BINDURA UNIVERSITY OF SCIENCE EDUCATION

FACULTY OF SOCIAL SCIENCES AND HUMANITIES

EXPERIENCES OF MENTAL HEALTH PRACTITIONERS IN UTILIZING THE STEPPED UP CARE MODEL FOR COMMON MENTAL HEALTH DISORDERS IN PRIMARY HEALTH CARE IN HARARE,ZIMBABWE

BY

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SUPERVISOR: MISS GAMBIZA

Declaration

I, Nissi Patricia Binton (B213220B) declare that this dissertation is my original work and has never been submitted to any institution for academic examination purposes or publication. I further declare that all other people's work cited is properly acknowledged and referenced. The work has been subjected to the University's anti -plagiarism check and it passed.

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Dedication

This dissertation is dedicated to my God, my family and l. My family have always been there from day one, supporting me, encouraging me and also picking me up when l was down. I thank God for making his promises be a testimony in my life. Surely his strength has been made perfect in my weakness. To myself, l appreciate all the hard work that l have put from day one. Without my strength, this research would not have been complete.

ABSTRACT

The experiences of mental health practitioners in utilizing the stepped up care model for common mental health disorders in primary health care in Harare, Zimbabwe was explored by the researcher. The research was qualitative in nature and made use of in depth interviews, key informants and focused group discussions for data collections. 30 participants were used as a sample were used as a sample for the study drawn from the target population for the purpose data collection. The Cognitive Continuum Theory was used in the study. The study deducted that stepped up care is essential when it comes to common mental health disorders. It deducted that all the levels of stepped up care are essential and should be taken seriously. The study also showed the challenges that are faced in utilizing the stepped up care model such as resource constraints, burnouts, poor health literacy and caseload pressure. In addition, the study also pointed out the strategies that the practitioners use to overcome challenges in stepped up care such as self-directed learning, participatory action research, emotional regulation techniques and proactive time management. This study shows the importance of including the stepped up care model to common mental health disorders in primary healthcare settings.

LIST OF ABBREVIATIONS

CBT : Cognitive behavioural therapy

CMD : Common Mental Disorders

CMHD : Common Mental Health Disorders

WHO: World Health Organisation

CCT: Cognitive Continuum Theory

SCM: Stepped Care Model

FGD: Focus Group Discussions

SSI: Semi Structured Interviews

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CHAPTER ONE: INTRODUCTION AND BACKGROUND OF THE STUDY

1.0 Introduction

Mental health is still one of the issues of the greatest magnitude in Zimbabwe, Africa and globally. The cohesive package of mental health and stepped up care equals more effective intervention, and filling gaps. This is because care is stepped up and mental health needs are met, which then leads to an effective use of resources, completion of mental health sessions and early support preventing escalation. An evidence based service delivery model of stepped-up care has been recommended to increase access efficiency and cost effectiveness. Stepped up care is a strategy that provides the least effective care first and then, if that is not effective enough, stepped up care to more intensive care. However there are challenges that can be faced by mental health practitioners when trying to apply the stepped up care model which includes shortage of resources , delays in stepping up care , training and skill gaps , stigma and expectations and even cultural mismatches . This study works to pluck out in depth the experiences of mental health practitioners in utilising the stepped up care model for common mental health disorders in primary health care.

1.1 Background of the study

This "stepped-up" approach to the care of common mental health conditions (CMHC) has been implemented at the global level as part of a broader effort to increase access to evidence-based mental health services, especially considering the increasing burden of mental health disorders, lack of appropriate specialist capacity and escalating health system costs (Mediavilla, 2023). The stepped care approach adopted in the United Kingdom (UK) is a stratified pathway that starts with low intensity interventions, such as guided self-help or computerised cognitive behavioural therapy (CBT), up to high intensity interventions, such as face-to-face CBT or medication as needed (Delgadillo , 2022). Mental health professionals have encountered challenges including resource shortages, lack of trained mental health professionals and delays in receiving more intensive interventions, patient engagement, getting patients to adhere to treatment plans, particularly with lower intensity interventions, and navigating the system to coordinate care for patients across the various tiers of the stepped-care pathway (Gureje, 2015). Australia has implemented a consumer-centred approach to stepped care, especially in primary mental health care. The importance of mental health practitioners thorough initial assessment to determine most suitable step in care is highlighted by mental health practitioners (Pugato,

2023). They provide ongoing support providing continuous support and monitoring to ensure treatment efficacy and patient satisfaction (Gureje ,2019).Stepped-care models have been introduced in primary care in the Netherlands. Implementing the model has been challenging due to factors, including lack of familiarity with interventions, such as specific treatments or tools, which can hinder implementation, patient adherence to treatment, e.g. poor adherence to treatment, particularly antidepressant therapy, can impede the model's effectiveness, and lack of reimbursement for certain services, or charges for patients receiving depression care, can impede the model's effectiveness (Roos , 2023).

In common with many other low-income countries, southern Africa has a massive treatment gap for depression and other common mental disorders (CMDs). Access to psychiatrists or psychologists is limited, there is stigma associated with common mental health disorders and limited infrastructure and access to appropriate care for many with common mental health disorders. Comorbidity with chronic diseases (HIV, TB, non-communicable diseases) is common. There has been an effort to increase the availability of care, reduce specialists, and integrate care into primary care. Task sharing or task shifting, collaborative care models are some methods used by practitioners and policymakers to help increase access (Josep, 2022).The stepped-up system of care (or stepped care from lower to higher intensity) is well suited to this. The issues mental health practitioners face are limited funding, stigma and social isolation, geographical barriers, trauma and burnout, and client resistance (Botha ,2020).They face these challenges because of lack of limited work force, historical and economic context, infrastructure resource and constraints and limited investment in mental health. The barriers to stepped-up care for depression in Southern Africa are problematic as they reduce access to care, worsen mental health problems, reinforce stigma and burden mental health practitioners, and impede economic and social development (Peterson and Lund ,2011).

The situation of mental health treatment gap in Zimbabwe is a serious concern, especially given that mental illness is often viewed with stigma and there are limitations in resources and economic challenges. Stigma, resource limitations, and economic struggles are all factors that contribute to the high treatment gap for mental health in Zimbabwe. The idea of stepped up care has emerged as a possible effective model to provide mental health services in resource-limited contexts, in response to this. Thus, the less intensive level of care possible is provided, but if needed, it could be escalated. It will be used to maximise the use of the resources and increase the availability of evidence-based mental health interventions (Abas, 2022).Although

some improvement in how care is delivered is promised, there are particular challenges to implementing stepped-up care in Zimbabwe. These include cultural attitudes towards mental illness, lack of staffing and the lack of infrastructure. Such models rely heavily on the mental health practitioner such as the psychologist, psychiatric nurse, social worker, community health worker and their role in the success of these models (Nhapi,2019). This is because there is little research that investigates their lived experiences, challenges and coping strategies in stepped-up care in the Zimbabwean context.

1.2 Statement of the problem

An issue that arises when having insights into the experiences of mental health practitioners is that there is little research and documentation on the experience of providing stepped-up care for common mental health disorders particularly in low resource settings such as Zimbabwe or Southern Africa (Visher and Bakken ,2014). Research has been conducted on effectiveness of stepped care or patient outcomes with little research involving the practitioner's perspective, challenges and decision making process (Storrie 2010).Mental health practitioners face problems such as lack of resources that is limited funding, stigma and social isolation, geographical barriers, trauma and burnout and also client resistance (Knooves ,2007).They face these challenges because of lack of limited work force, historical and economic context, infrastructure resource and constraints and limited investment in mental health (Blegen ,2010). The challenges faced by mental health practitioners in providing stepped up care for depression in Zimbabwe is a problem because they limit access to care, exacerbate mental health issues , perpetuate stigma , overwhelm practitioners and hinder economic and social development (Michaud and Fombonne ,2005). This leaves a void in understanding how the model can be applied in practical, real world contexts and the factors that impact the successful application of the model.

1.3Aim of the Study

The aim of this study is to explore the experiences of mental health practitioners in utilizing the stepped-up care model for common mental health disorders

1.4Research Objectives

1.To identify how mental health practitioners understand stepped up care for common mental health disorders

2. To identify the challenges faced by practitioners in providing stepped-up care for common mental health disorders

3 .To examine the strategies used by practitioners to overcome challenges in delivering stepped-up care for common mental health disorders

1.5Research Questions

1. How do mental health practitioners understand stepped-up care for common mental health disorders?

2. What challenges do practitioners face when implementing stepped-up care for common mental health disorders?

3. What are the strategies used by practitioners to overcome challenges in delivering stepped-up care for common mental health disorders?

1.6Assumptions Of the study

Participants are assumed to have given truthful and accurate accounts of their experiences. Stepped-up care is assumed to be openly described by mental health practitioners of their real experience, barriers and beliefs about stepped-up care. Another assumption is that the practitioners are experienced with stepped-up care for depression. Assumes that the participants have actually stepped up in their care or have stepped up care in the care they support. Participants have a clear understanding of the concept of stepped up care. A second strong assumption made by the study is that practitioners define stepped-up care in the same way (such as increasing treatment intensity when the treatment is not going well or when it is severe. Descriptions of the participants are their own, real-world experiences. Presumes recall bias, social desirability, and influence in the work environment do not strongly influence responses. Participant openness in research setting is not significantly restricted. The study assumes that practitioners feel safe to talk about issues with their own organization, system barriers, and their personal experiences without fear. The researcher can make clear interpretations of the participants' stories. The study makes the assumption that the researcher

can, for the purpose of the study, avoid introducing biases, can perform a credible thematic analysis, and can represent experiences in a genuine way.

1.7 Significance of the study

It is essential to study the experiences of mental health practitioners who deliver stepped-up care, as this will provide an understanding of how the model is applied in practice, its benefits, challenges and impact on practitioners. Their experiences can reveal what facilitates them to make effective decisions when escalating care, what challenges they experience e.g. workload pressures, limited resources, unclear pathways etc. and how these affect the quality of the client's experience.

1.7.1 To Social Workers

The study will enable social workers to improve treatment outcomes, increase accessibility of treatment, and improve patient engagement and capacity building. Stepped-care is gaining traction in the field as efficient and scalable methods of managing common mental disorders, yet little is known about how stepped-care is experienced by frontline health care providers responsible for implementing it. The lived experience, challenges and strategies need to be explored in this study so that policy makers could be able to scale up mental health services, inform resource allocation planning, reduce stigma and discrimination, and facilitate capacity building. The findings may contribute to more realistic, context-sensitive mental health policies and training programs that reflect the day-to-day realities of practice.

1.7.2 To Policy Makers

The study will be helpful to policy makers, training institutions, health program designers and researchers as a basis for future studies in the implementation and service delivery in mental health. In conclusion, the findings of this study are important to the social work body of knowledge as they provide greater understanding of the nature of the functioning of service systems at the frontline, and of practitioners' experiences of providing stepped-up care and reaching the complexities of matching clients to the level of care they need. The findings enrich theory and practice by providing information on the interaction of professional judgment and ethical decision-making, client engagement, and systemic constraints in stepped-care models.

1.7.3 To Non Governmental organizations

The experiences of mental health practitioners are also important to non-governmental organizations (NGOs) as it provides insight into the potential effectiveness of how NGOs can deliver services in a context of often constrained budgets and high demand. Practitioners' experience has illustrated what is working well and what is falling short within the current systems for stepped care that are in place in many NGOs, for example regarding training, staffing, referring to more intensive interventions, or access to resources.

1.8 Delimitations

1.8.1 Focus on Mental Health Practitioners Only

The study only includes licensed or trained mental health practitioners (psychologists, psychiatrists, mental health nurses, clinical social workers, counselors).Patients, administrators and other family members are deliberately not included.

Only Practitioners Involved in Stepped-Up Care Only practitioners who have first-hand experience of stepped-up care for common mental health disorders are included. In the study, practitioners do not include those with a non–stepped–care treatment model for common mental health disorders.

1.8.2 Geographical Location/Healthcare setting

The study is limited to an identified geographical area, country, or clinical environment (e.g., public clinics, community mental health centers, or hospitals).Findings will only be for those contexts as defined by these boundaries.

1.9 Limitations

1.9.1 Limited Generalizability

The results from this study are specific to the mental health practitioners and region/organization studied and may not apply to all mental health practitioners or healthcare settings.

1.9.2 Self-Reported Data May Be Biased

The accounts of the participants are based on their memory and openness to discuss and share experiences.This creates the possibility of introducing recall bias (omitting details), social desirability bias (showing themselves or the system in a positive light) and selective disclosure (omitting topics that could be considered sensitive).

1.9.3 Variability in How Stepped-Up Care Is Implemented

Increased care may be interpreted and/or implemented in various ways in different institutions. This variation can affect practitioners' experience of it, complicating the process of comparison and interpretation.

1.9.4 Small or Non-Random Sample

Limitations of representativeness come when a purposive or convenience sampling (typical in qualitative studies) is used. The views expressed by a small minority may not be representative of the views of the majority of practitioners.

1.10.0Definition of Key Terms

1.10.1 Social Work

Social work is a profession and academic discipline that aims to promote social change and social development, social cohesion and empowerment and the liberation of people through practice. Social work is a discipline that aims to assist people to operate to their maximum capacity within their environment. This can involve rendering direct services or therapy directly to individuals. Social work is the professional practice of supporting, strengthening or reinvigorating the capacity of individuals, groups or society to function in a social way, and to make the conditions of society favourable to this (Hare, 2004).

1.10.2 Common Mental Health Disorders

Common Mental Health Disorders (CMHDs) are generally accepted to be a cluster of common and frequently occurring non-psychotic disorders, which impact strongly on mood, thinking and behaviour, and disrupt functioning in everyday life. The World Health Organization and United Nations Children's Fund (2009) define mental disorders as clinically significant disturbances in an individual's cognition, emotional regulation or behaviour that reflect a dysfunction in psychological, biological, and/or developmental processes.

1.10.3 Stepped up care

The stepped care approach involves providing and monitoring treatments, with the more effective, but less resource-intensive treatment provided first, and only escalating to a more intensive or specialized treatment when clinically necessary. Stepped care is a system of health services in which the intensity, restriction, and cost of the service are arranged sequentially from least to most, starting with the most likely to be effective service (Straten, 2015).

1.11 Dissertation Outline

Chapter One

This study aims to provide an introduction to and background of the study.

The research problem is introduced and background is provided to it, its aim, its objectives, its questions and its significance and scope are presented.

Chapter Two

Literature Review and Theoretical Framework

The literature review on the topic of the research was carried out in this chapter.This is the theoretical framework, previous research and key concepts. The goal here is to pinpoint previously unmet needs and what this research aims to fill.

Chapter Three

Research Methodology

The qualitative phenomenological design, study setting, sampling and data collection techniques (interviews and focus groups), data analysis plan (thematic analysis) and ethical considerations were detailed in this chapter. This chapter justifies the methods used and their relation to the aims of the research.

Chapter Four

The findings will be presented and discussed.

The findings of the research were presented, analysed and discussed in this chapter.It involved representing the characteristics of the population and analyzing the data, frequently themed or categorized throughout the research process. This section included direct quotes, charts or tables to illustrate key points.

Chapter Five

Summary, Conclusions and Recommendations

The chapter summarizes findings, provides conclusions, offers policy and practice recommendations, proposes topics for future research and concludes with thoughts on the limitations of the study.

1.12 Chapter Summary

Chapter one set the scene for the study by describing the background, rationale and importance of studying the experiences of mental health practitioners in delivering stepped-up care for common mental health problems in primary health care. It pointed out that common mental health conditions are becoming a global challenge, and stepped-care approaches are gaining momentum, involving professionals in step-up/taper treatment depending on the patient's needs and clinical decisions. Although stepped-up care has been recognized as a critical component, little research has explored practitioners' experiences of providing stepped-up care, factors impacting on their practice, and the challenges and demands they face. The chapter also identified the problem that this study aims to solve, which is the lack of understanding of the lived experiences of practitioners implementing stepped-up care and how those experiences impact service delivery and patient outcomes. This resulted in the formulation of the purpose, objectives and guiding research questions of the study. To provide clarity around the scope of this study, key definitions of stepped-up care and mental health practice were provided. The chapter also explored the implications of the study for mental health services, policy, training, and the mental health of service providers. Assumptions, limitations and delimitations were well defined and it indicated the limits and conditions under which the study was conducted.

Chapter 2

Literature Review and Theoretical Framework

2.1 Introduction

This chapter presents a comprehensive review of literature relevant to the experiences of mental health practitioners in providing the stepped up care model for common mental health disorders in primary health care in Harare, Zimbabwe.

2.2 Theoretical Framework

2.2.1 The Cognitive Continuum Theory

The first supporting theory is the Cognitive Continuum Theory (CCT) that was initially developed by Hammond and was later adapted for clinical decision making situations. This theory suggests that clinical reasoning is not just intuitive or analytical, but lies on a continuum between the two extremes. The practitioners move on this continuum depending on the characteristics of the task, time pressure, information available, and their experience. The provision of stepped up care is fraught with judgments as to whether a person with a common mental health problem is responding well to a low intensity care; or if they need escalation to a higher intensity intervention, e.g. face to face psychotherapy or pharmacotherapy. When practitioners are well-trained, have clear protocols, and a good patient database, they work at the analytical end of the Cognitive Continuum Theory and make decisions based on evidence and consistency about stepping up. When practitioners have high workloads, they are less likely to have a complete patient record or clear symptoms, and can become more prone to intuitive reasoning, and make inconsistent steps up decisions. This theory offers a remedy for the Unified Theory of Behaviour Change theory's weakness by targeting the cognitive mechanisms related to clinical judgments in stepped care. Two recent studies have showed the validity of cognitive continuum theory in primary care (Mamede and Schmidt 2023) and the effectiveness of cognitive debiasing strategies to enhance stepped care decisions for mental health nurses (Croskerry et al. 2024).

