Community Mental Health **Resource Guide**

A Resource for Global Fund Applicants

PURPOSE

This resource supports Global Fund applicants in identifying entry points to integrate community mental health within HIV and TB programming. It presents a range of evidence-based community mental health interventions applicable in resource-limited settings.

Its purpose is to:

- Highlight practical, scalable options for Ministries of Health, Country Coordination Mechanisms (CCMs) and Global Fund implementing partners (PRs/SRs), as well as other civil society actors
- Illustrate how these interventions can be organized along a stepped-care continuum
- Underscore the importance of strong referral systems and integration with primary care
- Support the development of integrated, person-centred care systems addressing co-occurring mental health conditions, HIV and/or TB

The country dialogue process provides a key opportunity to discuss priorities, assess feasibility, and identify strategic entry points for integration, recognizing the current resource constraints. These discussions can also help clarify where Global Fund resources can be most catalytic, particularly in strengthening community mental health within HIV and TB platforms, where the Global Fund is already investing in community systems, differentiated service delivery, and health system strengthening.

This creates opportunities to complement domestic financing and investments from other development partners, particularly in scaling community-based and integrated mental health approaches.

Continuity of Care and Systems Approach

While the interventions outlined in this resource are evidence-based and scalable, their impact depends on how they are delivered within a broader system of care. Investments that focus only on standalone interventions risk fragmented services, weak follow-up, and missed opportunities to respond to changing needs.

Mental health and psychosocial needs are dynamic. Individuals may improve, relapse, or require different types of support over time. Effective programming therefore requires a continuity of care approach, where services are organized along a stepped care continuum and connected through functional referral pathways. This allows people to enter care at multiple points and move between community, primary care, and specialist services as needed.

Integrating community-based interventions with primary care, supported by bidirectional referral systems, improves efficiency and equity. It enables task-sharing, reduces duplication, and helps ensure that more resource-intensive services are reserved for those who need them most. Without this continuity, gains are often not sustained, and individuals may disengage from care.

Overview of Community Mental Health Interventions

The interventions below illustrate a continuum of community-based interventions, ranging from guided self-help to more structured psychological therapies. They include both individual and group formats and all can be delivered by lay providers (e.g., community health workers or peers) with appropriate training and supervision. Each intervention is supported by a strong evidence base.

Together, they provide a set of scalable options to expand access to care, reduce stigma, and address common mental health conditions in resource-constrained settings for people living with, at risk of, or affected by HIV and/or TB, particularly when embedded within stepped care systems.

Intervention	Delivery Type	Format	Target Population	Supervision/Training	Examples of where intervention has been delivered
Self-Help Plus (SH+)	Guided self-help intervention (ACT-based)	Group / Audio-assisted	Adults exposed to stress or adversity	Minimal facilitator guidance	Turkey, Uganda, Italy (refugee populations), Colombia. Available in 12 languages.
Problem Management Plus (PM+)	Brief psychological intervention (problem solving + behavioural strategies)	Individual	Adults impaired by distress in communities who are exposed to adversity	Lay providers; brief supervision	Pakistan, Kenya, Jordan, Uganda, Zimbabwe. Available in 23 languages.
Group Problem Management Plus (Group PM+)	Brief group psychological intervention (PM+ model)	Group (5–8 participants)	Adults impaired by distress in communities who are exposed to adversity	Lay counselors; supervision	Pakistan, Kenya, Jordan, Uganda, Zimbabwe.
Group IPT	Manualized group psychotherapy (IPT-based)	Group	Adults with depression (has been expanded to adolescents)	Lay facilitators; supervision recommended	Global reach including Uganda (Strong Minds), Tanzania, Kenya, Rwanda, Nepal, Colombia, multiple humanitarian settings. Available in Arabic, Chinese, English, Farsi, French, Greek, Russian, Spanish, and Swahili.
SEEK-GSP	Group supportive psychotherapy with behavioural components	Group	Adults with depression	Lay counsellors; moderate supervision	Uganda, Cameroon, Nigeria.
Friendship Bench ("FB IN A BOX" KIT)	Brief psychological intervention (CBT-based problem-solving therapy)	Individual; (community bench)	Adults with depression, anxiety, trauma, substance use	Lay counsellors; structured supervision	Canada, Colombia, El Salvador, Kenya, Malawi, UK, US, Vietnam, Zanzibar.
CETA	Transdiagnostic modular psychotherapy (CBT-based)	Individual	Adults with depression, anxiety, trauma, substance use	Lay counsellors; structured supervision	20+ countries including Ethiopia, Zambia, PNG, Myanmar, Moldova, Ukraine.
ENGAGE	Integrated stratified and stepped-care model / early community detection (mw Tool; +e-mw Tool) + brief interventions (IPT, MI + SBIRT, SPI)	Individual	Adults with common mental health conditions (depression, anxiety, PTSD, substance use, suicide risk)	Lay counsellors/ CHWs; structured training and supervision embedded in the system of care	Mozambique, South Africa, Thailand, Philippines, Malaysia, US, Israel. Available in English, Spanish, Portuguese, Thai, Filipino, Malay, Arabic and Hebrew.
mh-GAP*	Clinical care framework / decision-support system (non-psychotherapy)	Individual	Children, adolescents, adults with priority mental, neurological, and substance use disorders	Health workers (primary care providers), structured supervision	100+ countries including Mali, Ethiopia, Nigeria, Uganda.

