁹ The direct cost of treating a family member battling a mental illness ranges from ₹1,000 to ₹2,250 (approx. US\$12 to US\$30) per month.^{vii, 40, 41}

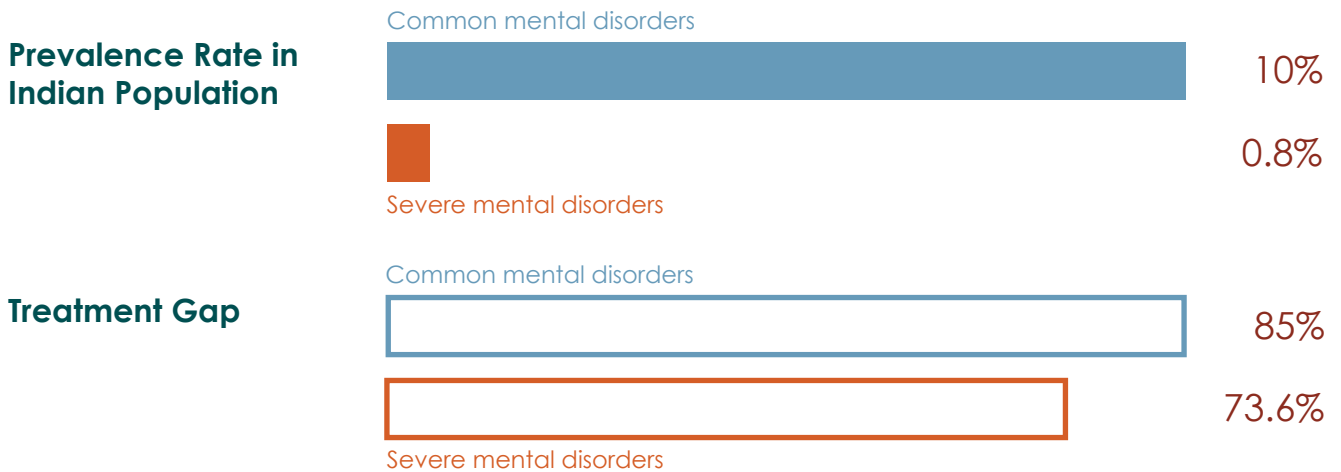
^{vi}A deficit in mental health human resources is calculated as the difference between the number of available mental health professionals and the number required to meet the standard of one professional per 10,000 people in a population. The table demonstrates this shortfall for a population of 1.3 billion in India.

^{vii}The average monthly household income in India was estimated to be around ₹21,647 (US\$259) in urban areas and ₹14,700 (US\$176) in rural areas by ICICI Securities. (Refer to endnotes 40 and 41.)

^{viii}The National Mental Health Survey of India, 2015-2016 defines **common mental disorders** to include depression (mild, moderate, and severe without psychotic features), neurotic and stress-related disorders, alcohol and other substance use disorders, and so on. **Severe mental disorders** include schizophrenia and other psychotic disorders, bipolar affective disorders, and severe depression with psychotic features. Psychotic features refer to hallucinations or delusions.

The **prevalence rate** of mental health disorders represents the proportion of a specific population that are affected by one or more mental health conditions within a given time frame. It is typically expressed as a percentage and provides insight into the extent of mental health challenges within a community, region, or demographic group.

The **treatment gap** highlights the difference between the prevalence of mental health issues in a population and the proportion of affected individuals who access and receive effective mental health care.

Figure 7 | Prevalence rate and treatment gap for mental health disorders^{viii}

Source: National Mental Health Survey of India, 2015-2016. (Refer to endnote 42.)

Marginalized groups are disproportionately affected by out-of-pocket costs, which strain family finances. Households lacking the means to afford direct or indirect costs, such as travel to a clinic or loss of a day's wage, often forego treatment for mental illness.

These factors combine to create a massive treatment gap, estimated at between 70% and 92% for various mental disorders (see **Figure 7**). A treatment gap refers to the divide between people requiring mental health services and those receiving appropriate treatment for their mental health conditions.⁴²

CAPI's findings suggest that action is needed on both sides. India must increase the supply of mental health care available and, simultaneously, improve awareness to enhance health-seeking behavior. On the supply side, this translates to enhancing access to and affordability of mental health care

through various means, such as integration of mental health into primary care, bringing services closer to rural areas, and so on. On the demand side, this essentially means encouraging health-seeking behavior through education, awareness, and sensitization, and normalizing mental illness throughout the country.

Fully and effectively implementing a mental health care service pyramid will need a massive commitment and collective action from the government, social sector, and private sector. In Chapter 2, we look more closely at the landscape of government action, including changes in law and policy and the provision of public infrastructure and direct government aid. This will establish the framework within which mental health care response and action take place in India, as well as point to the gaps in funding and care, where the private sector could play a role.

CHAPTER 2

GOVERNMENT POLICY AND ACTION

This chapter outlines the existing legal framework, policies, and direct government action on mental health in India. The historical context in which mental health care delivery has taken place as well as the more recent policy shifts can inform private action going forward. Further, while the government has enacted progressive legislation and provided direct aid, significant funding and implementation barriers remain. Understanding these can help identify opportunities for the private sector to intervene and move the needle on mental health care.

POLICY SHIFTS: INSTITUTIONALIZATION TO INTEGRATION

Traditionally, the primary focus of the government has been on institutionalized care. Psychiatric hospitals—often referred to as “mental hospitals” or “lunatic asylums” in India—have played a central role since colonial times, offering custodial care to individuals with mental illness. This has been the primary form of treatment and care offered through public infrastructure, often even for common mental disorders. Today, there are around 46 government psychiatric hospitals.⁴³ Of these, the National Institute of Mental Health and Neurosciences (NIMHANS), set up in 1974 with government funding, is renowned as a center of excellence and considered the country's apex mental health institution.⁴⁴

The reliance on institutionalization is a result of entrenched stigma, fear of mental illness, lack of knowledge on how to provide care, and

the legitimacy created by the erstwhile Indian Lunacy Act of 1912 (ILA), which regulated the detention of mentally ill individuals.⁴⁵

In 1987, the Mental Health Act replaced the ILA to govern mental health care in India. This was a significant step forward and included the establishment of mental health facilities and the protection of the rights of individuals living with mental illness. The 1987 law also introduced Mental Health Review Boards to ensure the protection of individual rights within institutions.⁴⁶ Additionally, it shifted focus from institutional care to community-based care. However, processes emphasizing the detention of persons with mental illness were retained, further contributing to societal perceptions that those with mental illness lacked the autonomy to make decisions about their health care.

In 2014, India adopted the National Mental Health (NMH) Policy as a guiding framework for mental health care in the country, in line with its commitments made at the 65th World Health Assembly (2013).^{ix} The Assembly asked countries to provide “a comprehensive, coordinated response from the health and social sectors at the community level to

address the issue of burden of the mental illness.”

Notably, the NMH Policy views mental health more comprehensively and acknowledges the two-way relationship between mental health and other conditions of life. Consequently, it integrates medical and non-medical care within its guidelines and encompasses values of equity and justice as well as a participatory, rights-based approach^x toward mental health care. Its objectives include promoting mental health, preventing, and destigmatizing mental illness, facilitating recovery, and fostering socioeconomic inclusion for persons with mental illness. While the NMH Policy is progressive, it remains a policy and not a law enacted by Parliament; its aims have not been fully realized.⁴⁷

In 2017, the Mental Healthcare Act (MHCA)

was enacted. Given this statute's rights-based approach toward care, it became an inflection point for the framework of mental health care in India. The MHCA protects the well-being of individuals with mental illnesses and aligns with principles from the 2007 United Nations Convention on the Rights of People with Disabilities (UNCPRD). The new

^{ix} The World Health Assembly serves as the governing body of the WHO, consisting of health ministers from its 194 member states. As the highest health policy-setting entity globally, the WHA convenes annually in May at the Palace of Nations in Geneva, WHO's headquarters. Its primary responsibilities include determining significant policy issues, endorsing the WHO work program and budget, and conducting elections for the director-general every five years and for 10 executive board members annually.

^x According to the UNCPRD, a rights-based approach to mental health ensures the full and equal enjoyment of all human rights by persons with mental health conditions. It emphasizes nondiscrimination, autonomy, participation, accessibility, quality of care, freedom from abuse, legal capacity, and accountability. This approach prioritizes the dignity, autonomy, and rights of individuals with mental illness, moving away from a solely medical perspective to one centered on human rights.

A Timeline of Key Legislation and Policies on Mental Health



law established a presumption of “decisional autonomy,” meaning it confers legal capacity on individuals with mental illness and protects their right to decision-making and choices about their health care, emphasizing informed consent while granting a statutory right to access mental health care. Additionally, it decriminalized suicide attempts, which were previously considered a criminal offense under Indian law.⁴⁸

Despite this, the MHCA is criticized for gaps in its implementation, as many government-run facilities continue to have serious inadequacies in infrastructure,⁴⁹ and for failing to address concerns around human rights violations of patients.^{50, 51}

As a result, those who can afford it opt to obtain care through private providers via privately owned/run clinics, hospitals, counseling centers, and so on. This scenario is no different from other types of health care in India—shortages and other deficiencies in government institutions create a market for private facilities. However, in this case, private facilities also face a shortage of staff given the severe undersupply of trained mental health professionals in India, as noted in Chapter 1.

DIRECT GOVERNMENT PROGRAMS AND IMPLEMENTATION GAPS

Aside from legislation, both national and state governments provide direct support for mental health care services through various programs and schemes. We examined the key government initiatives and the challenges associated with the effective rollout of these.

In the 1980s, India was the first country in the world to attempt to integrate mental health services with general health services at the primary care level.⁵² This was routed through the National Mental Health Programme (NMHP), launched in 1982 by the Ministry of Health and Family Welfare. The NMHP aimed to bridge the treatment gap and decrease the deficits in human resources. However, it fell short of achieving its intended outcomes, largely because it was a national-level program and lacked grassroots delivery and implementation.⁵³ Consequently, the District Mental Health Programme (DMHP) was launched in 1996 to supplement the NMHP, decentralize mental health care, and bring service delivery closer to the people.⁵⁴

The DMHP aims to provide essential medications to people living with mental illness, monitor their treatment outcomes, and build capacities among primary healthcare providers. It also focuses on reducing stigma through public education, facilitating community-based treatment, and integrating rehabilitation with family support.⁵⁵ Despite its laudable goals, the implementation of the DMHP is lagging even 28 years after its launch.

For instance, up to 40% of patients travel over 10 kilometers to access entitlements and services offered under the DMHP, often only available at district headquarters.⁵⁶

Moreover, despite the availability of funding from the national and state governments, its utilization has been poor, with expenditure varying among states.⁵⁷ Persistent administrative barriers, shortage of qualified professionals, insufficient training, and the high turnover rate of human resources worsen patient outcomes. Experts underscore the need for robust data monitoring and evaluation systems as well as the active involvement of communities to improve effectiveness.⁵⁸ Additionally, some major

determinants of mental health—such as substance use, unemployment, domestic violence, and discrimination—have not yet been integrated into the DMHP. Including these can enable a shift away from a medical-only approach to mental health care.⁵⁹

Encouragingly, some donors and nonprofits are helping local governments roll out the DMHP in various districts in India and integrate mental health care into local primary health care centers (PHCs). We showcase some of these examples in Chapter 3.