2.2.1.1 Relevance of the Cognitive Continuum Theory to the Study

The relevance of the Cognitive Continuum Theory to this study is immense because it offers an accurate explanatory lens to gain insight into the thoughts of mental health practitioners in Harre as they determined whether to escalate a patient from a low to a high intensity of care within the primary health care system. This theory was first developed by Hammond and then modified for contexts of clinical decisions, positing that clinical reasoning is not an either/or

proposition, but rather a continuum, ranging from pure intuition at one extreme and complete analysis, rule-based reasoning, at the other. The continuum on which the practitioners move depends on several factors such as the nature of the clinical task, time constraints, the available patient information, and the practitioner's skills and experience. Stepped-up care for common mental health problems means practitioners have to make on-going decisions about whether a patient with depression or anxiety is getting better from a low intensity intervention (brief counselling, problem solving therapy or guided self help) or whether care needs to be escalated to a higher level (face to face psychotherapy, antidepressant medication or referral to specialist mental health services). In the primary care setting, the Cognitive Continuum Theory was shown to be a good predictor of diagnostic accuracy, with practitioners who used analytical at the upper end of the continuum having an accuracy 35% higher than those who used intuition extensively at the lower end (Mamede and Schmidt 2023). Cognitive debiasing strategies that help practitioners recognise when they have deviated too far into intuitive thinking were effective in stepped care decisions made by mental health nurses, cutting down on inappropriate step ups by 28%, according to Croskerry and colleagues (2024).

The theory is especially useful in Zimbabwe's primary healthcare as practitioners are frequently expected to work at the "analytic" end of the continuum and be required to "educate their ears" as well, a situation that may have serious implications for patient safety and outcomes. This can be the case in settings such as high caseload (with 30-40 patients per day) and limited time for systematic step up assessments. Many patient records in Harare clinics are incomplete, often due to a lack of follow up notes, a history of previous treatments and/or a baseline symptom score for comparison of progress. Mixed symptoms are common in primary care, as well, because many common mental health disorders may manifest as somatic symptoms like headache, fatigue or abdominal pain, rather than overt psychological symptoms. The Cognitive Continuum Theory suggests that, in such situations, practitioners will develop intuitive reasoning as a cognitive adjustment to minimize mental effort and time. But this transition is fraught with dangers. Intuitive stepping up could result in over stepping; a patient would benefit from an intensity of care that is continued may be unnecessarily stepped up to a scarce and costly intensity of care service. Or, under stepping can happen when the deteriorating patient is not escalated in a timely manner, worsening symptoms, self harm and loss to follow up can occur. Delgadillo et al. (2023) conducted a study in the United Kingdom that revealed a higher rate for both types of errors with step up decisions that were intuitive, as compared to analytical

decisions. In Harare, where higher intensity services are already strained, it is vital that inappropriate step ups are reduced as well as ensuring timely step ups.

In addition, this research study will focus on the factors that affect or impact the decisions made in this process and take also into account the factors that cause practitioners to move vertically through this continuum as well as the factors that enable practitioners to stay closer to the analytical end of the continuum when faced with a range of environmental factors and the strategies used to do so. This theory proposes that practitioners can be supported to work in an analytical manner in a number of ways. Establishing guidelines for step up, e.g., minimum number of sessions attended, change score on validated instrument such as the Patient Health Questionnaire 9, time to review, etc., gives external structure to the process and decreases intuition. These protocols require sufficient training and practice with clinical vignettes and feedback on the accuracy of their decisions to enhance their analytical thinking. Complete patient information, with frequent monitoring of progress based on standardised monitoring tools, provides the information needed for analytical judgment. Supervision or peer consultation provides practitioners with a way to validate their own predispositions with the opinion of others: a mechanism of cognitive debiasing. In the Harare context, where electronic health records are not commonly used, paper tracking logs as piloted by Mandizvidza et al (2025) can have a similar effect of helping practitioners remain focused on the analytical approach. The study will systematically examine the cognitive continuum theory for step up decisions concerning the domain of intuition that Harare practitioners are operating in, the environmental factors driving practitioners to intuition, and what type of cognitive or procedural supports would shift practitioners towards more analytically based, evidence-based decision making. This theoretical relevance is thus explanatory and practical, providing a blueprint for the development of stepped up interventions that enhance the quality and uniformity of stepped up care in resource-limited contexts.

2.3 Conceptualization

2.3.1 Mental health

Mental health is an integral part of everyone's health and wellbeing and can be defined not as the absence of mental health conditions, but as the capacity of individuals to manage the demands of life, to learn and work effectively and to participate in their communities (World Health Organization [WHO], 2022). This definition highlights that mental health is a complex continuum, lived by each person in their own way, and different levels of difficulty and distress (Santé publique France, 2025). Positive mental health (well being, personal fulfilment,

psychological resources and functioning in social roles); Reactive psychological distress, which is a response that occurs in the face of difficult situations, not necessarily indicative of disorder, and may not require specialised care; Psychiatric disorders of varying length and severity that require medical management (Rural Health Information Hub, n.d.).

Mental health problems refer to a wide variety of illnesses, such as anxiety disorders, mood disorders, and psychotic disorders, which may impact functioning and relationships in everyday life (WHO, 2022). Approximately half of mental disorders occur before the age of 14 and depression is one of the most important causes of disability worldwide (Santé publique France, 2025). Mental health is influenced by socioeconomic, biological and environmental factors, and cost-effective strategies exist to promote, protect and restore mental health (WHO, 2022).

2.3.2 Stepped Care model

The Stepped Care Model (SCM) is an evidence based and patient centred approach to the organisation of mental health services. It provides a variety of services from least to most intensive, depending on the individual's needs and the capacities of the service provider, offering the least resource intensive treatment first, and then the most intensive and specialist treatment as needed; in other words, a person “steps up” to a more intensive or specialist service when needed (South Western Sydney Primary Health Network, n.d.). The model is based on the following principles: aligning service intensity with individual need; flexibility in adapting to the changing needs of individuals; client-led, recovery-centred approach; enhanced access via flexible delivery models; and quality accountability via clinical governance and measurable outcomes (Mareya et al., 2024).

Multiple levels of care are usually a part of the model. The Tiered Care Model, for instance, in Singapore takes a "stepped care" approach to mental health, with four levels of mental well-being promotion to high intensity specialist interventions (A stepped care approach to mental health in Singapore, 2025). A five-level model is widely used in Australia: Level 1 (self-management), Level 2 (low intensity services), Level 3 (moderate intensity services), Level 4 (high intensity services) and Level 5 (acute and specialist community mental health services) (Western NSW Primary Health Network, n.d.). New Zealand's three levels are: Level One (caring for everyone, everyone on the team can provide this), Level Two (caring for people whose needs affect their daily life, advanced knowledge clinicians can provide) and Level Three (caring for people who have persistent or severe difficulties, psychologists and psychiatrists can provide this) (Health New Zealand | Te Whatu Ora, 2025).

Some of the centre's key features include regular monitoring to inform the decision about steps and collaborative decision making with the client and provider (Centre for Innovation in Campus Mental Health, n.d.). The SCM has been increasingly implemented in primary care, campus mental health and in programmes like the Improving Access to Psychological Therapies (IAPT) programme in the UK (National Institute for Health and Care Excellence, 2022). It has been recognized as a feasible way to improve the mental health service delivery, access and efficiency, and reduce bottlenecks when there is high demand and limited resources (Salmon, 2025). Further research is needed to examine the factors that determine its effectiveness and the different ways SCM is implemented (Mareya et al., 2024).

2.4 General Overview of the Study

2.4.1 Global Overview

The stepped up care model for common mental health disorders has been embraced in a wide variety of global settings, as part of a larger trend to increase access to evidence based mental health services with the aim of reducing costs and optimizing scarce specialist resources. In high income countries, the model has been incorporated into national health systems and assessed using large-scale prospective studies and RCTs. In a large-scale mixed methods study, which surveyed 450 primary care mental health workers from Spain, Portugal and Italy, it was found that the most common problem reported was resource constraints, with 78% of the respondents reporting this as the issue. (Mediavilla et all., 2023) Specific challenges with resources were low number of trained psychologists to provide high intensity interventions, long waiting times (8–12 weeks) for face to face CBT, and not having information technology systems in place to monitor patient progress across steps. Delgadillo et al., (2023) conducted a related study on 12,000 patients in the Improving Access to Psychological Therapies programme in the United Kingdom (UK), with the addition of questionnaires from practitioners. They determined that caseload stress was a major problem and the actual number of patients that were active in the stepped care system ranged from 15 to 50, averaging 45. Hence, practitioners experienced less fidelity with the step up protocols. Formal step up assessments were seldom performed and when they were it was often based on intuition, and this was linked with both over stepping and under stepping.

Additional global evidence was collected from Roos et al., (2023), who followed 120 mental health practitioners for 18 months and identified the amount of time it takes to record step up decisions and complete insurance reimbursement forms as the most significant factor influencing practitioners' exhaustion. Experts in clinics with both paper and electronic health

records noted significant fewer problems than experts in clinics with paper-based records. In Scandinavia, Nilsen et al. (2023) interviewed 90 mental health practitioners from Sweden and Norway to identify 23 different strategies to overcome stepped care challenges – from self directed learning and emotional regulation techniques, to weekly case conferences and advocating for more resources. Van Straten and Cuijpers (2023) conducted a systematic review of 18 studies conducted in high income countries and found stepped care to be clinically effective for depression and anxiety disorders, but that there was considerable variability in implementation fidelities with only 40% reporting good practitioner adherence to the step up protocols. Croskerry et al., (2024) recently had a randomised controlled trial in Canada testing the use of cognitive debiasing strategies with mental health nurses, reporting that structured decision support tools increased the accuracy of steps up by 32% compared to intuitive decision making. In Germany, Austria and Switzerland, van Straten and Cuijpers (2023) surveyed 320 primary care psychologists by using a Stepped Care Knowledge Test, and found an average score of 68%, suggesting moderate, but not high, knowledge, with 30% of primary care psychologists stating that stepped care begins with the least preferred treatment, rather than the least intensive effective treatment.

Ho et al., (2023) have interviewed 35 community mental health practitioners in rural Australia in depth, finding that understanding existed in layers. While most practitioners could describe an initial low-intensity approach followed by a progression to higher levels of intensity if necessary, fewer practitioners could define the operational criteria for advancing to more intense levels, such as number of sessions, a specific change score on a validated scale, etc. The most advanced understanding (and only 20% of the sample had this) was flexibly moving through the steps rather than moving in a linear sequence, when treating patients with co-morbidities. Bower et al.,(2023) carried out a randomised controlled trial in the UK to investigate whether stepped care training through online modules is as effective as face-to-face workshops at increasing practitioners' understanding about the disorder, based on clinical vignettes presented before and after training. Both groups had baseline knowledge that was high at 82% and modest increases after training (88%), suggesting that most experienced practitioners would be intuitive to the stepped care approach. Nonetheless, it was pointed out that the practitioners had come from academic medical centres with existing stepped care programmes, restricting generalisability. Others have focused on Uganda and Malawi, using focus group discussions to highlight that factors limiting patient access are more likely to be patient related (e.g. poor health literacy, stigma, cultural mismatch) than material resources

(e.g. food, fuel, medicines, hygiene) as suggested by the resource centric perspective found in high income country research (Purgato et al., 2023). Gureje et al., (2023) conducted a meta synthesis of 45 qualitative studies from 22 LMICs and found that the most common and debilitating barriers to health care access worldwide are system coordination failures such as broken referral pathways and a lack of feedback from higher-level services, rather than individual resource shortages.

2.4.2 Regional Overview

The stepped up mental health care for common mental health disorders is implemented in a context of acute resource shortages in the Southern African region, high burden of infectious diseases and poor mental health governance. Josep and Lund (2023) found that 62% of the primary care nurses and clinical officers (PNCs) in Kenya and Tanzania had never heard the term stepped care; however, 85% described practising some form of stepped care as they automatically used simple advice and counselling before considering giving medication or referring patients for care. The gap between the labelled knowledge and tacit knowledge resulted the authors in drawing a conclusion that the formal knowledge about the model is generally low, while the practical knowledge revealed in the behavior is high. In South Africa, Botha et al., (2023) did a participatory action research study with 60 primary care mental health providers in the Eastern Cape, including implementing mobile health (SMS reminders and brief telephonic cognitive behavioural therapy), decentralising high intensity services to community health centres, and training family members to support patients between visits. After 12 months, these strategies resulted in a 40% lower patient attrition from stepped care and a significant increase in practitioner reported confidence. Ellis et al., (2023) carried out a longitudinal study in South African primary care clinics and found that the practices of the teams levelled resilience (including team bonding and task shifting) was found to have a significant positive effect on mental health practitioners' burnout scores, with those in teams who had been working as cohesive teams having a 45% lower score of emotional exhaustion.

The study of Mwangi et al. (2024) in a cluster randomised trial in rural communities of Kenya provides further evidence of a structured strategy toolkit, comprising of a monthly supervision group with a remote psychiatrist using mobile phone and a referral directory laminated card and a stepped care algorithm poster. Forty-nine months later, those in the intervention group reported using significantly more strategies, with a mean of 7.2 versus 2.1 for the control group, and demonstrated greater fidelity to the stepped care protocols. The most appreciated strategy was the monthly supervision group where the practitioners could discuss their challenges and

get expert advice on making step up decisions. In Uganda and Malawi, Purgato et al., (2023) held focus group discussions with 85 mental health practitioners, who identified "patient related barriers" as the major challenge, such as discontinue low intensity interventions before they were finished due to poor health literacy about mental disorders, stigma that made patients reject referrals for higher intensity services, and cultural mismatches because the usual stepped care protocols did not take into account local explanations of distress. For instance, practitioners shared narratives of patients who felt that their depression was due to spiritual reasons and thus could not accept antidepressants as a next step option. In Tanzania, Mmbaga et al., (2024) surveyed 200 primary care practitioners and revealed that only 35% were able to correctly identify the step up criteria for a patient with moderate depression who had not improved after 4 weeks of low intensity intervention, which is an important gap in knowledge to be addressed by training programmes.

Mooka at al., (2024) carried out a qualitative study which included 40 mental health practitioners from five districts in Botswana, where the lack of formal step-up protocols emerged as the most frequently reported challenge (88%). Improvisation around step up decisions based on practitioner's clinical decision making without any standardised guidance was described as leading to a wide range of practice. Some practitioners stepped up patients after two sessions of low intensity intervention, whereas others persisted in the low intensity care for six months or more when it was clear that patients are not responding. The authors suggested the need to develop contextually adapted step up algorithms that would define a time frame and a response criterion. In Zambia, Phiri and Zulu (2024) assessed a stepped care programme in HIV care clinics where nurses were trained to provide low intensity problem solving therapy for depression. They discovered that 72% of patients were able to access it without needing to step up, and of those that did need to step up, only half were able to access the higher intensity service as a result of not having the transport money or few appointments at the clinic they were referred to. This finding highlights the need to pay attention to step up as well as step down pathways. In Mozambique, Cuamba et al., (2025) evaluated the readiness of practitioners to implement stepped care, recording moderate scores for capability (65%) and opportunity (42%), with high scores for motivation (78%) because providers were highly motivated to implement stepped care. The authors suggested the need to focus on opportunity improvement as motivated practitioners cannot be successful in an unsupportive environment.

2.4.3 Local Overview

Stigma associated with mental illness, a brain drain of health workers, low government expenditure on health services and economic problems, which have existed for more than 20 years in Zimbabwe, are largely responsible for this large treatment gap. A cross sectional survey conducted by Chikwari et al., (2024) of 112 Mental Health Practitioners in Harare and Bulawayo revealed top 3 challenges of Medication Stock Outs (84% of respondents), High patient to practitioner ratios (One practitioner per 8,000 adults) and lack of clear step up guidelines (79% of respondents). The authors suggested task sharing by providing additional mental health training for primary care nurses, and mobile health support as possible mitigations. Only 40% of primary health care practitioners in Harare were able to correctly define stepped up care and only 25% were able to list three examples of low intensity interventions for depression, including brief behavioural activation, problem solving therapy or guided self help. (Abas et al., 2024) The authors suggested structured in service training through the current district health education system. Focusing on strategies implemented in mental health care by the mental health practitioners in Harare primary care clinics, Nhapi and Makoni (2024) conducted in-depth interviews with 25 practitioners. They came up with a number of innovative strategies, such as WhatsApp group consultations and urgent step up discussions, negotiating with the local pharmacies to distribute free samples of effective, but out-of-date, antidepressant medication, setting up paper based tracking logs if electronic options were not available, and embedding mental health and well-being topics into general health based conversations in waiting rooms, etc.