Key Notes on mhGAP

- **Scope:** Focuses on priority mental, neurological, and substance use disorders (depression, psychosis, epilepsy, dementia, substance use, child & adolescent mental disorders)
- **Delivery model:** Designed for non-specialist health workers, integrated into primary care
- **Supervision:** Requires training workshops, ongoing mentorship, and referral systems for complex cases
- **Evidence & Global Adoption:** Adapted and implemented in over 100 countries, with strong evidence for improving diagnosis and basic management in primary care settings
- **Complementarity:** mhGAP should be combined with community mental health interventions for stepped care

Stepped Care: Continuum of Options in Mental Health Care

Mental health care should be delivered along a spectrum of options, tailored to the severity of symptoms and the level of functional impairment. Some people with symptoms may improve with basic psychoeducation and self-help approaches. Others might need additional assistance, such as brief psychological interventions provided by a trained and supervised non-specialist workforce, including lay providers (e.g., community health workers). For some people, care from mental health specialists is required, including psychological therapies and/or medication.

A Series of Care Options Dependant on the Complexity of Symptoms and Impairment in Functioning

Figure from the WHO Operational Handbook on Tuberculosis. Module 6: Tuberculosis and commodities. Mental Health conditions.

1. Community Engagement

Community platforms provide the entry point into the system. Community health workers (CHWs), peer supporters, and lay counsellors raise awareness, reduce stigma, and deliver psychoeducation, helping to normalize mental health concerns and promote help-seeking.

2. Triage

Triage functions as the link between community engagement and service delivery. It involves the systematic identification and initial assessment of individuals who may require support, typically through screening integrated into HIV, TB, and primary care services or through community outreach. Trained providers (including CHWs, lay counsellors, primary care providers or others) use simple tools and protocols to assess levels of distress, functional impairment, and risk.

This process helps determine the most appropriate entry point into care, whether self-help, lay provider interventions, primary care management, or referral to specialist services, and supports timely movement across the continuum as needs evolve.