TECHNOLOGY AND DIGITAL TOOLS TO ENHANCE ACCESS

In 2022, the Government of India introduced Tele MANAS, the digital arm of the NMHP, signaling a focus on scaling digital mental health programs.⁶⁰ Digital mental health programs utilize technology, such as mobile apps including WhatsApp, chatbots, the telephone, and online therapy platforms, to deliver mental health services and interventions. These programs have several advantages, such as increased accessibility, reduced stigma, cost effectiveness, and the ability to reach individuals in remote or underserved areas.^{61,62}

As of 6th March 2024, Tele MANAS had received over 733,082 calls, and provided

counseling services to over 350,000 individuals through its 51 cells across the country. The helpline receives more than 1,000 calls on average daily.^{63,64} Alongside, many state governments are also deploying chatbots and WhatsApp as tools to deliver mental health services.⁶⁵

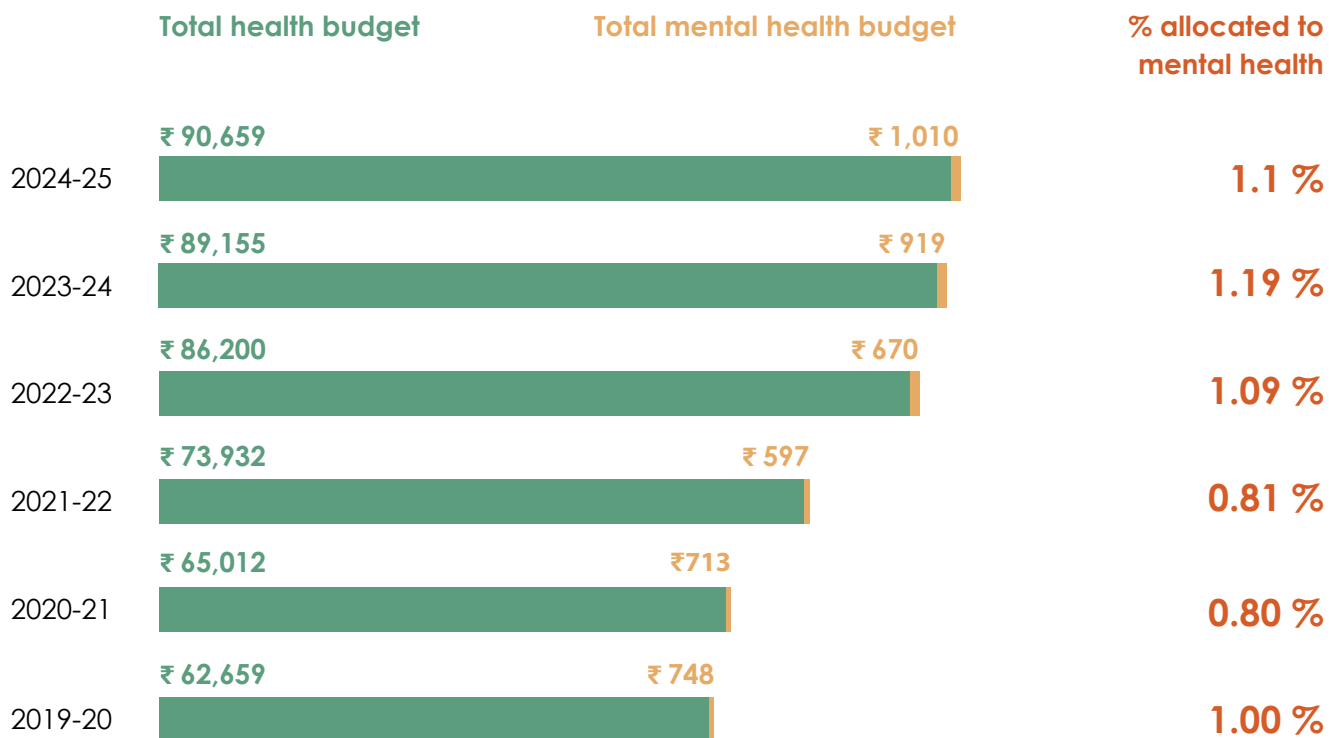
Enhancements in technology mean that helplines are increasingly using WhatsApp as a leading mode of communication. Reports find that the preferred mode of communication changes with age and gender, and that people younger than 35 use WhatsApp to a greater degree whereas those over 35 years of age prefer telephone conversations.⁶⁶

Additionally, in 2022, India launched the National Suicide Prevention Strategy (NSPS). The NSPS aims to decrease suicide rates by 10% by 2030, particularly in the 15–29 age group. The strategy focuses on leadership, health service capacity, community resilience, and surveillance for suicide prevention. It also engages with the agricultural and education sectors to achieve suicide reduction through various initiatives, such as reducing the stigma around seeking psychological support, regulating media reporting of suicides, and monitoring pesticide sales.^{xi, 67, 68} According to the Indian Journal of Psychiatry, limited

resources remain a critical hurdle to the effective implementation of the strategy.⁶⁹

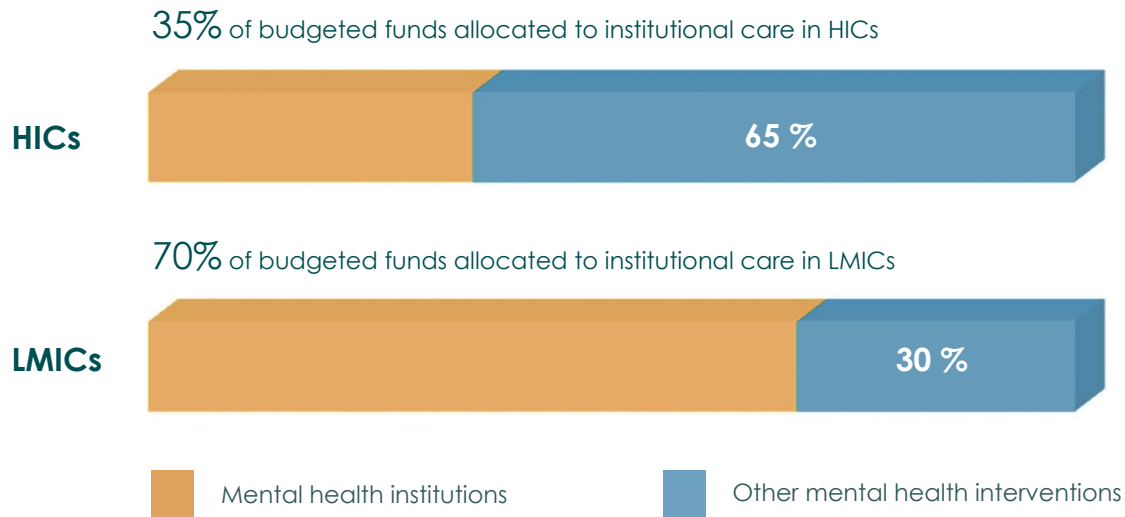
Despite the progressive legal reforms, policy changes, and initiatives aimed at improving mental health services in India, experts highlight significant challenges in the effective delivery of government programs primarily due to resource and funding constraints.^{70, 71} The next section explores the public spending and resource constraints facing mental health care in India.

Figure 8 | Budget allocation to health and mental health in crores (2019-2025)



Sources: Observer Research Foundation, 2019-21, Centre for Mental Health Law & Policy (CMHLP) Budget Briefs, 2021–24. (Refer to endnotes 72–76.)

^{xi} Pesticide ingestion is the leading method for suicide in India. (Refer to endnote 67.)

Figure 9 | Distribution of budget funds by LMICs versus HICs

Source: World Health Organization (2021). (Refer to endnote 77.)

FUNDING FOR MENTAL HEALTH IN INDIA

Low budget allocation

Over the last five years, on average, mental health has received less than 1% of the total health budget outlay of the Government of India. In the fiscal year 2023–24, there was a marginal increase in the funding allocated to mental health from ₹670 crores (approx. US\$54.9 billion) to ₹919 crores (approx. US\$75.3 billion), still accounting for only about 1% of the total health budget of ₹89,165 crores (approx. US\$7.31 trillion) (**Figure 8**).^{72, 73, 74, 75, 76}

Skew toward institutional care

Globally, studies show that low- and middle-income countries (LMICs) allocate over 70% of their mental health care funds to centralized psychiatric hospitals and institutions. In contrast, high-income countries (HICs) allocate only about 35% of their mental health

budgets to psychiatric hospitals, dispensing the rest toward integrating mental health into general health, general hospitals, community programs, education, and substance use interventions (see **Figure 9**).⁷⁷

Indian public funding is also predominantly directed toward two mental health institutions—NIMHANS and the Lokpriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH)—which together receive 85.4% of the total mental health budget, reflecting the Indian government's continued emphasis on institutional care despite policy stating otherwise (**Figure 10**). As a result, there is inadequate funding for the national- and district-level mental health programs discussed earlier. Additionally, a significant portion of the funding assigned by the Government of India

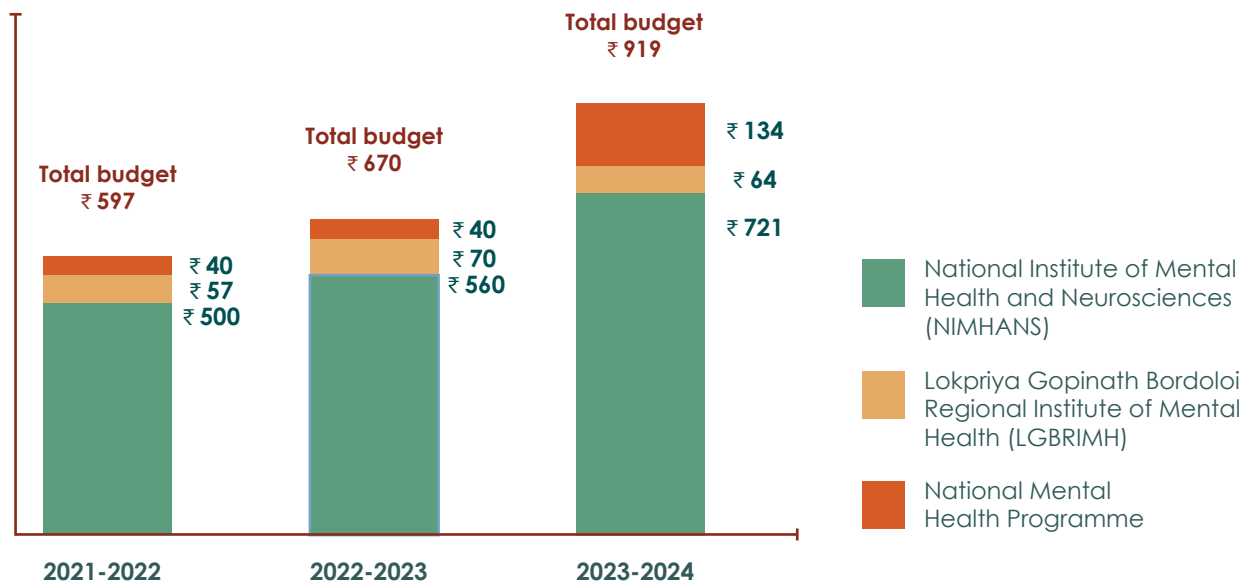
remains unutilized by state governments.⁷⁸ For instance, Telangana (5%), Uttarakhand (12%), and Jharkhand (12%) have the lowest rates of DMHP fund utilization. In contrast, Andhra Pradesh (78%), West Bengal (71%), and Chhattisgarh (64%) are the states with the highest utilization rates of the allocated funds, given that all these states report complete coverage of all districts under the DMHP.⁷⁹

Insurance for mental health care

Until 2017, health insurance policies specifically excluded coverage for mental illness using standard exclusionary wording. With the

enactment of the Mental Health Care Act, 2017 the situation changed to a certain degree. The MHCA places mental illness on the same footing as bodily disease via Section 21(4), which states, “Every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness.” COVID-19 prompted a directive from the Insurance Regulatory and Development Authority of India—the country’s insurance regulator for private insurance companies—to include coverage for mental illness.⁸⁰

Figure 10 | Union budget allocation for mental health (2021-24) in INR crores



Source: CMHLP Budget Briefs, 2021, 2022, 2023. (Refer to endnotes 72–74.)