Ndlovu and Harris (2024) identified a range of organisational strategies that facilitated practitioners to provide stepped up care when necessary, including flexible working schedules to work around periods of medication unavailability at the clinic, and mobile health resources to provide remote follow up using SMS and phone calls. The study demonstrated that resilience is not a personal attribute, but also happens to be a emergent health system attribute, and interventions should focus on practitioners and also team level/organisational level adaptations. Mangezi and Chibanda (2024) assessed the use of the Friendship Bench model in Harare where grandmothers are trained as community health workers to provide a low intensity problem solving therapy on park benches in clinic grounds. If patients do not improve after 6 sessions they are referred to the psychiatric nurse or psychologist. An evaluation determined that 76% of patients had responded to the low intensity intervention and were not referred for step up, but of those who did need step up, 45% managed to access the higher intensity intervention,

mainly because they had to wait too long for the specialist intervention. The authors suggested increasing the step up pathway by increasing the role for psychiatric nurses in primary care clinics. Mavhu et al (2024) completed an assessment of the needs of the 30 primary care clinics in Harare province, and they found that only 12 clinics had a mental health practitioner on-site, while only 8 had some supervisory mechanism with a psychiatrist or psychiatric nurse. The assessment also revealed that in only 35% of cases, step up decisions were recorded in patient-files, which meant that in the majority of cases, clinical reasoning could not be observed by supervisors and could not be audited for quality improvement.

Mudzi (2025) conducted a study on attitudes of 85 primary care nurses on stepped up care in Harare, and they found that 82% of the respondents agreed that stepped up care would have a positive impact on patient outcomes while 41% had the confidence to make a correct step up decision. There was a markedly higher level of confidence among nurses who had completed any mental health in service training over the last two years. The authors suggested the creation of a city wide stepped care supervision system, with skilled psychiatric nurse supervisors supervising primary care nurses who are working with stepped care patients through weekly telephone or WhatsApp supervision. Gwirayi and Shumba (2025) undertook a qualitative study of 18 mental health practitioners in high density suburbs of Harare, and concluded that the worst problem was not that there was a shortage of resources, but when the patients deteriorated while awaiting appointment with a step up service, they felt helpless. Practitioners reported the development of emotional numbing as a coping mechanism, which they acknowledged as a problem but that they knew they needed to do to survive. The study underscores the importance of providing organisational support for practitioners' mental health, as well as for mental health of patients. Mandizvidza (2025) conducted a pilot in three Harare clinics of a paper-based stepped care tracking log which resulted in a 28% higher uptake of appropriate step up decisions and a 35% decrease in patients lost to follow up. The log had pre written criteria for up steps that were based on scores on the PHQ9, and directed the practitioner through a decision tree. High acceptability was observed among practitioners as 92% of them reported that they would use the log if it were available. The result indicates that low cost paper based intervention tools can enhance fidelity of stepped up care without the need for EHRs. Although these studies have been conducted locally, there has never been any research to systematically explore the practitioner's everyday experience of the three challenges, understandings, and strategies together in the primary care system in Harare.The present study is a study that directly

addresses this gap as it systematically explores the practitioner's everyday experience of the three challenges, understandings, and strategies together in Harare's primary care system.

2.5 Challenges Confronting Mental Health Practitioners in Stepped Up Care Delivery

A substantial body of recent empirical literature has examined these challenges across diverse settings, revealing both common patterns and context specific variations.

2.5.1Resource Constraints

Mediavilla et al., (2023) conducted a large scale mixed methods study to sample 450 primary care mental health practitioners in Spain, Portugal and Italy, with resource constraints being the most commonly mentioned challenge (78%). Some specific resource issues were not enough trained psychologists to provide interventions of high intensity; the length of waiting time (8-12 weeks) to receive face to face CBT; and lack of information technology systems to track patients through the steps. A small number (60) of practitioners were interviewed in a semistructured format, explaining the emotional burden of being aware that patients were in need of stepping up but could not provide them with timely care.

2.5.2Caseload Pressure

Delgadillo et al. (2023) conducted a related study that included routine outcome data for 12,000 people in the Improving Access to Psychological Therapies programme in the United Kingdom, along with practitioner surveys. They identified caseload pressure as a major difficulty in which practitioners on average had 45 stepped care patients at the same time, resulting in lower fidelity to step up protocols. In particular, practitioners reported that they would often forgo formal step up assessments and instead rely on intuition, which they linked to both over stepping (escalating patients who may have only required less intensive care) and under stepping (not escalating patients who were deteriorating).

2.5.3Poor Health Literacy

A qualitative study by Purgato et al. (2023) conducted in the low resource primary care settings of Uganda and Malawi found a different order of problems. Through focus group discussions with 85 mental health practitioners the researchers identified that patient related barriers were the most salient challenges, rather than material resource challenges. Examples of this were poor health literacy around mental disorders, such as patients stopping low intensity interventions too early; stigma, in that the patients did not accept referral to higher intensity services; and cultural mismatch in that local models of distress did not fit the standardised

stepped care pathways. For instance, practitioners reported patients who complained of depression without believing it was caused by a spiritual state and thus were reluctant to take antidepressant drugs as a next step. This discovery raises questions about the resource centric perspective that has prevailed in high income countries studies and implies that, in African contexts, cultural and cognitive obstacles can be as or more significant.

2.5.4Burnout

The study by Roos et al. (2023) in the Netherlands focused on challenges faced by practitioners from a systems perspective. Over 18 months, they followed 120 mental health workers to assess burnout, perceived obstacles, and patient outcomes. The results indicated that the time spent documenting step up decisions and insurance reimbursement forms was the most predictive of practitioner exhaustion. Incretingly, practitioners who had a clinic that integrated electronic health records and automated step up alerts reported significantly fewer challenges than practitioners who had a paper based clinic. The discovery here highlights the importance of the technological infrastructure in reducing problems, aspects that is not always captured in qualitative studies.

There is conflicting evidence in the literature on the relative importance of various challenges. Mediavilla et al. (2023) stated that resource shortages are the primary concerns, whereas a metasynthesis of 45 qualitative studies from 22 low and middle income countries by Gureje et al. (2023) found that the most common and most severe issues are system coordination failures including the need for better referral/redirection and feedback from higher level services. The latter study highlighted the importance of not only having the resources available but for the practitioner to be able to refer to a psychiatrist or step up supervision when it is needed if the stepped care model is to be effective. In the Zimbabwean context, a recent cross sectional survey of 112 mental health practitioners (MHP) in Harare and Bulawayo, revealed that the three major challenges were: stock out of medications (reported by 84%), lack of clear step up guidelines (79%), and high patient to itioner ratios of an average of 1 practitioner per 8000 adults (reported by 71%). Some recommendations suggested by the authors were task sharing and mobile health support.

It is clear from this moderating role that although there are a number of reported resource constraints, there is also a wide range of different types of constraints, some of which are more specific to the context than others, and some are more specific to the level of the health system than others. In well-developed stepped care programmes in high income countries, administrative burden and caseload pressure are the most prevalent problems. The problems

are more fundamental in low income African countries, such as Zimbabwe, where basic medication is not available, the integrity of the referral pathways is compromised, and the steps of stepped care are not culturally acceptable. This study therefore anticipates that practitioners in Harare would report a combination of resource, systemic and patient related challenges, with the likely possibility of system coordination failures being prominent.

2.6 Mental Health Practitioners' Understanding of Stepped Up Care

The second goal is to gain insight into the definition of stepped up care in common mental health disorders among mental health professionals. Knowledge includes knowing the principles of the model, how to use the step up criteria and knowing what the model can and cannot achieve.

New studies have shown that there is a wide range of practitioner understanding. van Straten and Cuijpers (2023) conducted a survey based study, involving 320 primary care psychologists from Germany, Austria and Switzerland, who were asked to complete a Stepped Care Knowledge Test. This test was used to assess the understanding of step up thresholds, appropriate low intensity interventions and monitoring frequency. The mean score was 68%, which represents moderate, but not high understanding. Interestingly, 30% of practitioners reported that they began stepped care with the least preferred treatment option for patients, and not with the least intensive effective treatment for patients, which could mean suboptimal care. The authors also determined that there was a positive correlation between understanding and formal training in stepped care protocols; certified steppers scored 22 percentage points more than those who had no training.

Ho et al., (2023) undertook an indepth interview with 35 community mental health practitioners in rural Australia in a qualitative examination. They found out that there were layers of understanding. The basic definition of stepped care was understood by most practitioners and was "starting simple and getting more complex if needed." Less practitioners, however, were able to identify criteria for when to increase the intensity, such as a minimum number of sessions or a change score on a validated scale. The most complex understanding (20% of the sample) involved the ability to implement principles of stepped care in patients with comorbidities, such as depression and substance use disorder, while moving flexibly between steps and not necessarily following a linear sequence. This discovery implies that there is not a sharp division between nuanced and non-nuanced understanding, but that it's a continuum.

However, stepped care training provided through online modules compared to in-person workshops appears to offer a contrasting perspective, based on a study by Bower et al. (2023) that randomly assigned participants to either training approach. This study used vignettes to assess practitioners' understanding before and after training. Interestingly, both groups had a high baseline (82%) and training resulted in only minor improvements (88%). The authors acknowledged that the stepped care principles are easy to grasp by most experienced practitioners and that gaps in understanding are not as large as they are perceived in self report studies. Critics of this study point out that the practitioners were selected from academic medical centres where there are present stepped care programmes, which restricts the generalisability of this study to primary care settings in low income countries.

Joseph and Lund (2023) explored the concept of stepped care among 150 primary care nurses and clinical officers in Kenya and Tanzania in the African region. A mixed methods design was used, and they discovered that 62% of the practitioners had never heard the term “stepped care,” but 85% reported that they naturally practised some form of stepped care, by varying intervention methods from simple advice to counselling, to a medication or referral. It is noteworthy that there is a difference between the labelled knowledge and tacit knowledge. The authors acknowledged that there is a lack of a formal understanding of the model but a stronger practical understanding of the model in terms of behaviour. In the Zimbabwe context, a recent needs assessment by Abas et al. (2024) found that only 40% of primary health care practitioners in Harare were able to correctly identify stepped up care and that only 25% could name three suitable low intensity interventions for depression. The authors proposed structured in service training as a recommended training approach to enhance the understanding.

When these findings are synthesized, there is a clear debate in the literature as to whether such understandings deficits are really problematic. One perspective, taken by van Straten and Cuijpers (2023) and Abas et al. (2024), suggests that low formal understanding results in poor patient outcomes, inconsistent implementation, and inappropriate step up decisions. Bower et al. (2023) and Josep and Lund (2023) argue that tacit understanding might be enough, and that excessive formalisation of the knowledge of stepped care might be imposing undue rigidity. This study falls into the first category as the mental health training that is provided to primary care practitioners in Harare is limited, therefore the formal knowledge gaps are a real risk in terms of maintaining fidelity to the model. Thus, not only will the research determine if practitioners can define stepped up care, but also if practitioners are able to apply step up criteria appropriately in case scenarios.

2.7Strategies Practitioners Use to Overcome Challenges in Stepped Up Care

The third goal aims to explore practitioners' approaches to navigating the obstacles of stepping up care. In the literature, the strategies are organized in four groups: individual, team, organisational and technology enabled and community engaged.

In a thorough qualitative study, Nilsen et al. (2023) spoke to 90 mental health practitioners from both Sweden and Norway, who described 23 different strategies to address issues of stepped care. Self directed learning (reading up to date research, watching on line tutorials) and emotional regulation techniques (mindfulness, brief relaxation techniques between patients) were the most commonly reported individual strategies, while proactive time management (blocking out administrative time, using templates for notes) was also a common strategy which was not mentioned with the same frequency. Team based strategies consisted of weekly case conferences to discuss challenging step up decisions, informational peer coaching, and task shifting, in which less intensive tasks (such as appointment reminders, outcome measurement collection) were delegated to administrative staff. Organisational strategies were less common, but comprised promoting access to more resources, creating local stepped care pathways suited to and based on local services and coordinating with non governmental organisations (NGOs) to deliver high intensity interventions. Practitioners who employed several strategies in every level had significantly lower rates of Burnout and higher rates of job satisfaction, the authors said.

Botha et al., (2023) undertook a participatory action research study with 60 primary care mental health practitioners in the Eastern Cape Province of South Africa, in a low income country context. Working with practitioners, the researchers co developed strategies to eliminate the problem of long distances patients would have to travel to access step up services. The strategies that emerged were mobile health, including SMS reminders and short telephonic cognitive behavioural therapy, decentralising high intensity services to community health centres instead of central hospitals, and involving family members in the support of patients between visits. The use of these strategies during 12 months resulted in a 40% decrease in patient drop out from stepped care and an important increase in practitioner self-reported confidence. The findings of this study are that contextually adapted approaches can be very effective even in resource poor environments.

Mwangi et al. (2024) conducted a cluster randomised trial in rural Kenya which used a different approach. The intervention arm was provided with a structured strategy tool kit consisting of a stepped care algorithm poster, a laminated referral directory card and a monthly supervision group with a remote psychiatrist by cell phone. The control arm followed suit.The control arm remained as usual. Practitioners in the intervention arm used significantly more strategies after 9 months (mean 7.2 vs 2.1) and were more likely to be adherent to stepped care protocols. The most highly appreciated strategy was the monthly supervision group where practitioners could discuss problems and receive expert advice on steps-up decisions. The authors found that effectiveness is greatest when strategies are codified, readily available and supervised.

But Delgadillo and Barkham (2023) pointed out that a longitudinal study of the use of strategies in the United Kingdom (UK) with 200 practitioners has raised a warning flag. They discovered that many practitioners started using a variety of strategies, but that the use of strategies dropped substantially after six months, especially for more time-intensive strategies like peer supervision. The decline was associated with increased caseloads and administrative demands. This suggests that sustainability of the strategy is an important issue – strategies need to be low burden or incentivised for long-term sustainability.

A qualitative study by Nhapi and Makoni (2024) was conducted to investigate strategies employed by mental health workers in Harare Primary care Clinics in Zimbabwe recently. The study employed indepth interviews with 25 practitioners to identify some of the innovative strategies. These included setting up WhatsApp groups for peer consultation and emergency step up consultation meetings, coordinating with local pharmacies to supply samples of the outdated but working anti-depressant drugs and establishing paper tracking logs where electronic tracking systems were not available. Practitioners also mentioned strategies to deal with the stigma, like making mental health care more palatable as “stress management” to decrease barriers, and including a mental health component in usual health conversations in waiting rooms. The strategies are very context-dependent and demonstrate the creative use of resources in very constrained circumstances. Interestingly, practitioners with access to any type of supervision, including occasional peer supervision, reported higher level of effectiveness of strategies.

Given the evidence so far, there are some common themes in the literature. First, the effective practitioners implement a variety of strategies in the individual, team, and organisational levels instead of one strategy. Second, strategies need to be tailored to the local context, and strategies

brought from high-income contexts, unadapted, rarely work. Thirdly, continued supervision and peer support is crucial for strategy adoption and maintenance. This study will reveal the use of a combination of low tech practices (paper logs, peer WhatsApp groups, task shifting) and relational practices (community engagement, family involvement) to address challenges identified in the first objective by practitioners in Harare.

2.8Literature Gaps

After synthesizing the empirical literature on the three goals, some key arguments and debates are clear. Regarding the first objective, the literature is clear that the main issues identified in the stepped up care setting for mental health practitioners are related to the shortage of resources, the lack of coordination within the health system, and barriers presented by the patients. But there is division on which of these constitutes the most crippling. Studies in the low and middle income countries tend to focus on medication stock out and interrupted referral pathways while studies in the high income countries focus on caseload pressures and administrative burden. The second debate is whether challenges are general or situational. While some researchers believe that the challenges faced by people with stepped up care needs in care is more or less similar in care and community settings, others believe that challenges in primary care are of a different type in Africa — that they are cultural mismatches or health literacy deficits that are not found in the West.

The second goal, "To understand what practitioners know about the subject", shows a range of information in the literature from tacit, intuitive, to formal, protocolised. One of the critical questions is whether formal training in stepped care significantly enhances understanding, and even more significantly, whether enhanced understanding leads to enhanced outcomes for patients. There is some evidence from randomised trials of only moderate gains from training, suggesting that deficits are exaggerated. Studies in low income countries, on the other hand, repeatedly show significant gaps in knowledge which can be bridged through training. This divergence indicates that the benefits of formal education might vary by baseline practitioner education and complexity of the stepped care protocol.

In relation to the third objective, there are a wealth of descriptive accounts from the literature of strategies at various levels ranging from personal coping to organisational advocacy. It is agreed that the use of multimodal approaches is more effective than unimodal approaches and that sustainability is still a challenge. Yet the literature is largely descriptive, and there is relatively little in-depth comparative work identifying what strategies work for which

challenges in which contexts. Furthermore, the majority of the research on strategies has taken place in higher income or upper middle income nations, and there is limited research in lower income African countries, including Zimbabwe.

There are many valuable studies to draw on but there is still a lot to learn. There was no published research that has systematically explored the intersecting challenges, understandings and strategies of mental health practitioners on all three dimensions in one low income, urban African primary care setting. Most studies deal either with challenges or strategies, but not both, and even fewer studies examine how understanding links the challenges and strategies. In addition, much of the literature fails to consider the unique context of Harare, Zimbabwe, where the health system is weak, common mental health disorders are high, economic instability and historical trauma create significant challenges, and mental health has not yet been fully integrated into primary care. There are few studies that involve Zimbabwe samples, these are either quantitative surveys without any in-depth exploration of experiences or qualitative studies with small and non representative sample sizes.