3. Self-Help & Lay Provider Programs

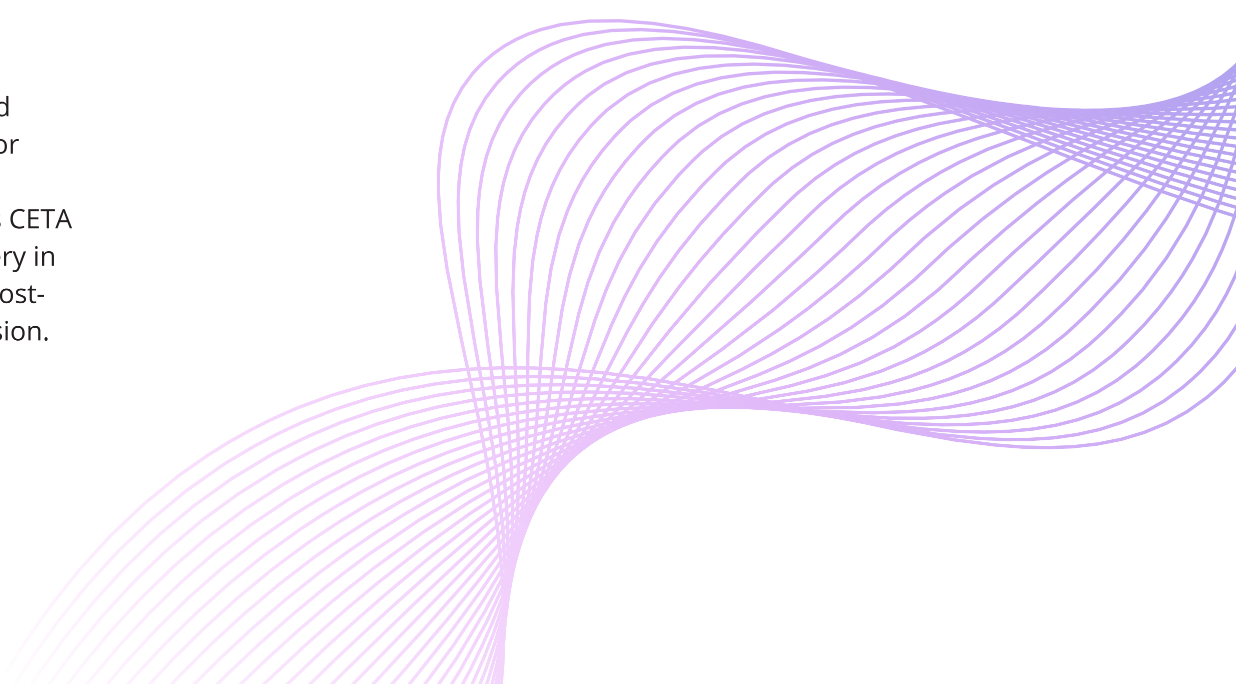
A range of evidence-based psychological interventions can be delivered by trained lay providers with appropriate supervision. These include, for example, SH+ for stress management, PM+ (individual and group) for distress, IPT-G for depression, and transdiagnostic approaches such as CETA and ENGAGE. These interventions form the backbone of service delivery in resource-limited settings, expanding access to care through scalable, cost-effective models while maintaining quality through structured supervision.

4. Primary Care (mhGAP)

The mhGAP framework enables primary care providers to assess, diagnose, and manage priority mental, neurological, and substance use disorders. It complements community-based interventions by providing pharmacological treatment and structured clinical care, while also supporting referral and supervision systems. Individuals identified through community or lay provider programs can be stepped into primary care when additional clinical support is required.

5. Specialist Care

For individuals with severe or complex mental health conditions, or those who do not respond to earlier interventions, referral to specialist services (e.g., psychologists, psychiatrists) is required where available. Specialist care provides advanced psychological therapies, medication management, and oversight for complex cases.