Presently, some insurance policies do provide mental health care coverage. However, nonpharmacological interventions, such as counseling or rehabilitation, which are frequently required to treat chronic mental illnesses, are still excluded from the scope of coverage.⁸¹ Most policies only insure fixed

treatment costs, such as hospital stays.⁸² Moreover, neurodegenerative diseases that have a large impact on mental health such as Alzheimer’s, dementia, and Parkinson’s are excluded if the buyer is already afflicted at the time of insurance purchase.⁸³

Insurance companies have no incentive under their current models of spreading risk to cover mental illnesses because of their chronic nature. Dr Nachiket Mor, one of India's foremost public health systems experts and a visiting scientist with the Banyan Academy of Leadership in Mental Health (BALM)^{xii}, explained why: "The current model of health insurance is best suited for high-uncertainty, high-cost episodic diseases, such as cancer or cardiac surgery, that are rare events. Chronic conditions that include mental illnesses, such as schizophrenia, do not fit this bill, as they require ongoing or continuing treatment and care."

“

A different insurance model that is called 'managed care' works better for mental health conditions.

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Dr Nachiket Mor,
Visiting scientist, Banyan Academy of Leadership in Mental Health (BALM)

The 'managed care' model is a new model of insurance that is based on a monthly/annual subscription fee that covers all forms of care, including unexpected in-patient care for mental health events, and emphasizes proactive diagnosis and early treatment.⁸⁴ Dr Mor added, "From an insurer's perspective, there is now an incentive to ensure their subscribers—the patients—stay well and get regular screenings to ensure that treatment

starts early. This can help prevent or minimize the occurrence of serious health events, such as hospitalization, that are expensive for the insurer. It is these kinds of insurance products that India needs."

In terms of government-provided financial support, mental health care is included in India's universal health coverage scheme, Ayushman Bharat Yojana (ABY), which was launched in 2018. This is the world's largest health insurance scheme, which provides health coverage of ₹500,000 (approx. US\$6,098) per family per year and aims to insure 500 million people. The scheme also extends to mental health, offering insurance, screenings, treatments, and referral services. However, all treatment and referrals are restricted to government-run facilities for mental health, whereas the insurance scheme provides coverage for physical health issues at private hospitals as well.⁸⁵ There is limited data on the implementation and effectiveness of the ABY.

Insurance for mental health is a subject that needs deeper study and exploration. At the same time, the current scenario presents an opportunity for the private sector to innovate and disrupt with the win-win goals of designing more inclusive policies while selling a product that one in every seven Indians needs. There is a need for additional resources to flow toward mental health care. Philanthropy has a critical role to play in supplementing governmental

^{xii} BALM was established in 2007 as a division within The Banyan to build pillars of research, education, training, and advocacy to influence policy change and augment stakeholder collaborations in mental health and social sectors.

efforts. Philanthropists interested in aligning their objectives with the government's policies and programs for mental health care can ensure that their investments complement and reinforce government efforts rather than duplicate them.

Encouragingly, some social sector organizations have taken their cues from these policy changes. Donors and nonprofits are helping local governments roll out the DMHP and integrate mental health care into PHCs. We showcase some of these examples in the following chapters. Simultaneously, in the aftermath of COVID-19, there has been a spike in mental health care collaborations between social sector organizations and the government. Notably, there is interest not only from health and welfare departments in the state and national governments but also within other ministries and departments, such as those overseeing youth affairs, livelihoods, and transportation. We outline the emergence of these partnerships in Chapter 3, where we also look at current efforts from private donors toward funding and supporting mental health programs in India, as well as their focus areas and approaches to mitigating this challenge.

CHAPTER 3

PHILANTHROPY FOR MENTAL HEALTH: A DYNAMIC TERRAIN

As discussed, government efforts alone are not sufficient to address India's ongoing mental health crisis—other stakeholders have important roles to play. However, despite the scale and sweeping nature of the challenge, mental health has begun featuring on the donor agenda in Indian philanthropy only now. One reason for the delayed start could be that India had, and continues to have, a multitude of competing needs for resource allocation, such as supporting better nutrition, education, housing, and physical health. Although vast strides have been made in reducing poverty, inequality, hunger, and gaps in education, shelter, and more, India is still a low-income economy, with an annual per capita income of approximately ₹198,703 (approx. US\$2,424).⁸⁶ Consequently, much of Indian philanthropy continues to support these causes even today. For instance, physical health and education made up 55% of the share of philanthropic contributions even as of 2023.⁸⁷

Encouragingly, in the last decade or so, green shoots have appeared in terms of domestic giving for mental health programming. The shared experience of the pandemic and the subsequent rise in awareness and sensitization around mental illness have elevated the issue to one that is critical and deserving of philanthropic support. Therefore, private sector efforts, including philanthropic funding and support for mental health, are on the rise, though they remain limited.

In this chapter, we highlight certain key Indian

donors who are supporting mental health today; how their portfolios are evolving and responding to needs; three key strategies for giving; and the diverse range of impact measurement tools donors and nonprofits have adopted to assess their work. We also shed light on the emerging trend of collaborations with the government across departments and sectors. Finally, we outline the key implications of these observations.

MENTAL HEALTH FEATURES IN DONOR PORTFOLIOS

Supporting mental health has, until recently, not been at the forefront of Indian philanthropy. The Tata Trusts were one of the earliest, and few, funders of mental health initiatives in India, giving to emerging nonprofits in the sector as far back as the 1990s.

“

The Tata Trusts were ameliorative funders: if there was human suffering, they would give to abate the suffering. With this approach, the Trusts were looking at mental health decades before anyone else was. The grants the Trusts provided were instrumental to many organizations being set up in this space.

Dr. Tasneem Raja,
Head of Mental Health Programs, of Indira Foundation (and former lead of the mental health portfolio at Tata Trusts)

”

This early funding was integral to the establishment of some of the most reputable nonprofits in the sector even today, including The Banyan, the Schizophrenia Research Foundation India, and the Parivartan Trust that CAPI interviewed for this report.

Over the last decade, more donors have entered the fray and begun funding mental health programs and initiatives. “We set up the Live Love Laugh Foundation almost 10 years ago. Since then, we have seen a positive change towards attitudes around mental health. During my early meetings with donors, I had to explain what mental health is and why it is important to fund this sector. But now, acceptance is growing, and people are more open to talking about and funding this issue,” said Anisha Padukone, Chief Executive Officer (CEO) of The Live Love Laugh Foundation (LLL Foundation), a nonprofit based in Bangalore (which also sub-grants to other nonprofits).

At present, many domestic donors, both individuals and philanthropic foundations, have an expressly stated mental health portfolio. **Table 1** captures the most prominent entities making grants and supporting mental health (and ancillary portfolios), most of whom were interviewed by CAPI for this report.^{xiii} Of these, the Vandrevalla Foundation, Mariwala Health Initiative (MHI), and The Live Love Laugh Foundation currently have an exclusive focus on mental health, while the others fund and/or implement mental health initiatives within a broader portfolio.

Table 1: Entities funding mental health initiatives in India

Entity	First mental health grant	Focus areas	Role
Cipla Foundation	1997	Rehabilitation and palliative care	Grant making and implementation
Tata Trusts	1998	Treatment and care through institutional reform and government partnerships	Grant making and implementation
Vandrevala Foundation	2009	Crisis helpline	Implementation
Motivation for Excellence Foundation	2013	Institutional reform, and government partnerships	Grant making
Pratiksha Trust	2014	Scientific research on degenerative disorders	Grant making
Mariwala Health Initiative	2015	Advocacy, capacity-building, and care at the community level	Grant making
The Live Love Laugh Foundation	2015	Awareness as well as treatment and care at the community level	Implementation and sub-granting
Mpower	2016	Awareness as well as treatment and care through helplines and counseling services	Implementation
Azim Premji Foundation	2018	Treatment and care at the community level and through institutions	Grant making
Raintree Foundation	2018	Treatment and care at the community level	Grant making
Biocon Foundation	2018	Awareness, treatment and care, and scientific research	Grant making
Rohini Nilekani Philanthropies Foundation	2020	Scientific research, mental health support for survivors of violence, and mental health helpline	Grant making
Shantilal Shanghvi Foundation (Mann Talks)	2020	Awareness, mental health support helpline, counseling services, and caregivers' support group	Implementation

Mental health is a relatively new area of focus for philanthropists, and CAPI found that most donors are still developing their mental health portfolios. For instance, Natasha

Joshi, Associate Director, Rohini Nilekani Philanthropies Foundation (RNPF), told CAPI, “We are in the early stages of building our mental health portfolio and in the process of

^{xiii} This is an indicative list of domestic donors in mental health in India, not an exhaustive one. CAPI has sourced the year of the first grant from publicly available sources. There may be some discrepancies regarding the actual year the grant was made.

understanding the space better.”

This process often involves modifying or expanding the current portfolio or programs based on a growing understanding of a field and identification of needs.

“

“Over the last few years, our strategy has changed. We have expanded our focus from awareness building and sensitization to also include improving accessibility and affordability of mental health services, especially among rural communities.”

Anisha Padukone,
Chief Executive Officer,
The Live Laugh Foundation

Another organization, Mann Talks—funded by the Shantilal Shanghvi family—was set up during COVID-19 as an emergency helpline and now also provides appointment-based, online counseling sessions; a support program for caregivers of terminally ill patients; and mental health awareness and sensitization programs with nonprofit and corporate partners, amongst others. Disket Angmo, Strategy and Operations Lead, told CAPI, “After the pandemic subsided, we identified a growing need for longer-term therapy that is high in quality but also affordable; this led to the creation of our new therapy program, MannKiTherapy. Similarly, through our research and workshops, we identified a gap in mental health support to caregivers of patients with

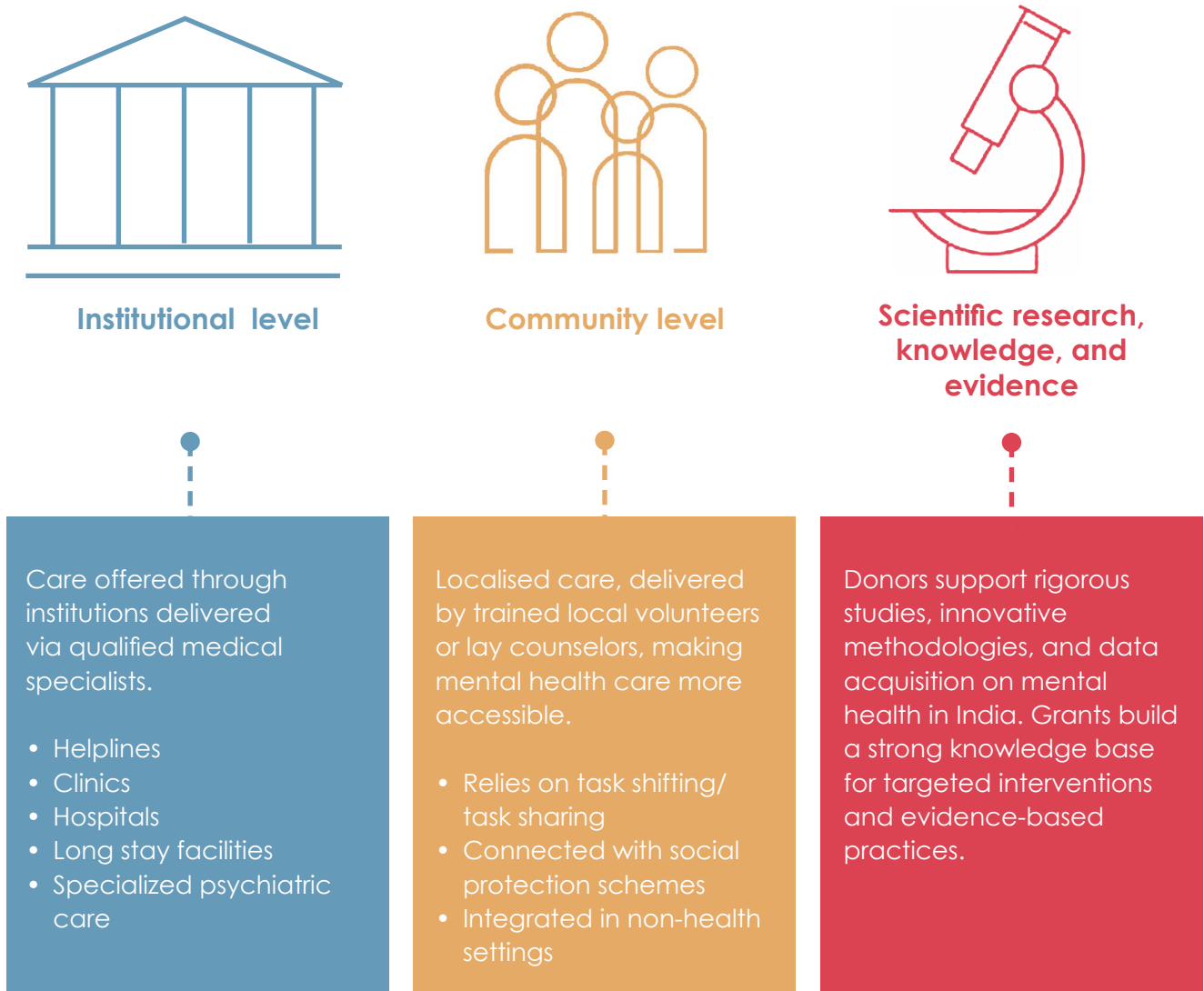
long-term or terminal illnesses, and hence set up a program for that beneficiary group also.”