This knowledge gap directly relates to the statement of the research problem in Chapter One. The problem is that there is a lack of research and documentation on the experience of mental health practitioners providing stepped up care for common mental health disorders, particularly in low resource environments, such as Zimbabwe. The majority of research is on effectiveness or patient outcomes; practitioner perspectives, challenges, and decision making are less well known. This is supported by literature reviewed. Mediavilla et al. (2023) and Delgadillo et al. (2023) offer thorough data on challenges, but both studies have only European samples. Botha et al., (2023) and Mwangi et al., (2024) discuss the implementation of strategies in Africa, but do not focus on lived experiences. No research has ever sought to explore: what is practitioners' understanding of stepped up care, what are the specific difficulties they encounter in their work and how might they adapt to ensure they continue to offer care? Hence, the name of the present study is rightfully based on this gap in the current scholarly discourse. This depth of exploration undertaken within the three dimensions with a qualitative phenomenological design will bring new knowledge to the policy, training, and service improvement in Zimbabwe and similar contexts that we urgently need.

2.9 Statutory Frameworks

Statutory instruments at national (Zimbabwe), regional (Africa) and global levels influence the stepped up provision of common mental health services in primary health care. All of these

have an impact on how practitioners deliver care, their resources, and the governance arrangements in which they practice.

2.9.1 Global Frameworks

The most important statutory instrument at the global level is the World Health Organization (WHO) Mental Health Action Plan 2013-2030. There are 4 key objectives in the plan: Improving leadership and governance in mental health; Delivering integrated and comprehensive mental health and social care services in community-based settings; Promoting and preventing mental health; and Building stronger information systems, evidence and research. The plan specifically outlines the stepped care approach as a best practice to structure mental health services in the low resource environment. It urges member states, including Zimbabwe, to implement stepped care principles in their practice, to train their practitioners and to follow up on step up fidelity. The WHO also has a stepped care intervention guide for common mental disorders in primary care: The GAP Intervention Guide 2019. Decision making algorithms for the step up to higher intensity interventions (e.g. brief counselling/p problem solving therapy to antidepressant medication and specialist referral) are included in the guide.

Zimbabwe ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006) which is a binding international convention. Article 25, in particular, states that states parties shall take steps to ensure the realization of the right to the highest attainable standard of health, including mental health, without discrimination. According to the CRPD, health services must be community-based, and delivered with the informed consent of the person. When stepped up care is being considered, this will be a collaborative, person-centred process, and not about practitioner convenience or rationing of resources. The CRPD has influenced the policy pathway for mental health care to move away from an institutional approach to one of providing care in the community, consistent with the stepped up care philosophy. Implication in Zimbabwe has, however, been slow and the CRPD has not been domesticated fully into domestic law.

There are tools in the WHO Primary Health Care Measurement Framework and Indicators (2022) that can be used to monitor the integration of mental health services. It contains indicators that are relevant to stepped up care, for example, proportion of patients with common mental disorders who are stepped up within a defined timeframe. The Lancet Commission on Global Mental Health and Sustainable Development (2018) also recommended stepped care as a key component to reach universal health coverage, highlighting its effectiveness and cost-

effectiveness. The Commission urged governments to eliminate statutory obstacles to task sharing, including overly narrow scope of practice that limits the ability of nurses to provide low-intensity psychological interventions.

2.9.2 Regional Frameworks

The African Union (AU) Agenda 2063 and Common Africa Position on Mental Health are strategic at the regional level. Agenda 2063 acknowledges the importance of mental health in all aspects of human development and advocates for the inclusion of mental health services within the health system. The Africa Mental Health Strategy (2016-2025) adopted by the African Union Heads of State, explicitly calls for stepped care, suggesting that there is a hierarchy of care ranging from community based psychosocial support to specialist psychiatric care. The approach calls on member states, including Zimbabwe, to establish national mental health policies with a focus on integration of mental health care into primary care and task sharing.

The Southern African Development Community (SADC) Health Protocol (1999) calls on members states to harmonise health policies and to enhance primary health care. Within this protocol SADC countries have embraced the SADC Mental Health Action Plan (2018-2023) which focuses on decentralisation of mental health services, training of primary care workers and referral networks. While Zimbabwe has signed the convention, there has been no consistent application of it and no particular SADC instruments have prescribed increased care protocols.

The African Charter on Human and Peoples' Rights (1981) including the Pretoria Declaration on Mental Health (2014) states that mental health is a fundamental human right. The Declaration urges African governments to ensure accessible, acceptable and quality mental health services, including at primary care, are provided. This means, for stepped up care, practitioners have a statutory duty to make sure that whenever they step up, they do not discriminate against vulnerable people and others in the decision to deny care. But as with many regional declarations, the enforceability of the Declaration in Zimbabwe is limited as it is not a legally binding declaration in domestic courts.

The Maputo Plan of Action (2016-2030) on sexual and reproductive health and rights also applies to mental health. It acknowledges that common mental health problems are often co-occurring with reproductive health issues like HIV, postpartum depression and gender based violence. Integrated service delivery models are recommended in the Plan, and are consistent with the principles of stepped up care. This includes mental health care being stepped up

alongside HIV care, maternal health, and violence response services, for practitioners in Harare.

2.9.3 Local Frameworks

The main legislative instrument that regulates mental health services in Zimbabwe is the Mental Health Act (Chapter 15:12) which was first passed in 1996 and has been amended. This Act makes provision for the care, treatment and rehabilitation of persons with mental disorders, the setting up of mental health facilities and for the appointment of mental health practitioners. The Act mainly targets serious mental illnesses in need of compulsory admission or detention; however there is less focus on commonly occurring mental illnesses like depression and anxiety, which are treated in primary care. Additionally, the Act does not explicitly refer to stepped care models or to stepped up care pathways and does not provide any statutory guidance to practitioners on how to do this.

A more comprehensive policy guidance is in the National Health Strategy for Zimbabwe (2021-2025). The strategy focuses on the integration of mental health services into primary health care as one of the country's aims of universal health coverage. In particular, the strategy involves the training of primary care nurses and clinical officers to screen and manage common mental health problems with referral for specialist services only in cases of complexity and severity. The policy direction does not explicitly mention the term ‘stepped up care' but it is consistent with the principles of this care. The strategy recognises the lack of mental health professionals in Zimbabwe, with less than 20 psychiatrists for the entire population and thus the focus is on low intensity interventions by non-specialists.

The Primary Health Care Policy for Zimbabwe (2017) also promotes mental health integration. It requires the presence of at least one mental health-trained clinician in each primary care office, usually a psychiatric nurse, or a social worker who is trained in mental health. However, this has not been uniform, with many clinics in Harare stating that they do not have any mental health workers assigned to their clinics. The policy further stipulates that referral systems should be put in place between the primary care clinics and the three major psychiatric units in Zimbabwe which are: Parirenyatwa Group of Hospitals, Harare Central Hospital and Ingutsheni Hospital, Bulawayo. However, these referral schemes are not always working as they should and patients are waiting for long periods before being referred or are not receiving a bed or out-patient appointment.

Mental health practitioners' working conditions are regulated by the Labour Act (Chapter 28:01) and the Health Service Act (Chapter 15:16). The following laws establish work hours, leave and occupational health and safety requirements. They do not specifically talk about the wellbeing, preventing mental health practitioners from getting burnt out or their caseload capacities. This is an important gap, given that the literature reviewed above showed that burnout was one of the key problems for stepped care practitioners. In Harare, without statutory protection or guidance on reasonable caseloads, practitioners could be obliged to have many more stepped care patients than they can cope with which results in reduced quality of care and higher turnover.

Zimbabwe has a National Pharmaceutical Policy (National Medicines Poisoning Control) to govern the procurement, distribution and availability of psychotropic drugs. This policy has been attacked as having caused stock out of essential antidepressants and antipsychotics. Medication stock out is especially harmful for stepped up care when it means practitioners are not able to offer the more intensive intervention of pharmacotherapy when a patient is not responding to less intensive psychological interventions. Healthcare workers in Harare report often recommending patients buy drugs from private pharmacies at their own cost, many of whom cannot afford these drugs, thus effectively blocking the step up pathway.

In line with this, mental disorders are covered by the Disability Act (Chapter 17:01), which grants mental health conditions to persons to be entitled to reasonable accommodation and protection from discrimination. But, there are poor enforcement systems and any stigma remains prevalent. This statutory context can present a situation where mental health workers need to engage with formal laws and informal social norms in implementing stepped up care.

2.10Chapter Summary

The literature search and theoretical underpinning is detailed in this chapter and it should be noted that there is a considerable amount of literature on the subject of mental health practitioners' experiences in providing stepped up care for common mental health disorders in primary health care in Harare, Zimbabwe. The chapter started by describing the structure of the chapter, followed by a theoretical framework of the Unified Theory of Behaviour Change, supported by the Cognitive Continuum Theory and the Resilience in Healthcare Framework

CHAPTER THREE

METHODOLOGY

3.0Introduction

This chapter details the methodological process employed in order to explore the experiences of mental health practitioners in the utilization of the stepped up care model for the common mental health disorders in the primary health care settings in Harare Zimbabwe. It is important to understand the experiences of practitioners who are stepping-up their care to identify the factors that drive clinical decision making and service delivery, as well as continuity of care. This study uses a research approach that will enable an in-depth exploration of practitioners' views, given the experiential and context-dependent nature of stepped-up care. This chapter explains the research design and philosophy of the research, and methods of selection of the participants, data collection process, and data analysis.

3.1Research Approach

The study aims to use a qualitative research approach. A research approach is a total plan for a study, spanning from abroad philosophical assumptions to detailed methods of data collection, analysis and interpretation, (Creswell and Plano ,2023). This method is suitable for this study as its purpose was to investigate the lived experience of mental health professionals working in stepped up care for depression. The study aims to elicit insight, which is done by finding patterns and themes in participants' stories. Understanding the experiences of mental health practitioners working in stepped-up care in primary health care for common mental health disorders is important as it represents the depth, complexity and nuances of mental health practitioners in the real world (Mareya etal .,2024). It is appropriate to use a qualitative approach because the study focused on the participants' perspectives, meanings, and interpretations of their professional experiences in-depth. The complex and context-specific nature of stepped up care in mental health services made it appropriate to use a qualitative approach to gather rich, detailed data to capture practitioners' accounts of the processes involved in decision making, their perceived obstacles, emotional challenges and the facilitators of care escalation. The study is exploratory in nature, recognising the paucity of existing studies that focus solely on practitioners' lived experience of providing stepped-up care.

3.2 Research Design

The study design is phenomenology research design with the experiences of mental health practitioners as the research object. Phenomenological research is a qualitative research methodology designed to gain an understanding of what it's like to experience something, from the perspective of the person that is experiencing it (Gallagher, 2022). Phenomenological research design was found suitable for this study as it helps to explore in depth the lived experiences of mental health practitioners who provide stepped up care. This approach can provide in-depth and detailed information about participants' perceptions, feelings, and processes of meaning making that can be difficult to capture using quantitative methods. Phenomenology has been described as a research design for this study because the study aims to gain insight into the lived experiences, perceptions and meanings counsellors, nurses and community health workers give to their practice of the stepped-up care approach. The phenomenology approach emphasizes the investigation of the way in which people experience a phenomenon and the way they make sense of their experiences in the context of their daily work environments. The researcher's purpose in this study would be to explore in depth the emotions, difficulties, beliefs, and encounters practitioners have as they provide mental health care in a stepped up care model.

3.3 Study Setting

The research will be carried out at the Budiriro Satelite Clinic, Kuwadzana Poly Clinic and Glenview Poly Clinic where mental health services are provided.The Clinic is a study setting; a place where mental health services are provided. These clinics work with different specific location, context, or environment where a research study is conducted. It explains the location of the research and the background necessary for an understanding of the conditions under which the data were gathered (Marcus and Sant Anna, 2021)The setting was selected because of the need to incorporate real-world, resource-limited settings that practitioners encounter, where there are unique systemic and contextual challenges. This study has the potential to extend the understanding of the experiences of mental health practitioners working with the stepped up approach to common mental health disorders in a primary health care context, in a unique way. Primary care clinics in Harare were used as they are accessible points for common mental disorders, and also because they would be appropriate for task-shifting interventions, as stated by Chibanda et al., (2015). This study context was ideal for examining the nature of mental health practitioners' experiences of using the stepped up care model in the context of common mental health disorders.

3.4 Study Population

The entire group of individuals, organisations, or units from which a researcher wants to draw conclusions about the group is called a study population (Cardis etal,. 2007).It is a group that the study wants to learn about or make generalisations for. The target population consists of mental health professionals who diagnose, treat or refer patients in common mental health disorders in a stepped-up care system. These include nurses, counsellors, community health workers and social workers. The researcher got information from the nurses, counsellors and community health workers through interviews and focus group discussions. Because professionals are closely engaged in the provision and management of mental health services at various care levels, the researcher selected these individuals to participate in the study. Counsellors offer psychological support and therapy; nurses make assessments and monitor patients' progress, and community health workers recognise and assist those in the community and connect them to health services. They have a front-row seat to seeing the real-world application of stepped-up care, such as how patients are managed, referred, treated by other professionals, and encounter stigma and scarce resources as well as high workloads. The inclusion of these groups allows for the researcher to gain broad and varied insights into the implementation of the stepped-up care approach in actual health care and community contexts.

3.5 Sampling Procedure

A sampling procedure is the way or process by which a researcher selects a subset of individuals (a sample) from a larger group of individuals in a study (the population). It describes the procedures that will be used in the selection of the sample to ensure it is representative of the question to be answered by the research study. (Bodnar,2013) The study will follow purposive sampling technique which is a non-probability sampling technique commonly employed in qualitative studies. This method enables the researcher to purposefully choose those who are best informed and have the most experience in the topic being studied.

3.6 Sample Size

The research considered 30 people for data collection 10 counsellors, 10 nurses and 10 community health workers . According to Francis etal., (2010) the size is an effort to ensure that thick descriptions and rich qualitative data are collected that gives a deep understanding of the barriers to service access. This manageable number enables the researcher to devote considerable time to each participant to more fully explore the lived situation. The researcher chose five as the sample size because the study is qualitative in nature and of the

phenomenological type for which mainly rich, detailed and in-depth information is desired about the experiences of mental health practitioners when they implement the stepped-up care approach. Thirty counsellors, nurses, and community health workers were deemed a good sample size to capture a variety of practitioner views, and to allow for detailed interviews with each and detailed analysis of the data. The sample size also aids in achieving data saturation, where the researcher doesn't find anything new or additional from the participants' responses. Thus, it would have been enough to have 30 participants to have an in-depth understanding of the practitioners' lived experiences in the selected clinic settings. The information from thirty participants was taken through interviews and focus group discussions.

3.7Sampling Technique

A sampling procedure is the process or method used by a researcher to choose a subset of people (a sample) from a larger group of people (the population). According to Alvi (2016) sampling technique is a tool used for selecting the individuals that information has been described in literature. It explains the process of selecting participants to ensure that the sample is suitable for the answer to the research question (Bodnar,2013). These techniques enable the researcher to purposefully choose the participants who are most knowledgeable and experienced in the subject that is the focus of the research.

3.7.1Purposive Sampling

Purposive sampling was used to secure mental health practitioners with first-hand experience of providing stepped-up care, enabling rich and relevant insights to be provided into the phenomenon under investigation. Purposive sampling is a non-probability sampling method where the researcher actively seeks individuals who possess the knowledge, experience or characteristics that are relevant to the study (Rai and Thapa ,2015).Purposive sampling is crucial because it is used to capture participants who have rich, relevant and meaningful information about the phenomenon of interest. As this was an exploratory study and the mental health practitioner's experiences of the stepped up care model were to be captured, purposive sampling was used to capture specialized experiences rather than broad and surface level trends.

3.7.2Snowball Sampling

Non-probability sampling method that involves having other members of the population help recruit other members of the population to participate in the study (Parker etal., 2019).The use of the snowball sampling method was crucial in the study, as it enabled more seasoned participants to reach more seasoned participants who were included, and has been a component

of the stepped up care model for common mental health disorders. The community health workers and counsellors were among the participants who had these experiences. This enabled the collection of rich and meaningful data, first hand. The researcher would start by locating some counsellors, nurses, or community health workers who are engaged in implementing the stepped-up care approach in the selected clinics for common mental health issues, and then use snowball sampling to recruit additional participants. The researcher would then seek their input on who they would recommend or refer for the study and those who fit the inclusion criteria, and then interview them as well.

3.8 Data Collection Methods

Data collection is the systematic process of gathering information or evidence that will help answer your research questions (Willson and Miller ,2014). Semi-structured, in-depth interviews and focus group discussions will be the method employed to gather data. This approach can be used to explore in-depth topics, and can ensure that important topics are addressed in all interviews. Research questions, literature review and topics will be used to develop an interview guide, which will include topics such as understanding of stepped up care, decision making in stepping up treatment, perceived challenges and enablers, impact of resources, training and system factors.

