# Before Capital Flows: Building Investment Readiness for Mental Health in Liberia

Global health capital can finance a facility, training program, or technology. It cannot, by itself, guarantee that a local institution is ready to put that investment to work. T2S C.A.R.E.S. (Creating Access Responsibly for Everyone, Sustainably) is testing a different starting point in Liberia: establish the conditions for sustainable mental health delivery before scaling resources. Through its C.A.R.E.S. Model, the organization assessed five institutional settings, identified three conditional implementation anchors, and assigned distinct coordination and future-training roles to the others. This was not a service-expansion result; it was an evidence-based decision about where resources could work, what must be fixed first, and who must sustain them. The proposition for funders is straightforward: targeted readiness investments can create a stronger pathway from philanthropic or catalytic capital to functioning mental health infrastructure, measurable implementation, and ultimately more equitable access within universal health coverage (UHC).

## Why Financing Alone Does Not Ensure Readiness

Worldwide, more than one billion people live with mental health conditions. Yet the World Health Organization reports that the median government allocation to mental health remains about 2% of health budgets. The financing need is unmistakable. Less visible is the execution problem: even where money or materials are available, institutions may lack the workforce, authority, safeguards, operating routines, or information systems required to convert them into sustained access.

For capital providers, this is a critical distinction. A funded activity is not necessarily an operational capability; a delivered asset is not necessarily a functioning service. Investments can stall between commitment and use because responsibility is diffuse, physical infrastructure is unprotected, or local teams cannot maintain the intervention after outside partners leave. Those are not merely administrative inconveniences. They are foreseeable threats to health impact.

T2S C.A.R.E.S. encountered this question while designing a national mental health knowledge and capacity-building infrastructure pilot in Liberia. Rather than select locations principally by institutional visibility or enthusiasm, it asked which partners could responsibly absorb new resources, which constraints had to be resolved first, and where an institution could add greater value through governance or future workforce development. The objective was to replace assumptions about

readiness with evidence that could guide the next financing decision.

## From Investment Intent to Implementation Readiness

In April 2026, T2S C.A.R.E.S. implemented the first phase of its Liberia National Mental Health Infrastructure Pilot. The C.A.R.E.S. Model (Creating Access Responsibly for Everyone, Sustainably) organizes implementation as a series of evidence-informed decisions rather than a fixed schedule of resource distribution. The immediate use case was a proposed network of mental health knowledge and learning hubs designed to support local professionals, trainees, and institutional capacity within a larger health-system integration strategy.

The field assessment examined five settings spanning academic, clinical, and national coordination functions. Local stakeholders and visiting team members contributed structured site assessments, debriefs, and contextual observations. Four practical questions organized the assessment: Is the place appropriate and protected? Are people authorized and accountable? Is the resource package relevant and feasible? Are there workable processes for access, tracking, maintenance, and continuity? These domains made institutional capability visible before deployment.

What emerged was not a simple pass-or-fail ranking. One academic setting showed strong promise as a learning anchor but still needed access and operating protocols. A county-level clinical site had committed local personnel yet required physical protections to safeguard resources. A mental health setting had relevant users and staff but needed stronger assurance about authorized use of space, storage, and continuity. A national health authority was essential to coordination and stewardship but was not an appropriate physical hub. Another clinically important institution was better suited to a future training relationship after reassessment.

This differentiation matters. Instead of allocating the same resources to every interested organization, T2S C.A.R.E.S. produced three conditional anchor recommendations, identified governance and future-training functions elsewhere, and tied advancement to site-specific safeguards. A favorable assessment does not override an unresolved authorization, preservation, or stewardship risk. Progress is gated by what can be verified—not by a calendar date or an attractive announcement.

The model also changes what funders are being asked to finance. A credible readiness package may include modest site corrections, protected storage, local custodianship, staff orientation, workforce consultation, access records, and ongoing assessment. None is especially glamorous on its own. Together, they are the operating conditions that can determine whether a larger investment becomes used capacity or stranded activity. The role of catalytic support, at this stage, is to resolve identifiable bottlenecks and produce verifiable milestones before subsequent deployment decisions. A funder could underwrite discrete site-activation packages, each with a documented constraint, local accountable

owner, corrective-action budget, verification milestone, and post-activation monitoring requirement. This makes the next financing conversation specific: what will this tranche unlock, and how will we know?