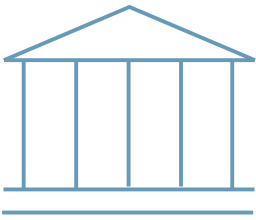
THREE APPROACHES TO FUNDING: INSTITUTIONAL, COMMUNITY, AND SCIENTIFIC RESEARCH

Although in its early stages, CAPI observed three key approaches in how domestic donors currently support mental health. These are not mutually exclusive, and some donors adopt a combination of the three. These approaches, or strategies, span a variety of interventions and focus on the various stages of mental health care described earlier: prevention, treatment, rehabilitation, and even palliative care, which has deep psychological implications for the patient and caregiver(s).

The first strategy, termed the “**institutional approach**” in this report, focuses on treatment and care through institutions and facilities and access to services via qualified professionals, such as psychiatrists and psychologists. The second, “**community approach**” funds models of mental health care in a localized setting at the community level. In the third, linked manner, donors also fund **research and science** via universities or health care institutes to create a knowledge base and data sets. This research can have implications for and support the first two approaches (**Figure 11**).

Figure 11 | Three approaches of philanthropy for mental health





1. INSTITUTIONAL APPROACH

CAPi interviewed several donors who have funded initiatives to bolster the institutional framework within which mental health care is delivered, such as hospitals, clinics, and counseling/therapy centers. These initiatives include supporting existing institutions as well as setting up new ones.

Like most institutional facilities within the larger healthcare framework, the goal of mental health facilities is primarily to treat individuals living with mental illness. Such institutions are particularly helpful for those with severe mental illnesses that require in-patient and focused care from trained professionals. Prevention or rehabilitation activities are usually secondary goals within these facilities. CAPi found that there are two kinds of facilities that donors have supported with the institutional approach.

Clinics, hospitals, and other treatment facilities

Many donors have established new mental health treatment facilities or enhanced existing ones. For example, Udaan—a collaborative effort between two donor entities: the Tata Trusts and the Motivation for Excellence Foundation—played a pivotal role in helping

the Regional Mental Hospital, Nagpur, Maharashtra, align with the principles outlined in the Mental Healthcare Act, 2017.⁸⁸ Central to Udaan's implementation was a human rights-focused approach: one of its key objectives was ensuring that clinical process reform prioritized patient rights and dignity. Simultaneously, infrastructural improvements were designed to create a more therapeutic environment. The staff capacity-building initiatives included skills enhancement and aimed to instill a rights-based perspective among caregivers to create a compassionate and rights-conscious workforce. Udaan also actively focused on improving the quality of care by establishing a library and meditation hall; creating employment opportunities through agricultural activities; installing a mobile cafeteria, bakery, hair salon, and tailoring unit on the campus; and implementing an internal banking system for financial inclusion.^{xiv,89,90}

The Cipla Foundation (Cipla) has a long history of working with terminally ill patients and their caregivers through a "family care" model. A multidisciplinary team guides patients and their families on assorted topics, including emotional and psychological support, nutrition, physiotherapy, and pain management alongside medical support. Family members or caregivers also receive ongoing psychosocial support, including much-needed grief and bereavement counseling.⁹¹ Cipla set up a

^{xiv} Concurrently, Tata Trusts also implemented a district-wide mental health program to improve the implementation of the District Mental Health Programme and established a technical support unit for the Government of Maharashtra.

residential care facility in Pune—the first of its kind in the country—in 1997. Since then, Cipla has expanded its palliative care program to many other parts of India and served over 22,500 patients with free-of-cost care.⁹²

In September 2023, Cipla tied up with NIMHANS to set up a neuro-palliative care unit to support patients with neurodegenerative disorders, such as Alzheimer's, dementia, and Parkinson's, through in-patient and out-patient care, home care services, and teleconsultation services to patients as well as their families and caregivers. Anurag Mishra, Head of CSR at Cipla, highlighted the various mental health needs that arise from a chronic or terminal illness: "The struggle of patients with a terminal or lifelong illness is hard to truly comprehend. These illnesses have a profound impact on not only the patient but also the caregivers, who find themselves in a relentless cycle of sleepless nights and confinement to their homes. Sometimes, patients, tragically unable to bear their condition any longer, contemplate risking their own lives, which at times becomes fatal. Therefore, it is crucial to consider the social, psychosocial, spiritual, familial, and caregiver dimensions, and look beyond the disease itself to the imperative for palliative care."

The Aditya Birla Education Trust established Mpower—a separate division focusing on comprehensive mental health services—in 2016. In addition to various mental health programs, Mpower provides psychiatrist consultations, counseling, and therapy virtually

as well as through physical clinics in Mumbai, Bangalore, Delhi, Pune and Kolkata. Mpower also collaborates with schools, colleges, nonprofits, and corporate bodies to provide accessible and quality clinical care for mental health. These services are also provided to low-income groups at subsidized rates through Mpower Foundation and Cell Model and various community projects. Moreover, Mpower combines clinical care services with awareness initiatives and widespread community outreach to reduce the stigma around mental health, provide accessible care, and empower individuals to seek help.

Helplines

Another way many donors support treatment is by funding helplines. Helplines offer counseling through various platforms—chat, email, telephone calls, and WhatsApp messaging—and often in regional languages. Mental health helplines provide immediate emotional support and crisis intervention and are easily accessible. Moreover, they offer an anonymous method of communication, which can be particularly appealing or helpful to those who do not wish to disclose their identity while still allowing them access to support.

From a donor's perspective, helplines are cost-effective, as they do not require heavy infrastructure or high capital investments and act as a safety net. This is often critical to managing emergencies, such as suicide prevention. Suicide is the leading cause of death among those aged 15–29 years in India and often requires urgent attention along with

the provision of an anonymous and safe space for engagement and care.⁹³

Helplines became especially pivotal during COVID-19 when people could not travel to clinics due to lockdowns and other restrictions. Many donors stepped up and established helplines during this period. For instance, Mpower helped set up a toll-free, 24/7 helpline in Mumbai called Let's Talk 1 on 1.

“While the intention to work in mental health was always there among the donor family, the need to step in, act quickly, and be accessible online became clear during the pandemic. A helpline fulfills all these criteria and from there, the Mann Talks helpline was set up in October 2020.

Disket Angmo,
Lead, Strategy and Operations,
Mann Talks

callers or following up with them. This implies that although the number of calls received can be tallied, the level of effectiveness of the call/exchange of communication in improving an individual's mental state cannot necessarily be gauged. Also, as many interviewees told CAPI, call statistics can fluctuate depending on a host of external variables—for instance, changes in the caller's environment and/or their ability to call in (particularly for survivors of abuse), referral to a specialist, switch in the mode of mental health care, or, simply, an abatement of distress. Many of the organizations that CAPI interviewed use anonymous feedback surveys from clients, client ratings, and peer reviews of the counselors staffing the helpline as internal tools to gauge their impact.

However, helplines have certain shortcomings, as Angmo also pointed out: “Mann Talks also introduced an email counseling service in addition to the helpline because we realized that even among some of our helpline clients, some people either didn't have a safe space to speak on the phone or just preferred to write in about their concerns.”

It is difficult to gauge the true impact of a helpline or chat-based service. Privacy concerns prevent administrators from tracking



2. COMMUNITY APPROACH

Social and cultural practices for mental health care in India have long relied on informal, community-based methods, such as family care and religious support.^{94,95,96} Some donors are also now funding and/or designing interventions based on such practices; these are being rolled out in different states gradually. While the traditional approach relies on an individual in distress approaching an institution or facility for care, a key distinction is that the community approach brings care outside of institutions and directly to communities/individuals who need assistance.

Rather than relying on health experts, such as psychiatrists or psychologists—who are in short supply in India as mentioned in Chapter 1—the community mental health (CMH) model draws in more resources from the target community itself.⁹⁷

“

Traditional service delivery by qualified individuals is not enough. Just look at the scale of the problem in India. To make a real impact, we must shift to community-based models. To support these models effectively, we needed a different approach to funding.

Priti Sridhar,
CEO, Mariwala Health Initiative

”

Further, CMH models focus not only on treatment but often also on prevention and rehabilitation. While the style of execution varies across programs, the CMH model relies on task shifting or task sharing, wherein individuals living with mental health conditions receive care from community-based mental health care workers or volunteers. This community-based cadre, often known as ‘lay volunteers’ is trained to deliver certain mental health services, recognizing that not all mental health services require the expertise of a psychiatrist or psychologist; tasks such as basic counseling, raising mental health awareness, and ensuring medication adherence can be carried out by non-specialists.^{98,99} Nonetheless, these non-specialists can and do provide referrals up the value chain to medical specialists as needed for more severe conditions.

For instance, the Azim Premji Foundation supports the Mental Health Action Trust (MHAT), a Kerala-based nonprofit that works with grassroots volunteers who act as case managers to provide mental health support. Case managers conduct regular follow-ups and monitor individuals with mental illnesses in their villages and towns, assist with early identification of mental health issues, and refer patients to specialists. Case managers are volunteers sourced from the districts where the MHAT’s grassroots partners operate, and they receive contextualized training to address the specific issues prevalent within their communities.

Meanwhile, Anjali, a Kolkata-based nonprofit supported by the Mariwala Health Initiative, trains women-led self-help groups to deliver psychological and social interventions within communities in West Bengal as part of its Janamanas initiative.

i. Community mental health in primary health care

Many CMH models also integrate mental health services into primary health care settings. Such a facility can help patients avoid the stigma associated with seeking support for a mental illness. The primary healthcare center (PHC) represents treatment in familiar, non-stigmatized environments and can

facilitate proximate access and, thus, early detection and intervention—all of which are particularly critical for rural India. Parivartan Trust, a Maharashtra-based nonprofit that the Azim Premji Foundation also funds, leverages the support of community health workers, such as Accredited Social Health Activist (ASHA) workers, social workers, and auxiliary nurse midwives (who are appointed by the government to provide health care services at the village or panchayat level), to deliver mental health programs.



Community health worker conducting a session with community volunteers
Image Credit: Parivartan Trust



Intervention facilitator and health worker interacting with community members

Image Credit: Parivartan Trust

The LLL Foundation implements its rural mental health program across Karnataka, Odisha, Tamil Nadu, Kerala, Himachal Pradesh, and Madhya Pradesh in collaboration with local partners. It aims to create sustainable and community-owned mental health care systems with buy-in from various stakeholders, including the local government, self-help groups, ASHA workers, and community volunteers. This program focuses on three key elements:

1. **Awareness** through activities such as street plays, wall paintings, and training frontline workers in mental health care.
2. **Accessibility** to psychiatric treatment, psychosocial support, and rehabilitation within

villages.

3. **Affordability**, with treatment provided free of cost and beneficiaries connected to government schemes, including the District Mental Health Programme (DMHP).

ii. Community mental health integrated with other non-health, socioeconomic programs

CAPI learned that it is also possible to integrate other socioeconomic goals with the CMH model or integrate mental health with programs whose primary objective is social or economic—such as livelihoods, gender, vocational training, and education programs. Some CMH models are designed to impact other variables (including the

structural determinants discussed in Chapter 1) that affect mental health in the long run and can play a key role in rehabilitation and prevention.