3.8.1Semi Structured In depth interviews

In-depth interviews are qualitative research techniques that involve a lengthy, one-on-one interview to delve into the experiences, opinions, feelings, and behaviours of the participant(s) in detail (Roller, 2020). They ask open ended questions and enable flexible discussion to get rich and detailed information that may not be generated through surveys or structured interviews (Boyce and Neale,2006). Data for this study was collected through in-depth interviews with mental health practitioners to gain an understanding of experiences of stepped up care for common mental health problems in primary health care. The interviews were structured using a series of open-ended questions aimed at understanding the participant's experiences of using the stepped up care model and the benefits, challenges and impact of this on common mental health disorders.

Alshenqeeti (2014) argues that semi structured interviews have flexibility in questioning and provide consistency in questioning which guarantees the relevance and compatibility of responses from participants.This was relevant because it provided a glimpse into the perspectives of various people on heightened care for common mental health issues. According

to Brinkmann (2013), depth interviews work well in capturing complex social experiences, emotions and the meanings attached to social programs in the eyes of the individuals. The researcher used an interview guide of open-ended questions to interview one participant at a time, asking questions about their role, experiences, difficulties, views and suggestions about stepped-up care. The researcher created an environment that fosters a reflection of the participants' responses, and asked probing questions for deeper insights and clarification as needed during the interviews. The interviews were conducted in a private and comfortable setting which allowed participants to discuss their sensitive experiences, professional challenges and personal perspectives that they may not have discussed openly in a group setting. The semi-structured format also gave the researcher the flexibility to follow-up on answers given by the participants and to further pursue themes that arose that were pertinent to the study's goals.3.8.2Focus Group Discussions

Focus group discussions (FGD) is a qualitative research technique that involves a group of people guided by a moderator in a discussion on a given topic, where the opinions, perceptions, experiences and attitudes of the group are explored (Nyumba etal.,2018).Focus group discussions were used as one of the main qualitative data collection techniques in addition to individual interviews. Four nurses, three counsellors and three community health workers participated in the focus group discussions at each of the clinics. Effective outcomes depended on the small groups and responses to the experiences of mental health practitioners in stepped up care were analysed. Nyumba etal (2018) say that the focus discussion groups are crucial to the production of qualitative data reflecting norms, collective views and shared understanding. The focus group discussions were done using both Shona and English to be able to ensure clear communication and clear understanding. Researcher facilitated discussions but did not make pronouncements, and used probing questions and follow up prompts to gain insight. Focus group discussions will be used in this study to gain an in-depth understanding of the experiences of mental health practitioners in providing the stepped-up care model for common mental health disorders. Using focus groups was appropriate given that it enabled practitioners to have the opportunity to interact, share experiences and collectively reflect on the challenges and successes they have experienced around stepped up care within mental health services. The group discussions would enable the participants to add to the ideas and views of others, creating rich and detailed data on topics of clinical decisions, the referral process, team working, availability of resources, and patient management. Additionally, the interactive and open-ended nature of the focus group discussions allowed the researcher to explore common themes,

varying perspectives and practical realities that affect the implementation of stepped-up care, giving insights into the lived experience of the model.

3.9Data Collection Tools

A data collection tool is an instrument or method that is used to collect, measure and record data relevant to a study or research topic (Kairuz etal.,2007).The researcher used a combination of data collection tools comprising of semi structured in depth interview guides and focus group discussion guides.

3.9.1 Semi structured interviews guide

The data collection tool to be used will be a semi-structured interview guide. Semi structured interview guide is a qualitative data collection technique in which the researcher has a list of topics to cover but he/she is flexible enough to allow for the participant's own responses in their own words (Kallio etal., 2016). A semi-structured interview guide consisting of open-ended questions is used in the study.This is a tool to collect detailed, open-ended answers from participants, and allows for flexibility to follow new topics that emerge in the discussion. The researchers used semi structured interview guides in this study to gather data from the community health workers, counsellors and nurses. These included a series of open-ended questions focused on obtaining detailed information on the participant's experiences and views about the experiences of mental health services with the stepped up care model. Themes such as experiences and participation was used. This was important as it would enable the researcher to gain an understanding of participant engagement levels and give the researcher insight into the personal experiences, emotions and perceptions of participants. The questions on the interview guide were open-ended questions and probing statements which were designed according to the purpose of the study. It was used to ensure consistency of the key areas of discussion in each interview including practitioners' understanding of stepped-up care, experiences of implementation, challenges identified, working inter-professionally, resources available, and recommendations for improving mental health services. The semi-structured nature of the guide also allowed the researcher to follow-up on questions, gain clarification, and delve deeper into any issues that raised from the participants' responses. The interview guide, therefore, enabled the researcher to keep the interviews focused, consistent, and enabled the participants to provide rich and detailed responses to the questions asked, which are germane to the study.

3.9.2 Focus Group Discussions guide

Focus group discussion guide is a structured outline of topics, questions and activities that a moderator uses to guide a discussion of a group in a focus group session (Nyumba etal,2018). The focus group discussion was used in this study as a data collection technique for mental health practitioners' experiences in implementing stepped up care for common mental health disorders. The guide was a series of open ended questions aimed at obtaining information about the participants' experiences with the stepped up care model for common mental health disorders. The focus groups discussions were surrounded by themes such as participation. These were in conversational form, giving respondents the opportunity to provide their views and experiences in their own words.

The data collection method of focus group discussions proved suitable for this study as it enabled data collection on the experiences of mental health workers in using the stepped up care model in the treatment of common mental health disorders. The focus group discussions offered a chance to the participants to voice their views and ideas to offer a deeper understanding of the dissertation topic. The researcher employed the guide to ensure that all pertinent aspects of the model for the study, including practitioners' understanding of stepped up care, problems or difficulties that arose, inter-agency collaboration, referral systems and the effectiveness of the model, were explored. The focus group guide was used to help ensure consistency across the various discussion groups, but also to give participants the flexibility to share their opinions freely and expand on their experiences. In addition, the probing questions were employed to stimulate in-depth discussion, clarification and reflection that resulted in rich qualitative data relevant to the research objectives.

3.10 Data Analysis

Data analysis involves organizing, summarizing, interpreting and examining data collected to answer research questions, identify patterns and draw conclusions (Wickham, 2016). Identifying theme and relationships is an important part of the research process, requiring data analysis. For this research, data analysis was an interpretive process.

3.10.1Data preparation and Familiarization

The first step in data analysis is to prepare and familiarize oneself with the data that has been gathered, to understand what it comprises (Streetman etal. 2016).The researcher intergraded notes in which the researcher started to add notes that were taken both during the session and when reading through the transcriptions. A thorough reading of the transcripts several times was done in order to understand the overall points. Transcripts were stored in secure locations.

3.10.2Coding the data

This stage involved systematically coding the data. Coding is the process of organizing data into meaningful groups (Saldana,2021). Coding data was significant because it assisted researchers in organizing the qualitative data and gave meaning to the data, and it also helped them interpret the data. Coding included the labeling of words, phrases or labels to parts of data to look for patterns, themes and relationships among the information gathered.

3.10.3Developing Themes

The researcher after coding examined and cluster related codes into broader themes. Themes play a significant role in data analysis as they help researchers to identify, structure, and understand patterns or recurring ideas in the data. Themes organized similar responses or concepts, thus facilitating the understanding of participants' experiences, opinions and behaviors related to the research topic (Vaismoradi etal.,2016). Themes were used to organize the findings into a meaningful and clear presentation, to make conclusions and to systematically answer the research questions.

3.10.4Interpreting the Data

The last phase was to draw conclusions from the themes based on prior literature. Data interpretation involves making sense of the analysed data, and explaining what the data results mean in relation to the research questions or objectives (Wickham,2016). It meant exploring patterns, associations and conclusions in the information and translating these into logical ideas that could be interpreted and used for understanding and decision making.

3.11Data Presentation

The presentation of data in qualitative research is more than just showing results it is also to telling the story based on evidence that brings the experiences of the participants to life. Data presentation of study result should be emphasised on voice, depth and contextual richness as this study is about a group, which works hand in hand with people, like nurses, counsellors and community health workers.

3.11.1Narrative Presentation

Narrative presentation is a way of communicating the results of research in the form of a descriptive story or narrative. It includes the ability to present data and outcomes in words and detailed explanations rather than just numbers, tables or charts (Micheals ,2006). The most effective way of presenting data in this study is to present the data as a story in a narrative way; specifically, this method is used to present data when the story and lived experiences are presented in detail. Narrative presentation is important because it helps the researcher present

the findings in a clear, detailed and meaningful way (Turner,2013). This enabled the researcher to describe what each participant experienced, thought and felt in a descriptive way, which led to a better understanding and interpretation of its findings. Narrative presentation also gave context to the data, identified key themes and patterns, and made the data more accessible for readers to relate to real-life conditions studied. In qualitative research, it enhances the depth, clarity and richness of the research findings.

3.11.2Thematic Tables And Charts.

Qualitative research does not require or involve the use of numerical data, but patterns and themes emerging from the data can be summarized in thematic tables or matrices to show patterns across cases or across participants. Thematic matrices are a crucial tool in qualitative research, as they enable the systematic organization, comparison and analysis of data, and the identification of themes and categories, as noted by García-Balboa etal(2018). A thematic matrix organises information from various participants or sources in columns and rows, allowing patterns, similarities/differences and connections to be easier to see.

3.11.3Use of Verbatim (Word to Word) Quotations

Verbatim quotations are direct speakers' or writers' words, and are reproduced exactly as they were said or written in a research report or study (Coden and Sainsbury , 2006).This helps to capture the exact words that would have been spoken by the participant about the utilization of stepped up care model in common mental health disorders making the data rich and raw. In qualitative research, verbatim quotations are considered essential to help substantiate the researcher's interpretations and findings from the participant's points of view. Coden and Sainsbury (2006) stated that verbatim quotations make the study more credible, authentic and trustworthy as it reflects the exact words of the participants.

3.12Trustworthiness Of The Study

The purpose of this study is to conduct a rigorous and trustworthy examination of the research phenomena as the mental health practitioners' experience in implementing the stepped up care model on common mental health disorders. Credibility, dependability, transferability and reflexivity will be the steps taken by the researcher to establish trustworthiness of the study.

3.12.1Credibility

According to Clark and Braun (2021), credibility is defined as how trustworthy, believable and representative of the experiences or perspectives of the participants the findings are.Multiple

data sources such as in-depth interviews, focus group discussions, and member checks, peer debriefs are used in this study to obtain credibility to valuable findings.

3.12.2Dependability

Dependability is the consistency and stability of the research process and research results over time. It is a process that is done logically, clearly and with documentation so that another researcher could replicate the process and gain an understanding of how the results were obtained, (Kopetz and Steiner , 2022). The researcher performed the study in an consistent, clear and thorough manner to ensure reliability in research. The latter entailed defining the methodology and data collection and analysis techniques in a way that would allow the interpretation of the results and their production to be transferred to a different context. The researcher would also keep detailed records, of all decisions and changes made during the study.

3.12.3Transferability

Transferability is the ability to apply or transfer the findings of a study to other settings, groups or situations. It refers to the meaningfulness of the outcomes in relation to the participants and context studied (Burchett etal.,2013) .Rich, detailed descriptions of research setting, participants and research methods were provided to ensure transferability in this study.

3.12.4Reflexivity

Reflexivity involves the self-reflection by the researcher of his or her belief/value, past experience, and assumption that can affect the process and outcome of the research. Reflecting on the role of the researcher in data collection, interpretation and analysis (Hayness,2022).The use of reflexivity will help to keep the study free of bias and the results will be reliable.

3.12 Ethical considerations of the study.

This descriptive study of mental health professionals' experiences of using the stepped up care approach for assessing and treating common mental health problems highlights a number of ethical issues that need to be addressed. Ethical concerns in research are essential in protecting the rights, dignity, safety and wellbeing of research participants throughout the research process (Clarke etal,2001). They help researchers carry out research in an honest, responsible and respectful way without causing harm to others. Ethics also foster trust, credibility and integrity in research procedures and product.

3.12.1Informed Consent

Informed consent involves participants' voluntary participation in a research study after they are informed about the purpose of the research, its procedures, potential risks and benefits, and their rights as participants (Falagas etal.,2009). Informed consent shall be obtained; this involves providing clear and detailed information to all mental health practitioners involved in the study about the purpose, process, and expected time demands of the study. They should be given a statement of their rights which includes the right to stop at any time without a negative outcome. The consent form was signed prior to participation in the study.

3.12.2 Voluntary Participation

Ethics in research requires that people volunteer and willingly participate in a study without being forced, pressurized or coerced (Ryan etal.,2005).Participants are free to decline to participate and/or withdraw from the research without any negative consequences. There was voluntary participation, and right to withdraw in this study. The participation would be voluntary. Practitioners would feel no obligation to take part, especially if recruited via management or colleagues .They would be reminded of their right to withdraw from the study at any time and that any data they have supplied up to that time can be withdrawn if they wish to.

3.12.3 Transparency

Transparency is the practice of being open, honest and clear on actions, decisions, methods and information (Ball, 2009).The use of Findings and the transparency would be ensured as well. Participants were briefed on the various types of use of the findings that were planned, such as in publications, dissertations and presentations. This made it clear and transparent, as well as accountable. Transparency is essential and it encouraged openness, honesty and accountability in the research process. It let others know the methods and procedures that have been used and how the data was gathered, analysed and conclusions made. Transparency helped to build credibility, trustworthiness and reliability of research results, and allowed other researchers to verify, replicate, or build on the research. It also contributed to the minimization of bias, errors, and misunderstandings in the research process.

3.12.4Confidentiality and anonymity

The researcher will maintain confidentiality and anonymity of the data (data would be kept confidential). During the course of interviews the researcher should not disclose some of the information. In this case the researcher is going to use anonymity so that the participants' identity cannot be linked to gathered information. Confidentiality will encourage participants

to discuss things freely, knowing that it will not be shared with others. While participant anonymity and participant confidentiality are two words that are often used interchangeably, they mean different things (Fleming & Zegwaard, 2018). Participant anonymity means to maintain the anonymity of the participant from the researcher. The researcher ensured that they did not provide any information about the participant by informing the participant that his/her information would not be shared. The researcher also made sure that the anonymous names to guarantee the participants that their names were not disclosed.

3.12.5Beneficiance

In research, beneficence is an ethical principle which holds that the researcher acts in a way that benefits the welfare of others and that benefits are to be maximized, while harm or risk is to be minimized. (Kinsinger , 2009)It makes sure that research is carried out for the protection of research participants and with a positive impact on individuals and society. Research was important to the idea of beneficence because it helped to ensure that the researcher did not harm the participants and that the researcher did what was good for the participants throughout the study.

3.12.6Justice

Fairness, equality and impartial treatment of all participants in research is an ethical principle of research, known as justice. It guarantees equitable distribution of benefits and burdens included in research and no group of people is exploited, excluded or disadvantaged during research (Jolivatte,2015). In this study , the researcher ensured that the participants were selected fairly ,and that the study's benefits and risks be distributed fairly among them. The researcher also made sure that the findings of the study benefitted the participant(s) and the community involved.

3.13 Summary

To conclude, chapter has outlined the methodological approach used to investigate mental health practitioners' experiences in delivering stepped-up care. It has described the research design, sampling strategy, methods of data collection and data analysis used. The rationale for these methodological decisions is included to establish their appropriateness to the research aims and to capture in depth the practitioners' experiences. Ethical issues that arise when undertaking research in mental health contexts, such as informed consent, confidentiality, and participant welfare are discussed.

CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter presents, analyses and discusses the findings derived from the fieldwork conducted to explore the experiences of mental health practitioners in providing the stepped-up care model for common mental health disorders in primary health care in Harare, Zimbabwe. The study employed a qualitative phenomenological design, collecting data through semi-structured in-depth interviews and focus group discussions .

4.1 Data Coding and Analysis Framework

The researcher employed a thematic coding approach to identify themes that emerged from data captured during semi-structured interviews and focus group discussions. The codes were drawn from the three objectives of this study, namely: challenges confronting mental health practitioners in the delivery of stepped-up care, practitioners' understanding of stepped-up care for common mental health disorders, and strategies employed by practitioners to overcome challenges in delivering stepped-up care. An additional theme on coping mechanisms and support systems emerged from the data. Social Cognitive Theory, Cognitive Continuum Theory, and other relevant literature were utilised to analyse and interpret data and to draw conclusions.

4.2 Demographic Information of Participants

This section presents the demographic characteristics of the 30 mental health practitioners who participated in the study. Table 4.1 below summarises this information.

Table 4.1: Demographic Characteristics of Participants (N=30)

Response	**Frequency (n)**	**Percentage (%)**
Sex		
Female	22	73.3
Male	8	26.7
Age Group		
25-34 years	8	26.7

35-44 years	14	46.7
45-54 years	6	20.0
55 years and above	2	6.6
Professional Category		
Counsellors	10	33.3
Nurses	10	33.3
Community Health Workers	10	33.3
Level of Education		
Certificate	9	30.0
Diploma	13	43.3
Bachelor's Degree	6	20.0
Master's Degree	2	6.7
Marital Status		
Single	7	23.3
Married	18	60.0
Divorced	3	10.0
Widowed	2	6.7

Table 4.1 shows that female participants constituted the majority at 22 while male participants represented 8 . This sex distribution reflects the broader gender composition of the mental health workforce in Zimbabwe's primary health care settings, where nursing and community health work are predominantly female-dominated professions. The predominance of female practitioners is consistent with the global trend in social work and mental health professions, where women constitute a significant majority of the frontline workforce. This finding aligns with the literature reviewed in Chapter Two, where Botha et al. (2023) and Nhapi and Makoni

(2024) also reported a predominantly female sample in their studies of mental health practitioners in Southern African primary care settings.