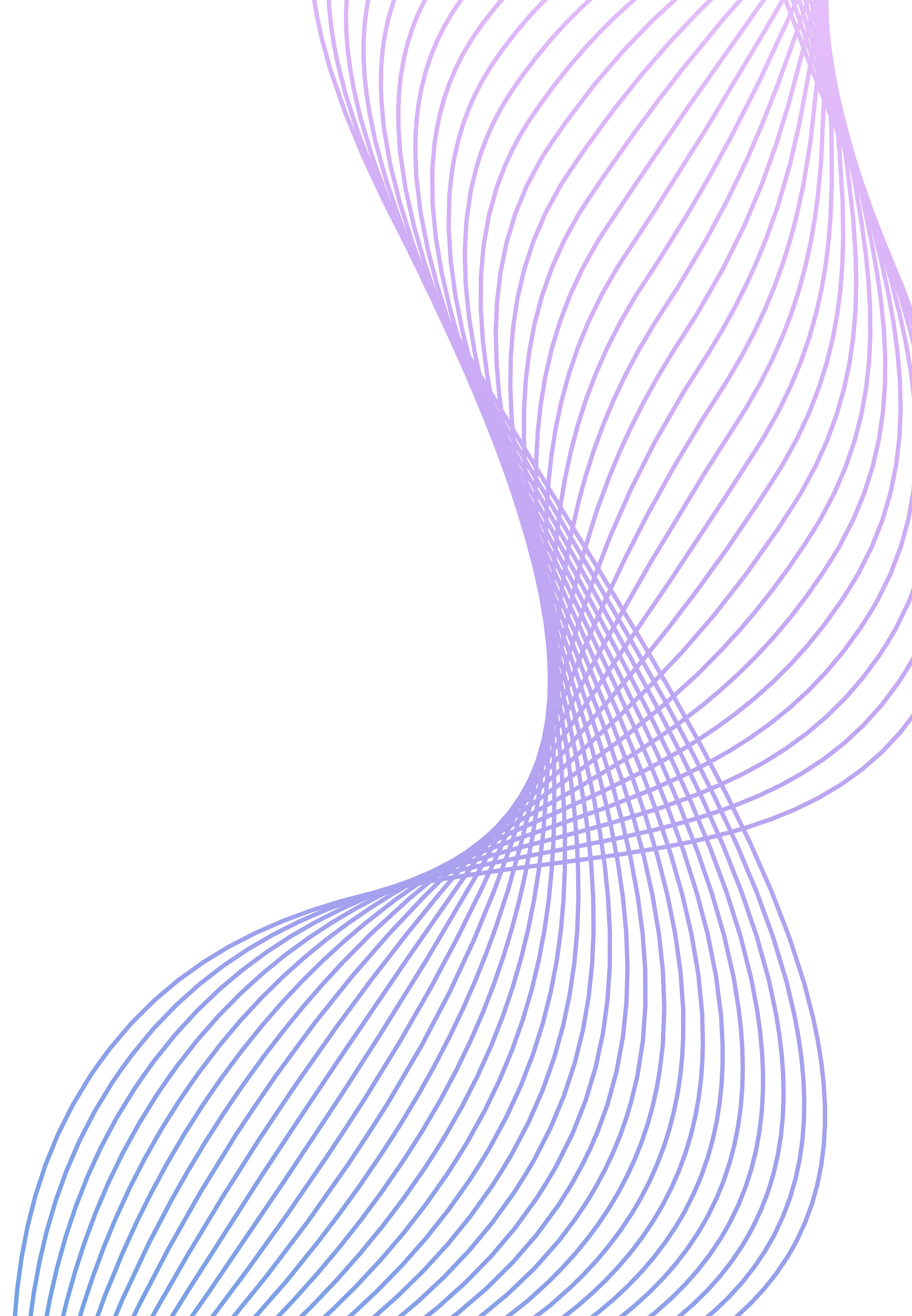
6. Core System Functions

The effectiveness of this model depends on how well services are connected and supported.

Key system functions include:

- **Referral pathways:** Clear protocols linking community, primary care, and specialist services, enabling movement across the continuum
- **Bidirectional linkages:** Mechanisms for both escalation and step-down of care as needs change
- **Supervision systems:** Ongoing support from specialists to ensure quality delivery by non-specialists
- **Integration:** Alignment with HIV, TB, and primary care programming needs to support adherence and retention
- **Continuity mechanisms:** Systems for follow-up, case management, and retention in care
- **Peer support:** Embedded across levels to improve engagement and acceptability

These functions ensure that interventions operate as part of a system rather than as isolated activities.



Implications for Investment and Coordination

To achieve this, investments should be aligned with core health system building blocks, with a focus on enabling the stepped-care model to function in practice:

- **Service Delivery**
  Integrate mental health into HIV, TB, and primary care platforms by embedding screening, brief psychological interventions (e.g., SH+, PM+, IPT-G, etc.), and mhGAP-based care within routine services. Ensure that services are linked through referral pathways that support continuity of care.

- **Health Workforce**
  Build a layered workforce model, including CHWs and other lay providers delivering frontline interventions, primary care providers implementing mhGAP, and specialists providing supervision and care for complex cases. Investment in supervision systems is critical to sustain quality and enable task-sharing.

- **Health Information Systems (HIS)**
  Strengthen systems to support case identification, referral tracking, follow up, and retention across the continuum. Integrating mental health indicators into TB, HIV, and primary care systems is essential to monitor both clinical and program outcomes.

- **Products for Care (Medicines and Psychological Interventions)**
  Ensure consistent availability of essential psychotropic medicines alongside the scale-up of evidence-based psychological interventions. This includes investing in manuals, tools, and adaptation of interventions such as SH+, PM+, IPT-G, CETA, and ENGAGE.

- **Financing**
  Move beyond short-term, intervention-specific funding toward sustained investments that support system functions, including workforce, supervision, and referral mechanisms. This enables continuity of care rather than fragmented service delivery.

- **Leadership and Governance**
  Strengthen coordination across stakeholders to define roles, align strategies, and embed mental health within national HIV and TB responses. A shared framework is essential to operationalize stepped care at scale.

This approach shifts the focus from funding individual interventions to building the system required to deliver them effectively.

Ultimately, the goal is not only to deliver discrete interventions, but to build a functioning, integrated mental health system, one that identifies needs early, supports adherence and retention in HIV and TB care, provides appropriate care at the right level, and maintains engagement over time. This landscape should therefore be understood not as a menu of standalone options, but as a set of complementary components that, when integrated, form a responsive and sustainable system of care.