One example is the Raintree Foundation, based in Mumbai and funded by the Dandekar family, which has adopted an intersectional lens in its work on climate change and rural development. Operating in a biodiverse rural area of the Western Ghats in Maharashtra, it places resident villagers at the center of its work and combines rural development and livelihoods; the environment; and disability and mental health in its interventions.

“The youth in these areas have migrated to cities in search of livelihoods, leaving the elderly feeling lonely and vulnerable. This is also an area prone to water scarcity and an onslaught of effects from climate change. We knew, therefore, that whatever work we did here would have to include building mental resilience in the community. This resilience building is crucial for mitigating the far-reaching effects of climate change on vulnerable communities.

Abha Dandekar,
*Co-founder and Philanthropist,
Raintree Foundation*

Partnering with the Bapu Trust, a Pune-based mental health nonprofit, the Raintree Foundation has established a rural counseling center in the nearby Velhe district to support individuals facing high levels of mental distress. It has also developed modules for training local community members to provide first responder-level support in volatile mental health situations and eventually take over the counseling center to ensure that there is no continued dependence on specialists. Training sessions cover diverse topics, including self-care, coping mechanisms, substance abuse, and issues at the intersection of mental health, climate, and gender. The Bapu Trust's approach is distinct from a conventional medical model of treatment, as its programs adopt an inclusion and resilience lens through initiatives in art, nutrition, community engagement, and peer support, emphasizing self-care, comprehensive health care, and building social capital at the community level.

Similarly, the MHI supports and funds the Law Foundation, a nonprofit based in Bihar, in implementing a socio-legal approach to mental illness. This nonprofit is committed to delivering sustainable mental health services within prisons, recognizing their crucial role in enhancing the well-being and mental health of incarcerated individuals. The Law Foundation provides free legal aid alongside mental health support to incarcerated people as well as their families. Mental health support is viewed as integral to prisoners' rehabilitation, their successful reintegration into society, and reduced likelihood of recidivism. The

organization offers a comprehensive suite of mental health resources, encompassing counseling to equip inmates with the challenges of prison life; psychiatric care; and access to mental health professionals, while also conducting educational programs to foster awareness about mental health

management. Additionally, it runs peer-to-peer support groups and listening circles among inmates and their families to improve the overall well-being of this community. Programs are run in collaboration with prison authorities, mental health experts, and civil society organizations.



An individual who recovered from a severe mental health illness, working on his farm
Image Credit: Parivartan Trust



Top: Listening circle in community and mental health awareness campaigning by a social worker in villages of Bihar; Bottom: Socio-legal awareness session by community social workers

Image Credits: Law Foundation



3. FUNDING RESEARCH AND SCIENCE

Aside from the institutional and community approaches, donors in India also recognize the importance of evidence-based interventions. Through its interviews, CAPI learned that donors fund research to build a credible knowledge base that is rooted in the Indian context to understand mental illness better. Some donors begin their grant-making journey in mental health by funding science and research at well-established institutions that have a reputation for excellence in the field.

For instance, the Biocon Foundation collaborated with NIMHANS for its Bangalore Urban Mental Health Initiative (BUMHI) to conduct and promote mental health research and literacy. Anupama Shetty, Mission Director, told CAPI, “The Foundation identified a massive gap concerning awareness and stigma associated with mental health, so working on mental health literacy was important. It was important for us to work in partnership with an institution like NIMHANS to achieve impact-based outcomes and fill the knowledge gap through research.” The project has developed several modules on self-awareness, emotional management, stress coping, empathy, effective communication,

mental health awareness, and bolstering social support for those with mental illness. The BUMHI initiative uses these models to train frontline workers, such as Nirbhaya counselors^{xv} and community workers, in grassroots organizations.

Additionally, the Biocon Foundation funds the St. John's Research Institute to address mental health issues among pregnant women from an urban slum located in Bangalore. The Foundation, which already supports a clinic in the area, identified peripartum depression among its female residents. Under the new program, doctors from the St. John's Epidemiology Community Medicine department visit this locale every month to increase mental health evaluations during the pregnancy and postpartum periods. The initiative identifies and addresses common mental disorders in pregnant and lactating women, providing counseling and proactive support for peripartum mental health concerns.

In March 2023, the Rohini Nilekani Philanthropies Foundation (RNPF) made a grant of ₹100 crores (approx. US\$12.2 million) to NIMHANS and the National Centre for Biological Sciences to set up the Centre for Brain and Mind. This grant, which will be disbursed in tranches over 10 years, is aimed at long-term research and practice related to five major illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, dementia, and addiction. The project plans

^{xv}Nirbhaya counselors are professionals appointed under the Nirbhaya Fund—instituted by the Government of India in 2013—who provide vital mental health and emotional support to the survivors of sexual violence and their families.

to deploy cutting-edge scientific techniques, such as stem cell technology and clinical data analysis, to better understand the complex biomarkers and genetic transmission of these disorders. It will follow a cohort of 1,500 families and track 75 points of clinical data from each patient.

“

In a media statement, Rohini Nilekani, a prominent philanthropist and Chairperson of RNPF, noted, “Mental health is an area that demands more attention and support. The recent pandemic brought out this need even more starkly. Through this grant, I hope that a collaboration between two apex institutions of this country will provide globally relevant insights, evidence, and pathways for better treatment for millions of people in India and the world. The Centre for Brain and Mind hopes to build an ecosystem for the larger community of mental health practitioners. Its research on five critical disorders, which will no doubt be path-breaking, will be open-sourced to allow more innovation in both academics and practice.”¹⁰⁰ She further emphasized “The need to fund pure research demands a high-risk approach and that was very important to me because that's what philanthropy is about.”¹⁰¹

Rohini Nilekani,
Chairperson, RNPF

”

Around the same time, Kris Gopalakrishnan, co-founder of India's tech giant Infosys Limited, granted ₹750 crores (approx. US\$91.5 million) to the Indian Institute of Science through his family foundation, the Pratiksha Trust. The grant aims to support research on neurodegenerative disorders such as dementia, Parkinson's disease, and other age-related cognitive disorders.¹⁰²

RISE IN GOVERNMENT PARTNERSHIPS

The massive scale of mental health needs in India, coupled with the interlinked adverse socioeconomic implications, implies that the government has a critical role to play in efforts to combat this challenge. As described in Chapter 1, the Government of India has laid down a broad policy and regulation framework to guide mental health care response and service delivery, in addition to providing direct funding and setting up state-run programs.



Top: Home Again clients at Ratnagiri, Maharashtra, celebrating Ms. S's birthday;
Bottom: Service-users engaged in sales of tiffin items at Home Again in Kundrukadu
Image Credits: The Banyan



Friends catching up with each other at the Home Again house in Therkupattu, Chengalpattu
Image Credits: The Banyan

Beyond regulation and direct funding, there is a third way in which governments, including state and local authorities, support mental health care: through partnerships with the social sector. For instance, The Banyan, a Chennai-headquartered nonprofit, works across nine states in India (and two low- and middle-income countries) to implement its “Home Again” intervention. Home Again adopts a rights-based approach,^{xvi} which offers women with mental health illnesses a chance to transition from institutional hospital settings to independent living. Beyond offering

housing support and reintegration with the community, the intervention center facilitates access to state-sponsored social entitlements, provides resources, and delivers skill-building training. Dr Nachiket Mor, a public health expert told CAPI, “We need the replication of many more such models of excellence. Governments need to leverage more such models and work with the social sector to enable social impact.”

COVID-19 catalyzed collaboration with the government. Many nonprofits, and donors

^{xvi}As per the UNCRPD and the Mental Healthcare Act (MHCA), 2017, a rights-based approach refers to the equal rights and dignity of individuals with disabilities, including mental health conditions. This includes advocacy for inclusive, nondiscriminatory practices and empowering individuals with mental health care needs in decision-making. The UNCRPD and MHCA frameworks emphasize accessible, community-based mental health services, aiming to focus on fundamental rights, dignity, and autonomy.

whom CAPI interviewed for this study, were approached by state governments during the pandemic. A public–private partnership was forged between the Delhi-based nonprofit Mind Piper, the state government of Delhi, and ACT (Action Covid Taskforce) Grants^{xvii} in April 2020 to set up a helpline. The helpline later began providing proactive outreach and counseling for COVID-19 patients. Partnering with the government enabled the initiative to expand to six more states: Karnataka, Uttarakhand, Chhattisgarh, Madhya Pradesh, Puducherry, and Arunachal Pradesh.

Similarly, Mpower began running mental health screening and well-being programs for the Central Industrial Security Force officials and paramilitary forces who serve as security at airports; this collaboration operates as a public–private partnership. The initiative—which began during COVID-19 with two airports, in Mumbai and Delhi—has expanded pan-India and covers 54 airports; it had screened over 8000+ personnel's for mental health issues at the time of writing this report. Over 16,000 personnel have been reached through Mpower's awareness sessions on mental health.

Collaborations with the government are not restricted to health or welfare departments alone but are taking place across sectors.

“Mental health is on the mandate across various ministries and departments within the government—including the departments of

women and child development, tribal affairs, education, youth and sports, agriculture and farmer welfare—so partnering with different ministries and departments is effective,” said Siddhanth Khurana, Founder, Mind Piper.

Other CAPI interviewees shared similar experiences of collaboration across different departments.

“ In Kerala, we have collaborations with the tribal and fisheries departments, primarily for short-term projects. While this is a modest start, it is a positive development. We have had to persuade them that effective mental health care is integral to the overall well-being of tribal, coastal, and other populations, and these departments have been able to grasp its importance. ”

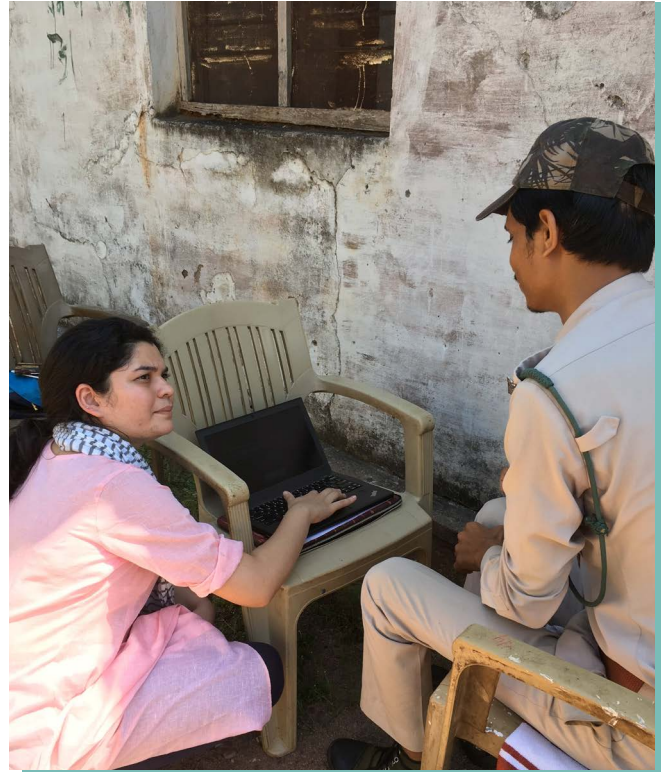
Dr Manoj Kumar
 Founder,
 Mental Health Action Trust

Kerala's Ministry of Fisheries has partnered with the MHAT to implement a mental health intervention for fisherwomen as part of a wider initiative aimed at the upliftment of this community through entrepreneurship and microenterprise development. MHAT conducts

^{xvii} ACT Grants was set up during the pandemic as a collective of venture capitalists, technology entrepreneurs, and social impact leaders who pooled their strengths to raise funds and deploy resources in response to COVID-19.

counseling sessions and provides mental health outpatient services in coastal areas within the districts of Thiruvananthapuram, Ernakulam, and Kozhikode. This government-funded intervention not only caters to the psychological wellbeing of fisherwomen but also offers healthcare support for physical ailments, including financial assistance for serious illnesses.