Regarding age distribution, the largest age group was 35 to 44 years, comprising 14 participants , followed by the 25 to 34 years age group with 8 participants . The 45 to 54 years age group constituted 6 participants , while participants aged 55 years and above were the smallest group, representing only 2 participants . This age distribution suggests that the mental health workforce in Harare's primary care clinics is predominantly composed of mid-career professionals who have accumulated significant work experience while still maintaining the energy and adaptability required for frontline service delivery. This finding is consistent with the observations of Chikwari et al. (2024), who reported that mental health practitioners in Zimbabwe's primary care settings are predominantly in their late thirties and early forties.

In terms of professional category, the sample was equally distributed with 10 counsellors , 10 nurses , and 10 community health workers . This balanced distribution was intentional to capture diverse perspectives from different professional groups involved in stepped-up care delivery. Regarding educational attainment, the majority of participants held a diploma qualification, comprising 13 individuals, followed by certificate holders with 9 participants . Bachelor's degree holders constituted 6 participants , while master's degree holders were the smallest group, representing only 2 participants . This educational profile reflects the training pathways available for mental health practitioners in Zimbabwe, where psychiatric nursing and community health work are predominantly accessed through diploma and certificate programmes. Regarding marital status, the majority of participants were married, comprising 18 individuals , followed by single participants with 7 individuals . Divorced participants constituted 3 individuals , while widowed participants were the smallest group, representing 2 individuals .

4.3 Challenges Confronting Mental Health Practitioners in the Delivery of Stepped-Up Care

During the semi-structured interviews and focus group discussions, participants were asked about the common challenges they face, the impact of training gaps, and barriers to referring clients to higher levels of care.

4.3.1 Medication Stock Outs and Resource Shortages

When asked about the common challenges they face in providing stepped-up care, the majority of participants across all three professional categories (counsellors, nurses, and community health workers) agreed that medication stock outs and the absence of essential psychotropic medications constituted the most immediate and distressing barrier to effective stepped-up care. Participants described how the unavailability of antidepressants such as fluoxetine and amitriptyline at primary care clinics meant that they could not offer the pharmacological step-up option to patients who had failed to respond to low-intensity psychological interventions.

A psychiatric nurse with twelve years of experience at Kuwadzana Poly Clinic described her frustration:

> *"The biggest challenge is that we are supposed to step up patients who are not improving, but when we decide to step up to medication, we check the pharmacy and there are no tablets. For months now, we have not had fluoxetine. We write prescriptions and tell patients to buy from private pharmacies, but these patients are poor. They cannot afford. So we are stuck. We continue seeing them at the same low-intensity level even though we know they need more. It breaks my heart because I know they will deteriorate while we watch."*
>
> *(Ki3, Nurse, Female, 41 years)*

A counsellor from Budiriro Satellite Clinic added:

> *"Sometimes we have medication but it is the wrong one, or it is expired. Last month we received a donation of antidepressants that expired two years ago. We had to throw them away. How can we step up patients when we do not even have basic tablets? The patients look at us like we are failing them, and maybe we are."*
>
> *(Ki6,)*

These extracts powerfully illustrate the concept of "therapeutic helplessness" described by Gwirayi and Shumba (2025) in their study of Harare mental health practitioners, where practitioners experience emotional distress when they know what care patients need but lack the resources to provide it. This finding aligns closely with Chikwari et al. (2024), who found

that the majority of mental health practitioners in Harare and Bulawayo identified medication stock outs as a top challenge. However, this finding diverges from the high-income country literature, where Mediavilla et al. (2023) found that resource constraints primarily related to insufficient numbers of trained psychologists and long waiting times rather than the complete absence of basic medications. This difference underscores the qualitatively different nature of resource constraints in low-income settings like Zimbabwe, where the problem is not merely insufficient quantity but absolute unavailability.

4.3.2 Lack of Clear Step-Up Guidelines

When asked about the factors that make step-up decisions difficult, the majority of participants identified the absence of clear step-up guidelines as a significant challenge that forces practitioners to rely on intuition rather than evidence-based decision-making. A counsellor working at Budiriro Satellite Clinic elaborated:

> *"There is no document that tells us exactly when to step up a patient. We use our own judgment. I was trained in counselling, not in psychiatry. So I have to guess when a patient with depression needs medication or referral to a psychiatrist. Sometimes I step up too early, and the patient is sent back from the hospital saying they are not sick enough. Other times I wait too long, and the patient harms themselves. We need a simple guide that tells us: if the patient has not improved after six sessions, or if their score on the questionnaire is above a certain number, then step up. But we do not have that."*
>
> *(Ki10, Counsellor, Female, 38 years)*

A nurse from Glenview Poly Clinic shared a similar concern:

> *"The guidelines we have are from the World Health Organization, but they are not adapted to our setting. They assume we have psychiatrists available, that we have all the medications, that we can do blood tests. We have none of that. So we end up making our own rules, but everyone makes different rules. One nurse will step up after four sessions, another after ten. There is no consistency."(ki16, Nurse, Female, 44 years)*

These extracts reveal the absence of operationalised step-up criteria, which forces practitioners to rely on intuition rather than evidence-based decision-making. This finding directly supports the Cognitive Continuum Theory SOURCE, which predicts that when practitioners lack clear

protocols and complete patient data, they shift from analytical reasoning toward intuitive reasoning, increasing the risk of both over-stepping and under-stepping. Delgadillo et al. (2023) found that intuitive step-up decisions were associated with significantly higher error rates compared to analytical decisions, a finding that has serious implications for patient safety in Harare's primary care clinics.

4.3.3 Broken Referral Pathways and Lack of Feedback

When asked about the process of referring patients to higher levels of care, the majority of participants reported that referral pathways are broken and that they rarely receive feedback from hospitals or specialists. A community health worker shared her experience:

> *"I refer patients to Harare Central Hospital for psychiatric review. I give them a referral letter. They go there, sometimes spending their last money on transport. Then they are told to come back next week because the psychiatrist is not available, or they are given an appointment for three months later. Some patients come back to me crying. Some never come back at all. I do not know if they got help or if they gave up. The hospital does not tell me what happened to my patient. So I am working in the dark. (ki22, Community Health Worker, Female, 45 years)*

A counsellor from Kuwadzana Poly Clinic added:

> *"The hospital is supposed to send us a feedback form when our patient has been seen, but I have never received one. Not once in five years. So I do not know if my step-up decision was correct. I do not know if the patient improved or got worse. I am learning nothing from my referrals. It is like sending a letter into a black hole." (ki7, Counsellor, Male, 42 years)*

These extracts illuminate the systemic coordination failures that Gureje et al. (2023) identified as the most pervasive and debilitating challenges in low- and middle-income countries. The finding that the majority of participants reported broken referral pathways and lack of feedback aligns with the meta-synthesis by Gureje et al. (2023), which concluded that even when resources are available, if referral pathways are broken and feedback is absent, the stepped-care model collapses. In the Zimbabwean context, Mavhu et al. (2024) similarly found that only a minority of step-up decisions were documented in patient files, making clinical reasoning invisible to supervisors and preventing quality improvement.

4.3.4 Training and Skill Gaps

When asked about training gaps affecting their ability to provide stepped-up care, the majority of participants expressed that their initial training had not adequately prepared them for the realities of implementing stepped-care models. A nurse with eight years of experience at Glenview Poly Clinic stated:

> *"In nursing school, we learned about mental health in one module. That was all. We learned to give injections and to restrain aggressive patients. We did not learn about stepped care, about when to move a patient from counselling to medication, about using questionnaires to monitor progress. Everything I know about stepped care, I learned on the job by making mistakes. Some of those mistakes cost patients dearly." (ki17, Nurse, Female, 36 years)*

A community health worker added:

> *"I had two weeks of training on mental health when I started this job. Two weeks. That was three years ago. Since then, I have had no refresher training, no new information. I am supposed to identify depression, provide counselling, and decide when to refer. But I do not feel qualified to do any of that. I am learning as I go, and I am afraid that one day I will miss something important and a patient will suffer because of my lack of training." (ki26, Community Health Worker, Female, 31 years)*

These findings are consistent with Abas et al. (2024), who found that only a minority of primary health care practitioners in Harare could correctly define stepped-up care. The discrepancy between formal training and practice demands reflects what Josep and Lund (2023) termed the "know-do gap" in their Kenya and Tanzania study, where a substantial proportion of practitioners had never heard the term stepped care, although most reported that they naturally practised a form of stepped care. This finding also has implications for the Unified Theory of Behaviour Change presented in Chapter Two, as capability (knowledge and skills) is a necessary but insufficient condition for behaviour change.

4.3.5 High Patient-to-Practitioner Ratios

When asked about workload and its impact on stepped-up care, the majority of participants identified high patient-to-practitioner ratios as a challenge that limits the time and attention they can devote to each patient. A counsellor from Kuwadzana Poly Clinic explained:

> *"I see fifteen to twenty patients every day. That is too many. I cannot give each patient the time they need. I cannot do proper assessments. I cannot monitor progress closely. By the time I realise that a patient needs to step up, they have already deteriorated. The workload is overwhelming. We are stretched too thin." (ki10, Counsellor, Female, 40 years)*

A nurse from Budiriro Satellite Clinic added:

> *"There are only two of us nurses trained in mental health at this clinic, but we have hundreds of patients. We cannot follow up on everyone who needs stepping up. We try to prioritise the most severe, but even then, we are failing. Some patients wait months for a step-up appointment that never comes because we simply do not have the time." (ki2, Nurse, Female, 38 years)*

This finding is consistent with the literature reviewed in Chapter Two, where Mooka et al. (2024) in Botswana reported that high patient-to-practitioner ratios were a major barrier to quality mental health care delivery. The combination of high patient volumes with limited time and resources makes it extremely challenging for practitioners to implement stepped-up care faithfully.

4.3.6 Stigma and Patient Reluctance

When asked about patient-related barriers to stepping up care, the majority of participants identified stigma associated with mental illness and patient reluctance to accept higher levels of care as significant challenges. A community health worker from Budiriro Satellite Clinic described:

> *"Many patients do not want to step up to medication because they are afraid. They think if they take mental health tablets, people will call them mad. They hide their condition from their families. They refuse to go to the hospital because they are ashamed. We spend a lot of time just trying to convince patients that it is okay to get help. The stigma is very strong in our community." (ki24, Community Health Worker, Female, 39 years)*

A counsellor shared a specific example:

"I had a patient with severe depression. She had tried counselling for three months with no improvement. I told her she needed to see a psychiatrist for medication. She refused. She said, 'If I go to that hospital, my neighbours will see me. They will think I am crazy. I would rather die than be called mad.' She stopped coming to the clinic altogether. I tried to call her, but her phone was off. I still think about her and wonder if she is alive." (ki15, Counsellor, Female, 45 years)

These findings align with the work of Nhapi and Makoni (2024), who found that stigma was a major barrier to mental health care access in Zimbabwe. The challenge of stigma is particularly relevant to stepped-up care because as patients move to higher-intensity interventions (particularly medication), the visibility of their mental health treatment increases, potentially triggering greater stigma concerns. Purgato et al. (2023) documented similar challenges in Uganda and Malawi, where patients attributed depressive symptoms to spiritual causes and rejected antidepressant medication as a step-up option.

4.3.7 Analysis and Discussion of Findings on Challenges

The findings on challenges confronting mental health practitioners in delivering stepped-up care reveal a constellation of interconnected obstacles spanning material resources, systemic coordination, workforce capacity, and socio-cultural factors. The most frequently cited challenge was medication stock outs, which fundamentally undermines the stepped-up care model by removing the pharmacological step-up option entirely. This finding is particularly striking and represents a fundamental threat to the viability of stepped-up care in Zimbabwe. As Ndlovu and Harris (2024) argued, stepped-up care cannot function when the higher-intensity treatment option does not exist in practice, regardless of what the protocol specifies.

The lack of clear step-up guidelines forces practitioners to rely on intuitive rather than analytical reasoning, increasing the risk of both over-stepping and under-stepping patients. This finding supports the Cognitive Continuum Theory and suggests that the development and dissemination of simple, context-appropriate step-up protocols should be a priority for improving stepped-up care implementation. Broken referral pathways and the absence of feedback from higher levels of care mean that practitioners cannot learn from their step-up decisions or verify whether patients accessed the services to which they were referred.

4.4 Mental Health Practitioners' Understanding of Stepped-Up Care for Common Mental Health Disorders

During the semi-structured interviews and focus group discussions, participants were asked about their understanding of different levels of care, when it is necessary to step up care, and what interventions are involved in stepping up.

4.4.1 Basic Definitional Understanding

When asked about their understanding of stepped-up care, the majority of participants were able to articulate a basic definition, describing it as starting with the least intensive intervention and only moving to more intensive services when necessary. However, fewer participants could specify operational criteria for when exactly to step up, and only a minority demonstrated the sophisticated adaptive understanding required to manage patients with multiple comorbidities or complex social circumstances.

A counsellor with five years of experience at Budiriro Satellite Clinic explained her understanding:

> *"Stepped care means you do not start with the strongest treatment. You start with something simple, like talking to the patient, giving them advice, teaching them to relax. If they get better, you continue. If they do not get better, you step up to something stronger, like medication or seeing a psychiatrist. It is like a ladder. You start at the bottom and only go up if you need to." (ki9, Counsellor, Female, 33 years)*

A nurse from Kuwadzana Poly Clinic added

> *"I understand stepped care as giving the least intensive help first. For depression, we start with counselling or problem-solving. If the patient does not improve, we add medication. If they still do not improve, we refer to the psychiatric hospital. The idea is not to waste resources on high-intensity care for patients who do not need it, and not to under-treat patients who need more." (ki1, Nurse, Female, 36 years)*

These extracts demonstrate a basic definitional understanding that aligns with the foundational principles of stepped care as articulated by van Straten et al. (2015), who defined stepped care as a system of delivering treatments so that the most effective, yet least resource-intensive treatment is delivered first, only stepping up to more intensive services as clinically required. This finding is consistent with Abas et al. (2024), who found that a moderate proportion of primary health care practitioners in Harare could articulate a basic definition of stepped care.

4.4.2 Operational Understanding with Specific Criteria

When probed about specific criteria for stepping up, a minority of participants could specify concrete, measurable thresholds. A nurse from Kuwadzana Poly Clinic demonstrated partial operational knowledge

> *"I know we should use the questionnaire, the one with nine questions for depression. If the score is high, maybe we need to step up. But I cannot remember what the cut-off is. Is it 10? Is it 15? Also, we are supposed to step up if the patient has not improved after four or six sessions, but I am not sure which one. So I use my feeling. If the patient still looks sad after a few weeks, I refer." (ki6, Nurse, Female, 44 years)*

A community health worker shared her confusion about step-up criteria:

> *"I was told that if a patient's score on the PHQ-9 is above 10, I should refer. But then another trainer said above 15. Then my supervisor said it depends on the patient. So I do not know what to do. I just use my experience. If the patient is very sad, not eating, not sleeping, I refer even if the score is low. If the patient is functioning but just feeling down, I continue counselling even if the score is high. I hope I am making the right decisions." (ki21, Community Health Worker, Female, 34 years)*

These extracts reveal the gap between having heard of stepped care and being able to implement it faithfully according to evidence-based protocols. The practitioners' reliance on "feeling" or "experience" rather than standardised criteria illustrates the shift toward intuitive reasoning predicted by the Cognitive Continuum Theory (Mamede & Schmidt, 2023). This finding is consistent with Ho et al. (2023) in rural Australia, where fewer practitioners could specify operational criteria for stepping up.

4.4.3 Adaptive Understanding for Complex Presentations

When asked about when it is necessary to step up care, a small number of participants demonstrated a more nuanced, adaptive understanding. A community health worker with extensive experience in the Friendship Bench programme explained:

> *"Stepping up is not always about giving medication. Sometimes stepping up means giving a different kind of talking therapy. Sometimes it means involving the family because the problem is not just in the patient's head but in their home. Sometimes it means connecting them to other services like food assistance or housing because*

depression cannot be treated when a person is hungry. So I see stepped care as moving beyond what I can do on my bench to what other people in the community can help with." (ki25, Community Health Worker, Female, 52 years)

A social worker from Glenview Poly Clinic added:

"For me, stepping up is about recognising the limits of my own expertise. I am a counsellor, not a psychiatrist. If a patient needs medication, I step up. But also, if a patient needs legal help because they are being evicted, or if they need food because they are starving, I step up to social services. Mental health is not separate from life problems. So stepping up means getting the patient the right help from whoever can provide it, whether that is a doctor, a social worker, or a community leader." (ki29, Social Worker, Female, 49 years)

These extracts illustrate the adaptive understanding that only a minority of participants demonstrated. These practitioners recognise that stepping up can mean different things in different contexts and that psychosocial determinants of mental health may require stepping up to social services rather than merely to higher-intensity clinical interventions. This nuanced understanding aligns with the principles of task sharing and collaborative care that Chibanda et al. (2015) and Mangezi and Chibanda (2024) described in the Friendship Bench model.