The financing vehicle should follow the intervention, not the reverse. Early readiness work may be most appropriately supported through philanthropy, technical assistance, and concessional funding; any later blended or return-seeking structure would require its own economics, partners, and evidence. T2S C.A.R.E.S.' contribution is implementation intelligence: making clear what resources are for, what risks they address, who owns the work locally, and what evidence should trigger the next tranche.




*Figure 1. Four readiness dimensions used to inform activation decisions; simplified for public communication.*

## Turning Readiness Evidence into Investment Decisions

The first result was not the distribution of equipment or a claim of improved clinical outcomes. It was greater precision about where and how to invest. Phase I evaluated five institutional settings and produced three conditional anchor candidates: academic, county/community clinical, and mental health/convening, along with one national coordination role and one potential future-training role. This converted a broad infrastructure ambition into a differentiated implementation portfolio.

The assessment also surfaced practical risks that would otherwise be easy to overlook: insecure or changeable space, physical preservation needs, reliance on a small number of committed individuals, incomplete operating procedures, and gaps in local follow-through. Each finding led to an action category rather than an undifferentiated request for more funding. The result is a clearer basis for sequencing resources and asking whether each site has met the conditions for responsible activation.

An especially useful finding concerned the difference between institutional importance and deployment suitability. A central health authority can be indispensable to policy alignment, governance, and coordination without being the right destination for physical materials. That distinction creates room to finance institutional roles according to their contribution to the system, rather than according to their prominence.

These are early implementation and planning outputs. The pilot has not yet established patient-level improvements, reduced disability, cost savings, or financial returns attributable to the model. Its demonstrated value is the creation of a decision framework with differentiated roles, documented risks, and measurable conditions for progression. For a funder considering the next commitment, that is a practical starting point for accountable, milestone-based support.

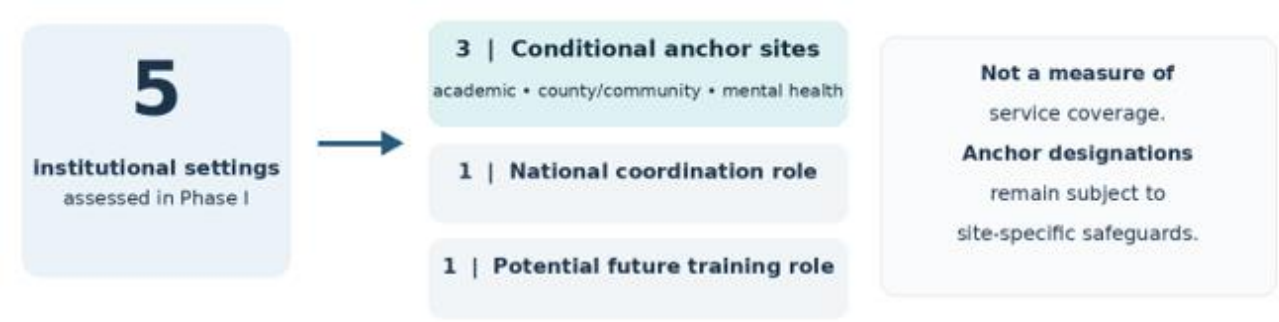



*Figure 2. Phase I classified five institutional roles; the three anchor candidates remain conditional, not operational hub counts.*

## From Investment Readiness to Sustainable Scale

The next phase is designed to move from validated readiness to controlled activation: confirm local approvals and stewardship, address priority infrastructure constraints, establish operating routines, place resources where conditions are met, and monitor actual use. Indicators can progress from activation milestones and resource utilization to workforce learning, consultation, continuity, service-access measures, and in time, with an appropriate evaluation design, health outcomes.

For philanthropists and catalytic partners, the near-term opportunity is a bounded one: finance the prerequisites that allow selected institutions to implement well, then release additional support against verified evidence. For development-finance partners, the longer-term question is where implementation evidence can improve financing decisions across UHC initiatives. Liberia is an initial test, not a ready-made replication claim. The ambition is to make capital more effective by first making health systems more capable of putting it to work.

Sources: World Health Organization, “Over a billion people living with mental health conditions” (2 September 2025); T2S C.A.R.E.S., Liberia National Mental Health Infrastructure Pilot, Phase I Technical Annex (30 April 2026).