Similarly, the Law Foundation (see the subsection "CMH integrated with other non-health, socioeconomic programs") has partnered with the Bihar state government to offer sustainable mental health services to the custodial population inside prisons.¹⁰³



Top: Conducting survey with a guard from Tadoba-Andhari Tiger Reserve, Maharashtra;
 Bottom: Understanding the relationship between communities and forest in Banni Grassland, Gujarat
 Image Credits: Wildlife Conservation Trust



Top: Conducting survey with a guard from Nauradehi Wildlife Sanctuary, Madhya Pradesh;
Bottom: Training Range Forest Officers from Navegaon-Nagzira Tiger Reserve, Maharashtra for Human Resource Management of guards.
Image Credits: Wildlife Conservation Trust

IMPACT ASSESSMENT TOOLS

In every part of the world, including India, philanthropists committed to creating meaningful change through their investments are also interested in seeing how their funds are used and to what ends. Donors and nonprofits involved in all three approaches described in this chapter are keen to understand the impact of their intervention, as this will influence their decision making regarding continued support or funding of mental health programs.

CAPI observed that there is a wide variance in capturing impact, and no one method has emerged as the standard or best practice.

“

Different organizations are using different tools to track the impact of similar interventions. As a donor, it is difficult to align and compare the impact outcome of different interventions being supported. There is a need to build a common understanding and consensus.

”

Dr. Tasneem Raja,
Head of Mental Health Programs, of Indira Foundation (and former lead of the mental health portfolio at Tata Trusts)

The reason for this variance lies in the difficulty of capturing mental health outcomes accurately, as discussed in more detail in Chapter 4. Many donors and nonprofits use either qualitative methods, quantitative tools, or a combination of both, depending on their interventions' nuances and impact evaluation goals. Qualitative methods rely on interviews with patients and caregivers, focus groups, case studies, participant observations, and storytelling—all of which can bring experiences to life. However, a purely qualitative approach can present difficulties with reporting changes at scale or obtaining a sharper degree of accuracy in measuring the change that occurred.

Quantitative tools include randomized control trials (RCTs) and psychometric assessments, such as the Patient Health Questionnaire-9 (PHQ-9)^{xviii} and Generalized Anxiety Disorder Questionnaire-7 (GAD-7),^{xix} at the baseline and the end line. While nonprofits have used RCTs in some instances, they are expensive to undertake and have been utilized to generate evidence around the CMH model, mainly to attract more funding.

The PHQ-9 and GAD-7 are utilized for “screening for the presence or absence of common mental health conditions; making a

^{xviii}The Patient Health Questionnaire-9 (PHQ-9) is a self-report scale used in mental health and primary care settings to assess and screen individuals for depression. It was developed by Dr Robert L. Spitzer, Dr Janet B. W. Williams, and Dr Kurt Kroenke and is widely used for clinical assessment of depressive symptoms. It is a brief and straightforward questionnaire that asks individuals to rate how often they have experienced specific symptoms of depression over the past two weeks. The nine items in the PHQ-9 correspond to the nine criteria for diagnosing major depressive disorder. (Refer to endnotes 105 and 106.)

^{xix}The Generalized Anxiety Disorder Questionnaire-7 is a self-report questionnaire assessing generalized anxiety disorder symptoms. It consists of seven questions, with scores ranging from 0 to 21, indicating the severity of symptoms over the past two weeks. (Refer to endnotes 105 and 106.)

formal diagnosis of a mental health condition; assessment of changes in symptom severity; and monitoring client outcomes across the course of therapy."¹⁰⁴ They focus on symptom reduction on a self-reporting basis at the beginning, middle, and conclusion of a program to measure changes in an individual's mental health status. However, these tests have also been criticized by some experts for inadequacies and inaccuracies in capturing certain mental health conditions.¹⁰⁵ Since these tests were designed for clinical use, they can be difficult to deploy in community settings.

A few donors have acknowledged the limitations of both these methods and instead approach success as a transformation of lives rather than predefined indicators.

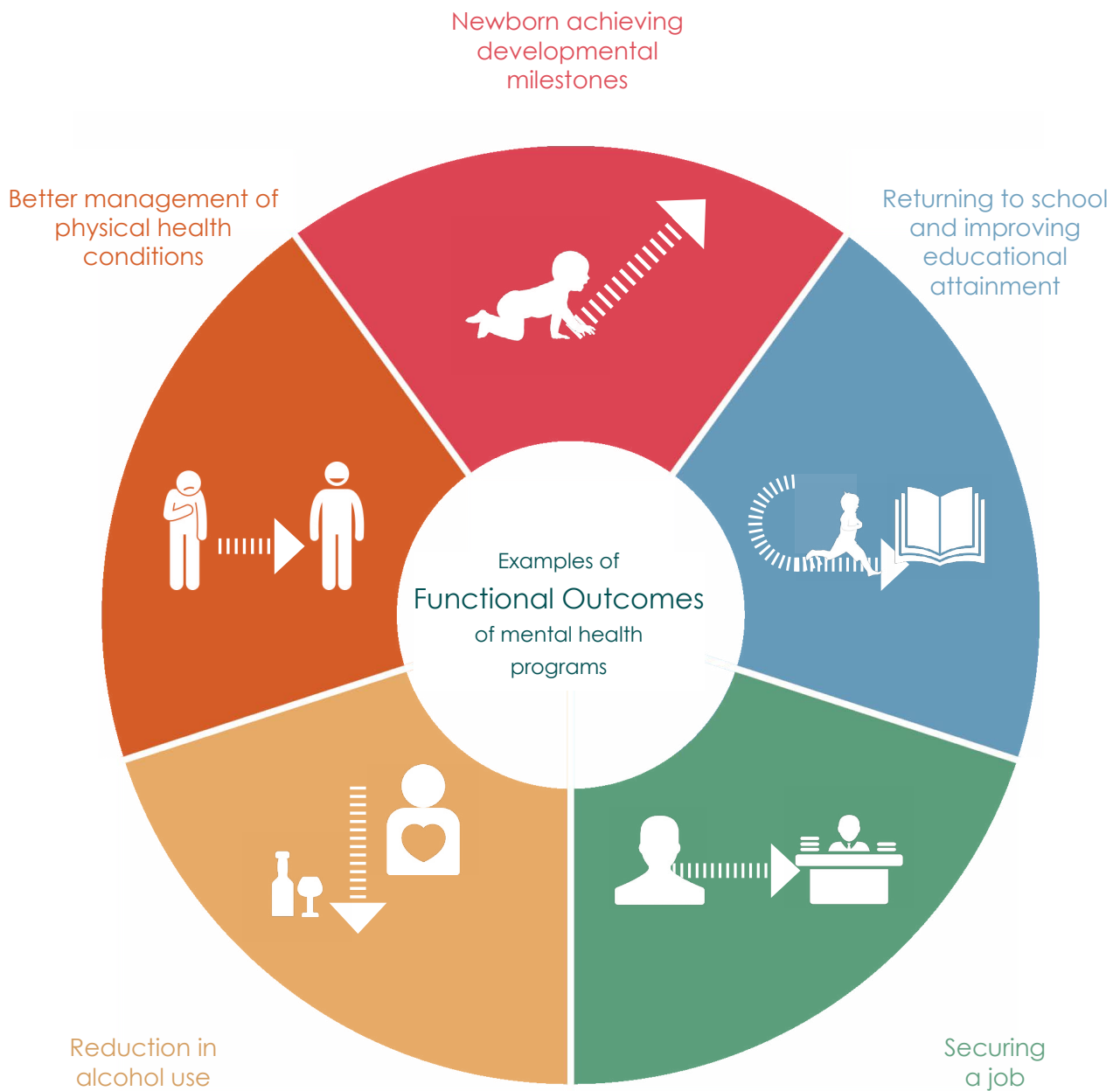
“ We don't have indicators for any of our funding. We typically ask our grantees to tell us what success would look like. Some [organizations] will give indicators, some [organizations] will not, and that's okay. For us, the impact is about changing the world by empowering those who understand their communities best. ”

Priti Sridhar,
Chief Executive Officer,
Mariwala Health Initiative

Similarly, for Rohini Nilekani Philanthropies Foundation, there is an understanding that the grant made to NIMHANS is risk capital, with no assurance of returns. As Natasha Joshi, Associate Director, told CAPI, “When you look at scientific breakthrough, it often needs that kind of risk capital, willing to invest without necessarily knowing the outcome ... On the bright side, we are guaranteed some positives: a pipeline of Indian scientists and researchers, a strong data set that's unique to the Indian population, and therefore very valuable in the future, scientific symposiums that we will host that will end up becoming spaces for consensus building, and discourse making in the larger mental health domain, and many other learnings as well!”

In a recent report titled *Paying for Outcomes on Mental Health Programs*, the Healthy Brains Global Initiative offers an alternative approach to capture the change effected by a mental health intervention. It makes a case for donors to invest in mental health interventions that promote “functional outcomes” such as improved school performance, reduction in alcohol use, better physical health management, or finding and sustaining employment in the long term (**Figure 12**).¹⁰⁶

Figure 12 | Examples of functional outcomes for mental health programs



Source: Healthy Brains Global Initiative (2023). (Refer to endnote 107.)

IMPLICATIONS OF CURRENT FUNDING APPROACHES

Despite its nascence, philanthropy's contribution to the Indian mental health care domain has resulted in the establishment of a range of interventions that have been influenced by the complexity and continuum of care needed. The examples cited in this chapter are not mutually exclusive or exhaustive. Given that philanthropy for this cause is at an early stage, donors are still experimenting and understanding which approaches best suit their goals: prevention and mitigation of stigma; immediate alleviation of suffering; a more high-risk view of backing bets in science and medicine that might pay off in the long term; or a combination of all of these and more.

These approaches will continue to evolve with the proliferation of knowledge and best practices. Given the scale of the ongoing mental health crisis, community mental health (CMH) models offer an important alternative funding model for new and current donors to support mental health in a bigger way. Many CMH models in India, assessed for effectiveness through impact evaluations and randomized control trials, have shown success. These assessments aim to create an evidence base to attract more funding so that the programs can be scaled up. For instance, Sangath, a Goa-based nonprofit, has undertaken extensive research to demonstrate

evidence of the success of its task-shifting CMH models in India.^{107,108, 109} Similarly, the Atmiyata program, designed and implemented by a Pune-based research and policy organization, the Centre for Mental Health Law & Policy, was evaluated through an RCT (the sample population was based in Gujarat), which confirmed its success in effectively lowering mental distress rates.^{xx,110,111}

Despite their proven effectiveness, the discourse around CMH models has not yet gained mainstream attention or acceptance because advocacy and amplification of the success of these models are lacking. Moreover, the historical inclination toward institutionalization is also at play. These factors limit the inflow of funds toward replicating or scaling community health models.

According to Chris Underhill, Founder of international nonprofit Basic Needs, "It has to be remembered that in many parts of India, a community mental health approach is the only viable way of reaching many people with long-term mental illness."

^{xx} Atmiyata is a community-led intervention that aims to reduce the mental health burden in rural communities with the help of volunteers, who spread awareness about mental health, identify distress cases, and refer patients to government-run primary health care centers.



Top: A community mobiliser briefing community members in Mehsana, Gujarat about actively identifying risk factors for self-harm and suicide; Bottom: An Atmiyata Champion in Mehsana, Gujarat narrowcasting an Atmiyata film for his community members, using the Atmiyata smartphone App. Image Credits: Centre for Mental Health Law & Policy

“ Even though nonprofits in India have been able to create significant evidence for their community mental health models, the messaging for investing in these has not resonated with funders because there has not been enough amplification of these results. Other stakeholders within the mental health sector—including medical specialists, donors that have funded community models, and intermediaries—can help in relaying the message to a broader audience.