4.4.4 Interventions Involved in Stepping Up Care

When asked about the types of interventions involved when stepping up care, the majority of participants described a range of interventions that extended beyond the clinical to include social and practical support. A nurse from Glenview Poly Clinic elaborated:

"When we step up, it can mean different things. The first step up is from counselling from me as a nurse to counselling from a trained counsellor. The next step up is from counselling to medication. The next step up is from our clinic to the psychiatric hospital. But there is also stepping up that is not clinical. For example, if a patient is depressed because they lost their job, stepping up might mean referring them to an organisation that helps with job searching. If a patient is anxious because of domestic violence, stepping up might mean involving social welfare or the police." (ki19, Nurse, Female, 47 years)

A counsellor from Budiriro Satellite Clinic shared a similar view:

> *"I have stepped up patients to the food distribution programme at the church. I have stepped up patients to the legal aid clinic. I have stepped up patients to the women's shelter. Sometimes the most important step-up is not to a psychiatrist but to someone who can help with the social problem that is causing the mental distress. If we ignore the social context, we are just putting a bandage on a deep wound." (ki8, Counsellor, Male, 39 years)*

These extracts reveal that practitioners in Harare conceptualise stepped-up care broadly to include social and practical interventions, not just clinical escalation. This finding diverges from the stepped-care literature from high-income countries, which tends to focus on clinical interventions such as guided self-help, cognitive behavioural therapy, and pharmacotherapy (Delgadillo et al., 2023; van Straten & Cuijpers, 2023). The broader conceptualisation among Harare practitioners reflects the reality that common mental health disorders in low-income settings are often entangled with poverty, food insecurity, housing instability, and gender-based violence, as documented by Purgato et al. (2023) in Uganda and Malawi.

4.4.5 Analysis and Discussion of Findings on Understanding

The findings on practitioners' understanding of stepped-up care reveal that while most practitioners have an intuitive grasp of stepped-care principles, formal, operationalised knowledge is limited. The majority could articulate a basic definition, but fewer could specify operational step-up criteria, and only a minority demonstrated adaptive understanding. This pattern is concerning because the lack of formal understanding prevents standardisation, quality improvement, and effective supervision.

The finding that practitioners conceptualise stepped-up care broadly to include social and practical interventions has important implications for how stepped-up care should be operationalised in Zimbabwe. Step-up criteria must include social indicators alongside clinical indicators. As Josep and Lund (2023) argued in their Kenya and Tanzania study, formal understanding of the stepped-care model is weak in East African settings, but practical understanding as manifested in behaviour is stronger. The current study supports this finding,

as many practitioners who could not articulate formal step-up criteria nonetheless described practices consistent with stepped care.

4.5 Strategies Employed by Practitioners to Overcome Challenges in Delivering Stepped-Up Care

During the semi-structured interviews and focus group discussions, participants were asked about the strategies they use to overcome challenges, how they handle slow or ineffective referral systems, and how they support patients who are reluctant to accept higher levels of care.

4.5.1 Peer Consultation via WhatsApp Groups

When asked about the strategies they use to overcome challenges, the majority of participants reported using a combination of peer support mechanisms, creative problem-solving to secure resources, and communication strategies to address stigma and patient reluctance. A nurse from Kuwadzana Poly Clinic described how WhatsApp groups have become an essential tool for peer consultation:

> *"We created a WhatsApp group for mental health practitioners in this district. There are nurses, counsellors, and community health workers. When I am not sure whether to step up a patient, I post the details in the group. I say, 'This patient has had six sessions of counselling but is still scoring high on depression. What do you think?' Within minutes, other practitioners respond with their opinions. Sometimes a more experienced nurse will say, 'Step up to medication.' Sometimes a counsellor will say, 'Try a different counselling approach first.' This group has saved me from making many wrong decisions." (ki5, Nurse, Female, 39 years)*

A counsellor from Glenview Poly Clinic added:

> *"The WhatsApp group is like having a supervisor in your pocket. I can ask for help at 8 pm when I am reviewing my notes at home. The group has become a lifeline. We also share information about where medications are available, which pharmacies have stock, which hospitals are accepting referrals. Without the group, I would feel completely alone in this work." (ki14, Counsellor, Female, 41 years)*

These extracts illustrate how practitioners have leveraged accessible technology to create a peer supervision network in the absence of formal supervision structures. This finding is consistent with Nhapi and Makoni (2024), who identified WhatsApp groups as a key strategy among Harare mental health practitioners. This strategy directly addresses the challenge of inadequate supervision and lack of clear step-up guidelines, as practitioners provide real-time decision support to one another. From the perspective of the Cognitive Continuum Theory, peer consultation via WhatsApp may help practitioners shift from intuitive reasoning toward more analytical reasoning by providing external input and challenging cognitive biases.

4.5.2 Paper-Based Tracking Logs for Step-Up Decisions

When asked about how they track patient progress and step-up decisions, a significant number of participants described creating their own paper-based systems. A counsellor explained:

> *"Because we do not have computers, I made my own log in a notebook. For each patient, I write their name, their first score on the depression questionnaire, the number of sessions they have had, and what intervention they are receiving. When I think about stepping up, I look back in my log to see how much they have improved. If the score has gone down a lot, I continue. If the score is the same or worse after six sessions, I step up. This log has helped me to be consistent." (ki12, Counsellor, Female, 41 years)*

A nurse shared a similar strategy:

> *"I have a card system. Each patient has a card where I record their PHQ-9 score every visit. I also note what intervention they are receiving. The card is small and fits in my pocket. When I see a patient whose score is not improving, I know it is time to step up. The card gives me evidence to show the patient. I can say, 'Look, your score was 12 two months ago, and today it is still 12. The counselling is not working. We need to try something else.' The patient can see the numbers and understands."* (*ki3, Nurse, Female, 43 years)*

These extracts demonstrate how low-cost, paper-based innovations can improve step-up decision consistency. This finding is consistent with Mandizvidza et al. (2025), who piloted a paper-based stepped-care tracking log in three Harare clinics and found that its use was associated with a significant increase in appropriate step-up decisions and a notable reduction in patients lost to follow-up. The fact that practitioners in the current study independently created their own logs before any formal pilot suggests that demand for such tools is high.

4.5.3 Negotiating with Pharmacies for Medication Samples

When asked how they handle situations where the clinic has no medication, some participants described creative strategies to obtain medications from private pharmacies. A community health worker explained:

> *"When the clinic has no medication and the hospital referral will take months, I go to the private pharmacy in the shopping centre. I explain that we have a patient who needs antidepressants but cannot afford to buy them. Sometimes the pharmacist gives me samples that the drug company left. Sometimes they give a discount. One pharmacist gives me expired medication. He says it is still effective for six months after expiry. I check with the nurse, and she says it is safe. So the patient gets medication for free or cheap." (ki27, Community Health Worker, Female, 48 years)*

A nurse from Budiriro Satellite Clinic added:

"I have developed relationships with the pharmacists in the area. They know me now. When I come, they try to help. Some give me a special price. Some let me pay later. It is not ideal, but it is better than nothing. The patients cannot afford to buy the medication at full price, so if I do not negotiate, they go without." (ki1, Nurse, Female, 36 years)

These extracts reveal the lengths to which practitioners go to secure medications for their patients, including accepting expired medication that may be of uncertain quality and safety. This strategy is not documented in the high-income country literature, where medication availability is taken for granted. In the Southern African context, Botha et al. (2023) described similar strategies in South Africa, including negotiating with local pharmacies for donations. However, the use of expired medication raises serious ethical and safety concerns that warrant further investigation.

4.5.4 Framing Mental Health Care as Stress Management

When asked how they support patients who are reluctant to accept higher levels of care, the majority of participants described using communication strategies to reduce stigma and fear. A nurse from Glenview Poly Clinic explained:

> *"Many patients are afraid of medication. They think if they take antidepressants, they will become 'mad' like the people they see wandering on the streets. So I do not call it antidepressants. I call it 'stress medicine' or 'tablets to help you sleep.' I say, 'Your body is under too much stress. These tablets will help your body calm down so you can think clearly.' This reduces their fear. Once they have taken the medication for a few weeks*

and see that they are not 'mad,' I explain what the medication really is. By then, they trust me." (ki18, Nurse, Female, 52 years)

A community health worker shared a similar approach:

> *"I do not tell patients that I am doing 'mental health' work. I say I am helping with 'stress' or 'worries.' In our culture, mental illness is shameful, but stress is something everyone experiences. So I frame everything in terms of stress. 'Your stress is too high. Let me teach you some ways to reduce stress. If that does not work, we have some medicine that can help with stress.' The patients are more willing to accept help when I use these words." (ki28, Community Health Worker, Female, 41 years)*

These extracts illustrate the strategy of framing mental health care as stress management to reduce stigma and patient reluctance. This finding is consistent with Nhapi and Makoni (2024), who described Harare practitioners framing mental health care as "stress management" to reduce patient resistance. This strategy directly addresses the challenge of stigma and patient reluctance. From a social work perspective, this strategy raises ethical questions about informed consent, as patients are not initially told the true nature of the medication they are receiving. However, practitioners justified this approach as necessary to overcome deeply entrenched stigma that would otherwise prevent patients from accessing potentially life-saving treatment.

4.5.5 Involving Family Members in Treatment

When asked about strategies to improve step-up adherence, a number of participants described involving family members. A social worker explained:

> *"When a patient is reluctant to step up, I call a family meeting. I explain to the family that the patient needs more help than I can give. I ask the family to support the patient in accepting referral. Sometimes the patient listens to the family even when they will not listen to me. The family can also help with transport money for the hospital visit or can remind the patient to take medication. Family involvement has saved many patients who were ready to give up." (ki30, Social Worker, Female, 44 years)*

A nurse from Kuwadzana Poly Clinic added:

> *"Family members are often the ones who notice when a patient is getting worse. If I can educate the family about what to look for, they can bring the patient back before it becomes a crisis. I also ask families to accompany the patient to the hospital for step-*

up appointments. Having a family member there reduces the patient's anxiety and increases the chance that they will attend." (ki20, Nurse, Female, 50 years)

These extracts illustrate the strategy of involving family members in treatment. This strategy is particularly relevant from a social work perspective, as social work practice emphasises the importance of the client's social environment and support systems. The strategy aligns with the resilience in healthcare framework presented in Chapter Two, which emphasises that resilience is not merely an individual trait but an emergent property of the entire system, including family networks. In the Zimbabwean context, where extended family remains central to social life, involving family members may be more effective than individual-level interventions alone.

4.5.6 Analysis and Discussion of Findings on Strategies

The findings on strategies employed by practitioners reveal a portfolio of innovative, low-cost strategies developed by practitioners themselves to navigate the resource-constrained environment. The most frequently used strategy was peer consultation via WhatsApp groups, which provides real-time decision support in the absence of formal supervision. Paper-based tracking logs, while low-technology, provide an external memory aid that anchors practitioners to analytical reasoning rather than intuition.

Comparing these findings with the literature, there is strong convergence with the strategy portfolios described by Nilsen et al. (2023) in Sweden and Norway, who identified numerous distinct strategies across individual, team, and organisational levels. However, the specific strategies used in Harare are adapted to the resource-constrained context. While Swedish practitioners used strategies such as self-directed learning through online tutorials and proactive time management using digital templates, Harare practitioners use WhatsApp groups and paper logs. The creativity and resourcefulness of Harare practitioners in developing these strategies under conditions of extreme constraint is remarkable and deserves recognition.

4.6 Coping Mechanisms and Support Systems for Mental Health Practitioners

This section presents findings related to an additional theme that emerged from the data but was not originally formulated as a separate objective. During the semi-structured interviews and focus group discussions, participants were asked about the coping mechanisms they use, what support systems are currently in place for staff, and how effective these support systems are.

4.6.1 Informal Peer Debriefing with Colleagues

When asked about how they cope with the emotional demands of their work, the majority of participants described relying on informal support from colleagues. A nurse from Budiriro Satellite Clinic explained:

> *"After a difficult day, when a patient has died or when I have failed to help someone who really needed stepping up, I talk to my fellow nurses. We sit in the tea room and we cry together. We say, 'This work is too heavy.' Then we say, 'But we must continue because there is no one else.' That is how we cope. We do not have a counsellor for us. We do not have debriefing sessions. We have each other." (ki3, Nurse, Female, 43 years)*

A counsellor from Kuwadzana Poly Clinic added:

> *"My colleagues are my therapists. When I have a patient who died by suicide, I cannot just go home and pretend everything is fine. I need to talk about it. I need someone to tell me that I did my best, that it was not my fault. My colleagues do that for me. We have an informal agreement that we will always make time for each other when someone is struggling. Without that, I would not last a year in this job." (ki9, Counsellor, Female, 33 years)*

These extracts illustrate the centrality of informal peer debriefing as a coping mechanism in the absence of formal psychological support for practitioners. This finding is consistent with Ellis et al. (2023) in South Africa, who found that team-level resilience practices, including mutual support and task shifting, significantly reduced burnout among mental health practitioners. However, the reliance on informal support is problematic because it places the burden of coping on practitioners themselves rather than on the employing organisation.

4.6.2 Emotional Numbing and Detachment

Some participants described using emotional numbing and detachment as a way to protect themselves from the emotional weight of their work. A community health worker explained:

> *"I have learned not to get too attached to my patients. If I care too much, it hurts too much when they get worse or when they die. So I keep a distance. I do my job, I give the best care I can, but I do not let myself feel too deeply. Some people might say that is cold, but it is the only way I can survive. If I felt everything, I would break." (ki23, Community Health Worker, Female, 49 years)*

A nurse from Glenview Poly Clinic shared a similar perspective:

> *"You cannot carry every patient's pain with you. You would drown. So you learn to compartmentalise. At work, you are a professional. You help. You care. But when you leave, you close the door on those feelings. Sometimes that is hard. Sometimes the feelings leak through. But you keep trying to close the door. It is the only way to keep going." (ki17, Nurse, Female, 36 years)*

These extracts reveal that emotional numbing and detachment are used by a significant number of practitioners as coping mechanisms. This finding is concerning because emotional numbing is a symptom of burnout and compassion fatigue. As Maslach's burnout theory would predict, practitioners who cannot access adequate resources to meet job demands will experience emotional exhaustion, depersonalisation, and reduced personal accomplishment. The current study suggests that many Harare practitioners are already experiencing these symptoms.

4.6.3 Religious and Spiritual Practices

When asked about coping mechanisms, many participants described relying on religious and spiritual practices. A community health worker explained:

> *"Sometimes I go home and I cannot eat. I see the faces of my patients who are suffering, who I cannot help because we have no medication, who I refer and they never come back. I ask God, 'Why did you put me in this work if I cannot help?' Then I pray and I read my Bible. I ask God to give me strength for tomorrow. That is the only way I can come back to work. If I did not have my faith, I would have left long ago." (ki23, Community Health Worker, Female, 49 years)*

A nurse from Budiriro Satellite Clinic added:

> *"My faith keeps me grounded. When I have done everything I can for a patient and they still suffer, I trust that God has a plan. I pray for my patients. I pray for myself. I attend church every Sunday. The church community supports me. They pray for me. They ask how my work is going. Without my faith, I would feel very alone in this work." (ki2, Nurse, Female, 38 years)*

These extracts illustrate the role of religious and spiritual practices as a coping mechanism. This finding is consistent with the broader Zimbabwean context, where religion and spirituality are central to daily life and are often the first source of support for both patients and practitioners facing distress. However, the reliance on spiritual coping in the absence of

organisational support is concerning, as it suggests that practitioners are expected to manage their own psychological distress without professional help.

4.6.4 Absence of Formal Support Systems

When asked about the support systems currently in place for staff, participants overwhelmingly reported that formal support systems were either nonexistent or ineffective. A counsellor from Glenview Poly Clinic stated:

> *"There is no support system for us. We are expected to help patients, but no one helps us. We have a supervisor in name, but I have not seen her in six months. There is no employee wellness programme. If I am struggling, I cannot go to my manager because she is also struggling. There is no budget for practitioner support. We are on our own."(ki12, Counsellor, Female, 36 years)*

A nurse from Kuwadzana Poly Clinic added:

> *"We are supposed to have clinical supervision once a month, but it never happens. The psychiatrist who is supposed to supervise us is based at the hospital and is too busy. The last time we had supervision was eight months ago. And even then, it was not really supervision. It was just the psychiatrist telling us what we were doing wrong, not supporting us or helping us with difficult cases."(ki8, Nurse, Female, 46 years)*

A community health worker expressed frustration:

> *"What support? There is no support. We are told to attend a workshop once a year if there is funding. That is not support. That is training. Support means someone checking on us regularly, asking how we are doing, helping us with difficult cases, giving us time to recover after something bad happens. We have none of that. The system is using us until we break, and then they will replace us with another worker." (ki26, Community Health Worker, Female, 31 years)*

These extracts reveal the complete absence of formal organisational support for mental health practitioners in Harare's primary care clinics. This finding is consistent with Mavhu et al. (2024), who found that only a minority of clinics in Harare province had any form of supervision arrangement with a psychiatrist or psychiatric nurse. This finding is also consistent with the statutory framework reviewed in Chapter Two, which noted that the Labour Act and the Health Service Act do not specifically address mental health practitioners' wellbeing, burnout prevention, or caseload limits.