Chris Underhill,
Founder, Basic Needs

Moreover, collaborations between the government and the social sector can be instrumental in amplifying the impact of philanthropy. Philanthropists aligning their objectives with government policies and programs for mental health can ensure that their investments complement and reinforce government efforts rather than duplicating them. This is especially important in the context of CMH models, where integration into government-run primary healthcare centers is key and can enable more effective implementation of the DMHP.

“ A key reason CMH models have not been scaled is not that nonprofits cannot do so. We have generated evidence-based interventions. The issue is the lack of funding. We need institutional funders to support scaling up the community mental health models.

Dr Hamid Dabholkar,
*Senior Team Member and Psychiatrist,
Parivartan Trust*

CHAPTER 4 CHALLENGES TO GIVING

There is an urgent need for private resources when addressing India's mental health challenges. However, existing donors and new entrants face serious impediments in giving to this cause. Through interviews, CAPI identified several major challenges that get in the way of enhanced funding and support from donors.

Figure 13 | Challenges in funding mental health



PERSISTENT STIGMA

Despite efforts from various stakeholders in raising awareness and sensitization, mental health continues to remain a heavily stigmatized issue in India.

“

Funding for mental health initiatives frequently falls behind, largely due to the prevailing stigma and misconceptions surrounding mental health, even among high net-worth individual circles. The apprehension of potential repercussions looms large, discouraging open discussions about personal experiences with mental health challenges, whether it's an individual, a family member, or someone seeking therapy.

Abha Dandekar,
Co-founder of Raintree Foundation

Often, it is individuals who have themselves experienced mental illness or seen it among their family and friends who are motivated to give. A personal connection to mental health issues led Bollywood actress Deepika Padukone to set up the Live Love Laugh Foundation (LLL Foundation) in Bangalore. She has also championed the cause publicly in forums and spoken about her battles with mental illness.

“

One understands mental health concerns even more sensitively when one has personally experienced it. That can become a powerful agent of change. If somebody has dementia in your family, or if you have witnessed the challenges of caring from close quarters, that might trigger your thinking about funding for dementia. You have a kid with autism in your family, you may become more attuned to various initiatives established to address the cause.

Dr Pratima Murthy,
Director, NIMHANS

Raj Mariwala, Director, Mariwala Health Initiative (MHI), was driven by a personal experience with learning disabilities. Mpower was established by Neerja Birla and her daughter, Ananya Birla, both of whom also feel strongly about championing mental health.

However, such a perspective is a double-edged sword. On the one hand, donors give because they feel a sense of personal responsibility to act. On the other, personal experiences can deter donors who fear the stigma of association with a mental illness.

“

If people have diabetes or cancer, they don't mind acknowledging that. They say, 'My wife passed away due to cancer, and so I'm giving money to cancer.' Very few people will say, 'My son has schizophrenia, and so I'm funding schizophrenia.' Very few donors will want people to have linkages to mental health coming back to them.

Dr Soumitra Pathare,
Director of CMHLP

Although COVID-19 did serve to normalize mental illness and well-being to some extent, more efforts and advocacy are needed to generate large-scale acceptance of the issue.

NO CLEAR PATHWAY

As this report has shown, the sector is extremely complex: a mix of health, socioeconomic, identity, and several other factors play a role in determining mental health, meaning that efforts to counter the mental health crisis also need to be multipronged.

Indian philanthropists in sectors such as education or nutrition have access to a plethora of trusted experts, philanthropic intermediaries, case studies, evidence, knowledge, and understanding of desirable outcomes—all necessary for donors to feel confident in their giving. As Anupama Shetty at Biocon Foundation told CAPI, “Data-backed

decisions are a critical driver for any of our investments.”

Unfortunately, mental health faces a dearth of relevant information and knowledge. Indeed, many donors told CAPI that they find it challenging to access information that can inform the strategy for their mental health portfolios. “In India, the mental health field lacks a centralized resource or platform on mental health. While experts do have valuable insights, this knowledge is confined to them.

There is a deficiency of public discourse and a scarcity of easy-to-access proofs of concept or approaches,” said Natasha Joshi, Rohini Nilekani Philanthropies Foundation.

There is also a lack of clear communication with donors.

“

There is very little guidance for donors on where they should be putting their money. While evidence-based interventions and demonstrable models do exist in India, donors find it challenging to source that information.

Dr Abhijeet Nadkarni,
Co-director, Addictions & Related Research Group, Sangath

More data is needed on many aspects of mental health, including the total amount of philanthropic funding flowing toward it or even the distribution of the nonprofits working on mental health in the country. A post-pandemic exercise to understand the distribution, frequency, and severity of various mental illnesses can help update the figures from the oft-quoted 2020 Lancet study¹¹² that presents data collected in 2017.

One reason for this lack of knowledge could be the lack of intermediaries who can bridge the gap between funders and implementers in mental health. This includes policy and research organizations that can generate trusted and credible knowledge; collaborative platforms or convenings that can share best practices and learnings; and advocacy entities that can guide and influence government around macro change—all of which are sparse in the mental health field. The existence and proliferation of these supporting organizations could spur giving in many ways, as it has, for instance, in education or climate change as well as for specific issues within these domains.^{xxi}

According to Professor Shekhar Saxena at the Department of Global Health and Population, Harvard T. H. Chan School of Public Health, “The mental health ecosystem

is not as evolved as some of the other ecosystems within health or like the education sector in which most donors put in money.” As described in Chapter 2, there is also limited amplification or messaging around programmatic models and approaches in mental health that have registered success in case studies and rigorous analyses by independent bodies. While some evidence around impact indicators exists, it is largely confined to professionals and experts within the mental health sector and is not readily available for donors to make data-backed decision.

CAPACITY CONSTRAINTS

Another challenge is the lack of capacity to support giving in mental health. There are an insufficient number of implementing organizations working in mental health, as well as limited human resource capacity.

Dr Tasneem Raja of Indira Foundation told CAPI, “There is little absorption power in the mental health sector in India. You do not need a lengthy list to name the people and organizations working in mental health. So even if there is funding, how much money can you pour into these organizations?” A few other donors also shared similar concerns around the limited absorption power

^{xxi} For example, within the environmental sector, organizations such as the India Climate Collaborative, Council on Energy, Environment and Water and World Resource Institute, India are constantly conducting applied research, gathering evidence, and bringing together various stakeholders to promote dialogue on climate change in India. Similarly, in the education sector, entities such as the Annual Status of Education Report Centre, the Pratham Network, the Quest Alliance, Education Initiatives, and others are engaging in comparable efforts to mainstream discussions on education.

for mental health within the civil society ecosystem.

For donors, it can be hard to find the right partners to implement a program in alignment with their vision. “When we started, we found it difficult to find the right set of partners with a similar approach and philosophy we were interested in supporting,” said Minal Karani, Project Manager, Raintree Foundation. As described earlier, the Raintree Foundation has adopted a unique strategy that incorporates mental health and resilience alongside climate change and rural development. The organization eventually partnered with Bapu Trust to implement its mental health intervention.

Some donors also recognize the need to build implementation capacities among their partners. The LLL Foundation, for example, offers long-term support in implementing its mental health initiative alongside supporting the organizational development and capacity building of its local partners. The Azim Premji Foundation has assisted Ashadeep, a mental health nonprofit based in Assam, in providing technical support to two non-mental health organizations for implementing community mental health programs in Northeast India.

India's acute shortage of trained psychiatrists, psychiatric nurses, psychologists, and other specialists has already been discussed in Chapter 1. Additionally, when it comes to mental health, a diverse set of skills is required to deliver services attuned to the sociocultural

nuances of a particular community. Including a broader spectrum of non-specialists for service delivery can help. This cohort includes s teachers, doctors, journalists, police officers, lawyers, and community workers—who recognize the needs, problems, and cultural contexts of the communities they are embedded in.

Nonprofit organizations and funders have initiated workshops, courses, and training to cultivate a more robust talent pool and enhance the capabilities of existing resources. For instance, MHI hosts the “Queer Affirmative Counselling Practice” course, which trains mental health practitioners to address the needs of LGBTQIA+ individuals through a six-day program, and help re-orient mental health practitioners toward a more inclusive therapeutic practice.

Another example is the CMHLP-designed “Reporting Suicides Responsibly,” course—a free and virtual training for media professionals and journalism students. The course teaches responsible reporting of suicides and mental illnesses through evidence-based guidelines.

INTANGIBLE IMPACT

The impact of mental health programs/ interventions is not always visible or tangible when compared to other domains—especially other areas of health care, where donors can often quantify the outcomes, their funds have achieved vis-à-vis a certain number of people cured, surgeries performed, patients treated, and so on.

“

Mental health is nebulous. People do not find it as heart-warming and attractive as issues such as girl child education or hunger alleviation programs. Donors often favor concrete, measurable outcomes, and fund tangible activities such as access to medicines and MRI scanning. However, this approach overlooks the importance of psychological and social interventions, which are vital. Consequently, mental health requires a different approach from donors.

Dr Abhijeet Nadkarni,
*Co-director, Addictions & Related
Research Group, Sangath*

Three factors make the mental health space unusually difficult for impact measurement:

First, mental health outcomes can be deeply personal and difficult to measure with precision.

Second, mental health does not always follow a linear path akin to physical health issues. For example, tuberculosis can be detected, treated, and cured. Mental illnesses can occur and re-occur through a patient's life, necessitating ongoing support and management.

Finally, it is not easy to separate poor mental health from factors such as socioeconomic status, family dynamics, gender-based violence, traumatic experiences, and substance use. These factors both impact mental health and can, in turn, be impacted by mental health or illness.

Experts suggest that their subjective and nuanced nature renders mental health outcomes inherently different from those in other healthcare fields.¹¹³ Uma Sunder, former impact manager at Basic Needs India, shared, “While standardized clinical tools in psychiatry or psychology offer valuable insights, they fall short in capturing the long-term impact on an individual's overall quality of life or functioning.”

”

As described in Chapter 3, donors in India currently use a range of tools to understand the impact of their giving. In the long term, the sector needs some convergence around the effectiveness of an intervention and general agreement around standards or methods to assess impact. Beneficiary organizations can also capture the most relevant data and evidence to reassure donors that their money is being used appropriately, and to prove

the long-term effectiveness of interventions. The challenges described in this chapter that accompany philanthropy in mental health are not insurmountable. Some pathways could address donor concerns while also enabling a more robust response from the private sector. We lay out a few recommendations based on our analysis of the landscape of the mental health sector in Chapter 5.

CHAPTER 5

A PATHWAY FOR PHILANTHROPY TO DO MORE

Philanthropy for mental health in India is new, but an increasing number of Indian philanthropists are now driving much-needed resources to this often-overlooked issue. Through our study, we learned about philanthropic funds being directed toward all aspects of mental health—from prevention to treatment to rehabilitation. Funding for prevention includes promoting education and awareness programs in urban and rural areas and enabling access to screenings. Donors also fund treatment, either through an institutional approach—where patients can obtain medical care at a clinic/hospital or through an emergency helpline—or through community-based models—where community workers and volunteers are trained to deliver on-ground care and provide referrals up the value chain where needed. Philanthropy also supports rehabilitation by funding long-stay homes, palliative care, and ongoing therapeutic support. And, finally, we also noted funds directed toward science and research to improve care for the mentally ill in the future. These initiatives are critical to India, as they provide indispensable services and set the stage for future giving and interventions.

Despite these laudable efforts, the philanthropic outlay for mental health is dwarfed by the enormity of the mental health crisis in the country. Approximately 197.3 million people in India suffer from mental illness, yet due to limited awareness, stigma, and the prohibitive costs of treatment, there is an estimated 70% to 92% treatment gap for mental disorders. This scenario is compounded

by the severe shortage of mental health professionals, with only two mental health workers and fewer than one psychiatrist per 100,000 people.

Traditionally, the focus of government interventions has been skewed toward institutional care, centering on treatment at psychiatric hospitals rather than integrating mental health into general and primary health care. However, common mental illnesses can often be prevented or managed at the community or primary care level, with referral to medical specialists as needed, thereby reducing the burden on professional and institutional care systems. As around 10% of India's total population experiences a common mental disorder (compared to 0.8% living with a severe mental illness), they require a proportionately greater allocation of resources and services (see Chapter 1).

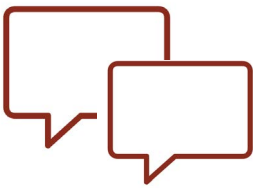
The share of severe mental illnesses that require the attention of medical specialists or stay at a hospital—such as schizophrenia, bipolar disorder—is smaller and thus requires proportionally fewer resources.¹¹⁴ Based on this distribution of needs, the WHO recommends that countries deploy mental health care services in a pyramid distribution, with fewer resources directed to the top of the pyramid, which corresponds to specialist services or long stays at psychiatric facilities, and greater emphasis on self-care, treatment at general hospitals, and community models (see Chapter 1).

To implement such a mental health service pyramid effectively, we need strategic allocation of resources as well as collective cross-sectoral action. Through the interviews conducted for this study, we discerned a growing consensus that a profound mindset change is the need of the hour. The sheer scale of the mental health care challenge means that dependence on mental health specialists and clinical interventions in isolation from socioeconomic factors is not enough. Mental health should no longer be seen as purely a health or wellness issue but as a challenge affecting all segments of society.^{115, 116}

Reframing mental health in this manner also creates a new pathway that highlights collective responsibility across sectors. Beyond government, the social and private sectors, including private donors and companies, have important roles to play in supplementing government efforts.

Given these specific contours of the mental health challenge and the availability of state resources, what can be done? Our research has identified a few key opportunities for philanthropy to play a strategic role:

- 1 Championing mental health as a cause worthy of greater support and advocacy.**
- 2 Supporting overlooked and underfunded programs or initiatives.**
- 3 Funding innovative financing strategies, novel applications of technology, and new ways of talent building in the sector.**
- 4 Engaging in cross-sectoral partnerships and collaborations to pool resources and knowledge effectively.**



1. CHAMPIONING MENTAL HEALTH

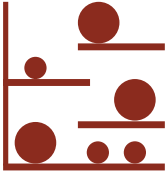
Philanthropists can champion mental health; help catalyze the issue and bring them to the fore. Champions can help dispel stigma, increase awareness, and advocate for greater priority and resources to be devoted to mental health. While donors are increasingly speaking up about their experiences, or what someone close to them has experienced, there is certainly headroom for many more voices to shape the discourse.

While the evidence around the impact of community models of care is growing, nonprofits still lack the means to communicate their findings and learnings. Donors can help amplify these success stories on their platforms and lend greater credibility to these models.

Philanthropy can also fund convenings, seminars, advocacy, and other avenues—through virtual and physical platforms—to help synthesize the existing knowledge and best practices and drive the discourse going forward. Inviting and creating spaces for underrepresented communities and voices from the margins can help bring their specific issues to the fore as well as shift the mental health narrative toward a two-way relationship by bringing socioeconomic issues into the fold.

Donors can collaborate to set up centres of excellence in the mental health care domain across the country. These can operate on a 'hub-and-spoke' model, wherein the hub is connected to a range of institutes, nonprofits, social enterprises, local governments, and other organizations. This will enable them to act as a one-stop shop for inviting as well as disseminating credible scientific and social guidance and thought leadership on mental health. Centres of excellence can also facilitate collaborations and partnerships among existing regional donors and actors to integrate best practices, knowledge, and learnings. This will further help them understand the gaps in their respective regions and assist on-ground nonprofits and local governments in providing effective care. Most importantly,

centres of excellence can serve as a platform for all the other recommendations that follow.



2. SUPPORTING OVERLOOKED AND UNDERFUNDED AREAS

Philanthropists can play a vital role in supplementing gaps in government resource allocation. For example, existing prevention and rehabilitation initiatives are starkly underfunded and present an opportunity for donors to make a real impact. Philanthropists can consider funding programs that promote the overall mental well-being of a community through educational materials, self-care programs, anti-stigma campaigns, and capacity building of volunteers. Additionally, systematic prevention efforts can also help identify and support individuals at a higher risk of developing mental illness, even before the onset of symptoms. Targeting vulnerable and at-risk groups and leveraging existing technology applications are other workable solutions.

As discussed in Chapter 3, the evidence around community mental health (CMH) models has shown promise and potential for replication. CMH models are cost-effective and can leverage India's strong community networks, self-help groups, and grassroots nonprofits working on rural upliftment. CMH programs can also be integrated with socioeconomic programs to reach

underserved communities and areas—for instance, by integrating social and emotional learning in rural education programs or building rehabilitation and resilience into socioeconomic interventions.

Since knowledge and data on mental health are limited, funding further research offers another strategic opportunity for philanthropists. Projects that can inform and guide philanthropic contributions going forward include research to understand strategies that have succeeded in integrating mental health initiatives within the primary and district government health care schemes; comparative insights from programs in other sectors, such as gender or livelihoods, that have included mental health as a pillar; in-depth studies on suicide prevention; comparative insights from successful CMH models; and finding methods for equitable distribution of funding to the more remote parts of India.



3. FUNDING INNOVATION IN TECHNOLOGY, FINANCING, AND TALENT CREATION

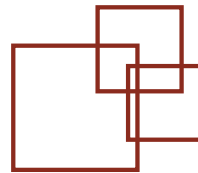
While the current focus of technology is on wellness, therapy, and mindfulness applications for smartphones,¹¹⁷ there are additional opportunities for integrating technology into mental health care. Philanthropy can support the development of

these technologies in safe, clinically validated, and ethical ways without the expectation of profits or returns. For instance, digital training programmes or modules for community health workers, the use of technology to assist in creating personalized treatment plans; digital screenings or analyses of large data to identify markers for mental illness; virtual reality for immersive therapy; and simulators to train non-specialists to deliver mental health care are some methods being explored in India and elsewhere.^{118, 119, 120, 121} Given the immense need for mental health services, these have a significant potential to be impactful.

Donors can find and support innovative ways of funding mental health, for example, by establishing scholarships and awards or sponsoring competitions that provide seed capital as prize money for innovative solutions in mental health. Social impact bonds or blended finance instruments could help attract private capital from other sources. Donors can also support mental health nonprofits to list on India's newly formed Social Stock Exchange. Another gap that philanthropic funding could fill is support for alternative insurance models that can provide coverage for chronic illnesses.

With the skewed ratio of professionals available to meet the Indian population's mental health needs, donors can focus on supporting initiatives on capacity building for specialized as well as nonspecialized stakeholders for mental health care delivery. There are efforts by nonprofits directed toward

cultivating a more extensive talent pool that encompasses a range of interventions, workshops, courses, and training programs aimed at equipping not only medical professionals but also non-specialists like teachers, doctors, journalists, police officers, lawyers, and community workers. However, consistent support is required to sustain such efforts, and philanthropy can assume this role in partnership with others.



4. MORE CROSS-SECTOR COLLABORATIONS

There have been few formal collaborations between the government, mental health organizations, and philanthropic entities. As with some of the initiatives highlighted in this report, donors can support and foster partnerships that involve joint efforts, shared resources, and expertise exchange to leverage the strengths of various stakeholders.

Such collaborations can help promote shared research efforts and uncover best practices to enhance the knowledge base and inform evidence-based interventions.

Collaboration can also help drive advocacy efforts and influence policy changes at the local, regional, and national levels that support mental health and philanthropic initiatives. Finally, the engagement and involvement of community stakeholders and

members—including individuals with lived experience of mental health challenges—in cross-sector collaborations is indispensable. Their perspectives and insights are invaluable in designing and implementing effective, culturally sensitive interventions.

MOVING FORWARD

A common thread running through these recommendations is the importance of maintaining a long-term perspective on impact. Mental health is critical to the people of India, but at the same time, it is a complex and intersectional issue that will require change on many fronts and collaboration among many stakeholders. Attitudes toward mental health are improving, and gradually, people with mental illnesses can lead normal lives by getting the care they need. However, change needs to take place much more rapidly to ensure a future where mental well-being is prioritized and mental health care is accessible to all. Adequate funding for these efforts will be vital.

Philanthropy plays a pivotal role in fostering positive change and progress in the realm of mental health. Unlike corporate social responsibility funds that are time bound, or private capital that is return bound, philanthropy has unique advantages. Its flexible nature makes it better positioned to create greater impact and long-lasting change. Moreover, philanthropy can provide the transformative risk capital that innovation, science, and research need. It simply needs to persevere.

ANNEXURE I: LIST OF INTERVIEWEES

Organization	Interviewee
Philanthropic/Donor organizations	
1 Aditya Birla Education Trust: Mpower	Parveen Shaikh, Vice President, Operations Dilshad Khurana, Head Counselor (Helpline) Jaanki Pandya, Manager, Monitoring and Evaluation
2 Azim Premji Foundation	Archana Sudhakaran, Program Manager, Mental Health and Disability
3 Biocon Foundation	Dr Anupama Shetty, Mission Director
4 Cipla Foundation	Anurag Mishra, Head, Corporate Social Responsibility Operations
5 Indira Foundation	Tasneem Raja, Head, Mental Health Initiatives (and former lead for mental health, Tata Trusts)
6 Mariwala Health Initiative	Priti Sridhar, Chief Executive Officer
7 Raintree Foundation	Abha Dandekar, Director Namita Dandekar, Chief Operating Officer Minal Karani, Senior Program Associate
8 Rohini Nilekani Philanthropies Foundation	Natasha Joshi, Associate Director
9 Shantilal Sanghvi Foundation (Mann Talks)	Disket Angmo, Lead, Strategy and Operations Neha Kathuria, Program Coordinator
10 Swades Foundation	Mangesh Wange, Chief Executive Officer Dr Ajitkumar Sudke, Director, Health and Nutrition

Nonprofits/Social enterprises

11	Anjali	Kathakali Biswas, Program Head, Janamanas
12	Bapu Trust	Dr Bhargavi Davar, Director Kavita Nair, Assistant Director, Training (Inclusion Trainer)
13	Centre for Mental Health Law & Policy, Indian Law Society	Dr Soumitra Pathare, Psychiatrist and Director Meera Damji, Lead, Communications and Media Research Dr Kaustubh Joag, Senior Research Fellow Jasmine Kalha, Program Manager and Research Fellow Arjun Kapoor, Program Manager and Research Fellow
14	Institute of Psychological Health	Dr Shubha Thatte, Founder, Trustee, and Supervisor
15	Jai Vakeel Foundation	Ashwini Vaishampayan, Head, Healthcare
16	Law Foundation	Praveen Kumar, Founder Subhendhu Shekhar, Co-founder
17	The Live Love Laugh Foundation	Anisha Padukone, Chief Executive Officer
18	Mental Health Action Trust	Dr Manoj Kumar, Founder and Clinical Director
19	Mind Piper	Siddhant Khurana, Co-founder and Chief Executive Officer
20	Parivartan Trust	Dr Hamid Dabholkar, Senior Team Member
21	Sangath	Dr Abhijeet Nadkarni, Co-director, Addictions Research Group

22	The Schizophrenia Research Foundation of India	Dr R. Padmavati, Director
23	The Banyan and The Banyan Academy of Leadership in Mental Health	Mrinalini Ravi, Co-lead, Sundaram Fasteners Centre for Social Action and Research
24	TrustCircle	Sachin Chaudhary, Founder
25	Wildlife Conservation Trust	Prachi Paranjpye, Lead Social Psychologist

Sector Experts

26	National Institute of Mental Health and Neurosciences	Dr Pratima Murthy, Director
27	The Banyan Academy of Leadership in Mental Health	Dr Nachiket Mor, Visiting Scientist and Health Systems Expert
28	Harvard T. H. Chan School of Public Health	Prof. Shekhar Saxena, Professor of the Practice of Global Mental Health, Department of Global Health and Population
29	Basic Needs	Chris Underhill, Founder
30	The Chemical Khichdi Project	Aparna Piramal Raje, Writer and Founder
31	Impact Veritas	Uma Sunder, Consultant, Impact Assessment, Monitoring, and Evaluation

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