4.6.5 Analysis and Discussion of Findings on Coping Mechanisms

The findings on coping mechanisms and support systems reveal that practitioners rely primarily on informal, peer-based coping mechanisms in the absence of formal organisational support structures. Informal peer debriefing was the most frequently reported coping mechanism, followed by emotional numbing and detachment, and religious and spiritual practices.

The finding that practitioners rely on emotional numbing and detachment is particularly concerning because it represents a maladaptive coping mechanism that may protect practitioners in the short term but leads to depersonalisation, reduced empathy, and poorer quality of care in the long term. As Maslach's burnout theory would predict, practitioners who cannot access adequate resources to meet job demands will experience emotional exhaustion, depersonalisation, and reduced personal accomplishment. The current study suggests that many Harare practitioners are already experiencing these symptoms.

The absence of formal support systems represents a systemic failure that places practitioners at risk of burnout, compassion fatigue, and secondary traumatic stress. This situation is unsustainable in the long term, as practitioners will eventually experience burnout and leave the profession, further exacerbating the workforce shortage. As Gwirayi and Shumba (2025) noted in their Harare study, practitioners described developing emotional numbing as a coping mechanism, which they recognised as problematic but felt was necessary for survival.

4.7 Chapter Summary

This chapter has presented, analysed and discussed the findings from the fieldwork conducted with 30 mental health practitioners in three primary care clinics in Harare, Zimbabwe. The demographic characteristics of participants revealed that the mental health workforce in these settings is predominantly female , mid-career aged 35-44 years, diploma-level qualified , and married . Findings paint a picture of dedicated, resilient practitioners who are implementing stepped-up care under extremely challenging conditions, using their creativity and peer networks to fill the gaps left by a failing health system. However, the findings also reveal significant threats to the sustainability of stepped-up care in Zimbabwe, including the absence of basic medications, broken referral pathways, lack of formal training and supervision, and the complete neglect of practitioner wellbeing. These findings have important implications for policy, practice, and future research, which will be discussed in Chapter Five.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0Introduction

The chapter presents a detailed account of the key findings from the research into the experiences of mental health workers in implementing the stepped up care model for common mental health conditions. This chapter consists of three parts: summary of key findings aligned with the study's findings and research questions. The second section presents the conclusions from the analysis, both theoretical and practical, of the findings.The final section offers recommendations based on the evidence, which inform the process of developing policy and program and conducting future research.

5.1 Summary of findings

This sections provides a comprehensive synthesis about the key findings that emerged from the study on the experiences of mental health practitioners in utilising the stepped up care model for common mental health disorders. The findings of this study are presented in the sequence given in the objective of the study. Findings include challenges faced by mental health practitioners in utilizing the stepped up care model for common mental health disorders, how mental health practitioners understand stepped up care model for common mental health disorders and also the strategies used by mental health practitioners to overcome challenges in delivering stepped up care for common mental health disorders. The following is a summary of these findings.

5.1.1 Challenges faced by mental health practitioners in utilizing the stepped up care model for common mental health disorders

One of the major barriers is frequent medication stock-outs, which disrupt continuity of care and negatively affect patient outcomes. When essential psychotropic medications are unavailable, practitioners are unable to provide timely and effective treatment, leading to relapse, worsening symptoms, and reduced patient trust in health services. These shortages also limit the ability of healthcare providers to appropriately escalate care for patients whose conditions require pharmacological intervention.

Another significant challenge is the lack of clear stepped-up care guidelines and protocols. In many healthcare settings, practitioners do not have standardized frameworks to guide decision-

making regarding when and how to intensify treatment. This creates inconsistencies in patient management and may result in delayed referrals, under-treatment, or inappropriate escalation of care. Without structured guidelines, practitioners often rely on personal judgment, which can vary widely depending on experience and training.

High patient-to-practitioner ratios further compromise the effectiveness of stepped-up care models. Mental health professionals are frequently overwhelmed by large caseloads, leaving limited time for comprehensive assessment, follow-up, and individualized care planning. The heavy workload contributes to burnout among practitioners and reduces the quality of mental health services provided. As a result, patients may experience long waiting times, brief consultations, and inadequate monitoring of treatment progress.

5.1.2 Level of understanding of mental health practitioners to stepped up care model for common mental health disorders

. Frequent stock-outs of medication is one of the major challenges that is hampering continuity of care and affecting patient outcomes. Without availability of essential psychotropic medications, practitioners cannot offer timely and effective treatment, resulting in reversion, exacerbation, and less faith in health services. Such deficits also constrain healthcare providers' capacity to adequately escalate care of patients when pharmacological intervention is required.

There is also a lack of clear stepped-up care guidelines and protocols. Many health care providers have no standardized decision-making processes for when and how to escalate treatment. This leads to gaps in patient care and can cause significant delays in referrals, undertreatment or over treatment. When there is no systematic framework, practitioners may depend on their own experience and training, and can have widely different perspectives on their practice.

Stepped-up care models are further undermined by high patient to practitioner ratios. Mental health providers often have high caseloads, and have limited time for detailed assessment, follow-up, and personalized care planning. The burden of work leads to burnout among practitioners, and it decreases the quality of mental health services offered. This can lead to patients waiting longer than necessary, having shorter appointments and not being monitored as well as they could be when they begin treatment.

Lack of training and skills among health workers is also a major barrier. Many practitioners, particularly in primary health care, may not have specific training in mental health assessment,

psychosocial interventions, and stepped-care approaches. This reduces their self-confidence and self-competence to handle typical mental health problems and to seek help when needed. These gaps are also exacerbated by the lack of continuous professional development opportunities, and make it challenging to integrate mental health services into routine health care.

Lastly, poor institutional and supervisory assistance is a challenge to the successful implementation of stepped up care. Mental health professionals frequently operate in resource-constrained, poorly resourced and managerially under-supported settings. Not having multidisciplinary support, mentorship and psychological support of healthcare workers may also decrease their job satisfaction and motivation. Practitioners may not have the necessary supports to provide holistic, patient-centred care in line with the principles of stepped up care models without proper supports.

5.1.3 Knowledge of mental health practitioners about stepped up care for common mental health disorders

There is significant variation in the knowledge of the stepped-up care model among mental health workers in health care workplaces. Some practitioners show an adaptive understanding of the model, by offering the use of the principles of stepped up care flexibly to meet the patient's needs, the availability of resources and the nature of mental health problems. These professionals understand the need to scale up care in a graduated fashion, starting with low intensity measures and increasing to more specialized services if patients are not responding well. Their knowledge is often related to experience and linked with patient-centered thinking and clinical judgment.

Other practitioners have an understanding from an operational perspective. This group understands the process and procedures of stepped-up care including screening, referral, follow-up plan and criteria for stepping up treatment. They can recognise the need for a change in care setting for a patient and comprehend the need for reviewing outcomes of treatment. But their grasp may be more technical than conceptual, largely concerned with implementing requirements, instead of philosophy of stepped-up care.

Few mental health professionals have only a basic definition-level understanding about stepped-up care. They might just refer to it as a stepped care program where patients are moved from lower level to higher level of care according to their condition or response to care. They

are familiar with the overall model, but may not be knowledgeable of the specifics of how the model will work in the actual clinical setting such as coordinated care planning, evidence-based interventions, and multidisciplinary teamwork. This is a limited understanding can impact quality and uniformity of service delivery.

There are others who exhibit a lack of knowledge or understanding about the stepped up care model. This may belong to people who have no knowledge of the concept of at all or mix it up with regular referral systems and/or standard mental health services provision. The lack of training exposure and limited dissemination of policies and lack of mentorship are some of the factors that lead to this lack of knowledge. This can make it difficult for practitioners who are unfamiliar with stepped-up care to make the appropriate assessment, monitoring and escalation of patient care, which can impact the quality and continuity of mental health services.

5.1.4 Strategies for mental health practitioners to address issues in providing stepped up care for common mental health disorders

In the face of constraints on resources, mental health providers have a number of practical ways to improve the effectiveness of stepped-up care approaches. Peer consultation and collaboration among health care workers is one important strategy. Practitioners have the opportunity to share experiences, ask for advice and support in difficult cases and enhance the quality of their decision making relating to when to escalate or adapt patient care through regular case discussions, mentorship and team working. Peer support also helps to counteract professional isolation and to foster lifelong learning, particularly if there are fewer specialist mental health professionals available.

A good support plan is also to involve family members in the treatment plan. Families have valuable roles to play in helping to keep track of symptoms, remind patients to take medication, and ensure follow-up appointments. Engaging family members also enhances communication between the practitioner and the patient, giving a clearer picture of the patient's home and social context and addressing their social and psychological needs. Family involvement may help to support continuity of care and aid in the identification of decline which could need escalation of treatment.

In the event of a shortage of medications, mental health practitioners can also ask pharmacies, non-governmental organisations (NGOs) or pharmaceutical companies for samples and shortage drugs. This approach can be used to ensure continuity of treatment of patients who

cannot afford medication or where healthcare facilities run out of medication. These partnerships, while not a cure-all, can help decrease treatment disruptions and enhance treatment outcomes in resource-limited communities.

Last, paper tracking logs and monitoring tools can help practitioners make informed decisions for step up care. Simple record-keeping systems can be a useful way of recording the patient's progress, treatment responses, missed appointments and referral requirements. These tracking logs enable practitioners to review cases in a systematic way and identify patients for which further interventions are needed and/or specialist referral needed. When electronic health records are not present, paper health records are an economical and convenient way to facilitate continuity, accountability, and timely changes in care.

5.2Conclusions

Based on the result of the research, the study made the following conclusions:

In this study, the challenges encountered by mental health practitioners who adopted the stepped up care model for common mental health disorders were explored. They found there were multiple systemic barriers that impact the implementation of stepped-up care as a way to enhance mental health service delivery. Medication stock-outs, shortage of mental health providers, lack of institutional support, and lack of clear stepped-up care guidelines were cited as significant challenges that inhibit the effectiveness of ongoing mental health interventions and mental health care continuity.

This study also found that the mental health professionals' knowledge about the stepped up care model varies. Some practitioners showed adaptive understanding and were able to flexibly use the model as required by patients, and available resources. Others demonstrated operational understanding primarily around procedures (referrals and treatment escalation), and some practitioners had only a basic understanding or no understanding of operational procedures. The results of this study indicate that there is a need to develop and implement more extensive education and training programs to enhance practitioners' knowledge and confidence in the use of stepped-up care approaches.

The results also pointed to the effects of workforce problems on mental health services provision. Increased workload pressures, decreased consultation time and implications for the

quality of patient care were identified as being associated with high patient-to-practitioner ratios. In addition, gaps in training and skills of healthcare providers restricted their ability to assess, monitor and manage common mental health disorders. The study thus highlights the need to build the human resources capacity through ongoing professional development and supervision.

In addition, a number of coping mechanisms employed by mental health practitioners to deal with the constraints of their workplaces emerged from this study. Peer consultation, use of family members in patient care, negotiating drug samples from pharmacies, and paper tracking systems were cited as helpful strategies that are practical to assist in continuity of care and informed decision making. The strategies highlight practitioners' dedication and flexibility to providing mental health services to patients even in the face of limited resources.

Finally, the study illustrates that a coordinated approach at the policy and institutional level is needed to implement the stepped up care model in a successful manner. Funding, secure supply of medication, guidelines on implementation, and more training for healthcare professionals are needed for mental health services. Improving collaboration between practitioners, healthcare institutions, families and policy makers will help to enhance mental health outcomes and better service provision of stepped-up care for those with common mental health disorders.

5.3Implications for social work practice

The findings of the experiences of mental health practitioners in providing stepped up care have significant implications for the practice of social work. These implications are far-reaching, concerning method of practice, training needs of practitioners and ethical issues. The following is an outline of the impact of each domain.

5.3.1Social Work Methods And Approaches

This study highlights the need for a range of social work techniques and approaches to implementing stepped-up care for common mental health problems. The results underscore the importance of casework for the individual assessment, intervention, and follow-up care of patients with mental health issues. Throughout group working approaches, peer support, psychoeducation and collaborative problem-solving between practitioners and patients are also

important. The study also highlights the role and importance of the community work approach, such as in the field of family involvement, building supportive structures and raising awareness about mental health services among communities. The study also demonstrates the significance of the systems theory and person-in-environment approach, which emphasizes the social, economic, family and institutional dimensions that affect mental health.

5.3.2 Training and capacity building of social workers

Clinics' social workers play a critical role in supporting effective mental health service delivery and enhancing mental health outcomes. To be able to provide effective support to people with common mental health conditions, social workers need to be continually trained in mental health assessment, psychosocial interventions, counselling skills, crisis management, case management and referral systems. Capacity needs should also include improving the knowledge of stepped-up cares principles (such as monitoring the patient, treatment escalation decision-making, and working co-operatively with other health care professionals). Additionally, social workers should be able to document, utilize monitoring tools, engage families, advocate and mobilize resources for continuity of care. Continuous professional development, peer consultation, mentorship and supervision are also crucial in enhancing social workers' competence, confidence and resilience in their clinical work, especially in resource-poor and time-poor settings.

5.3.3Ethical Considerations In Practice

This study identifies a number of relevant ethical issues in clinical practice in the context of the stepped-up care model for common mental health disorders. The results highlight the importance of confidentiality and privacy in the management of the patient's sensitive data, especially in assessment, treatment, referral and follow-up. The study also highlights the need for informed consent – informing patients of what they are being offered, what they are being referred to and what they are being asked to do if they are asked to take steps forward in their care. Supporting patient dignity, autonomy, and culture values was identified as central to ensuring the patient-centred caring approach and developing trust between practitioners and patients. Moreover, the study identifies ethical issues of inequity and access issues to care, particularly in the context of medication stock-outs, limited resources and high patient to practitioner ratio, that can potentially impact the timeliness and quality of service provision.

The results also highlight the necessity of professionalism, responsibility, and proper supervision to provide mental health care safely and ethically in clinic environments.

5.4 Recommendations

This section offers a series of specific recommendations based on the study's results. The recommendations are targeted to key stakeholders such as government, communities, researchers and extension officers. The intent and goal of these recommendations is to assist in evidence based decision making, inclusive development and effectiveness of interventions in the study area.

5.4.1 Recommendations to the government

Investing more resources in mental health care in primary health care systems to implement the stepped up care model for common mental health conditions would increase the quality of implementation. Greater resources to mental health care in primary health care systems would increase the quality of implementing the stepped up care model for common mental health conditions. This involves employing and keeping a larger number of mental health practitioners including social workers, psychologists, psychiatric nurses and psychiatrists, which helps to cut the ratio of patient to practitioner. The government should also enhance work environments, offer supportive supervision and ensure ongoing professional development, making practitioners aware of and proficient in using stepped-up care approaches to effectively manage mental disorders.

The government must continue to improve and share step up care policies, guidelines and referral protocols that are being used in clinics and health care institutions. Standardisation of guidelines would facilitate informed decisions around the assessment, treatment, referral and escalation of care of patients. Further, there is a need to enhance training and capacity building initiatives on mental health assessment, psychosocial interventions, case management and collaboration between the different disciplines. These would help to enhance the uniformity and quality of mental health care delivered in various health care contexts.

The government should also focus on resource issues, including improving the systems of medications, and maintaining regular supplies of essential psychotropic medicines in clinics. Opportunities for financing infrastructure, early intervention and patient monitoring systems are needed to promote continuity of care and early intervention. Moreover, public mental health

awareness raising programmes to combat stigma and early help seeking should be promoted by the Government. The development of inter-institutional, inter-community and inter NGO collaboration can also improve the support systems of people with common mental health conditions.

5.4.2Recommendations to the community

To ensure the stepped-up care model for common mental health disorders is put into practice, communities need to be an active part in increasing the awareness around mental health and decreasing the stigma around mental illness. Signs and symptoms of common mental health disorders and the need to seek early professional help should be taught to community members, community leaders, and community organizations. Raising awareness can help people use mental health services without discrimination concerns, thereby making it easier to provide early and effective intervention and treatment. Communities should also cultivate a positive climate that allows people to feel accepted, included and emotionally supported when they are struggling with mental health issues.

Family and social support systems should be further strengthened within the community to support people accessing mental health care. It is important for family members and carers to be involved actively in treatment processes, supporting their adherence to treatment, attending follow-up appointments and observing changes in patients' behavior and wellbeing. There are also other people who can offer emotional and practical support through community support groups, peer networks and local initiatives who will have people with common mental health conditions. This engagement can contribute to better continuity of care, alleviation of isolation and better recovery outcomes in patients' social settings.

Communities should also partner with health facilities, social workers, and other mental health service providers for better access to mental health services. Community leaders and organizations can help raise awareness, provide support for outreach, and help promote better mental health care in clinics and health care facilities. Communities would also like to see the development of safe places and programs to support mental wellbeing, resilience, and psychosocial supports, especially for vulnerable populations. Increased community involvement and collaboration can play a major role in helping to successfully implement stepped-up care models and enhance overall mental health outcomes.

5.4.3 Recommendations for extension officers

Extension officers need to have a basic understanding and skill set in mental health awareness and the stepped-up care model, to be able to help people in the community. Programs should be developed for extension officers to recognize symptoms and signs of common mental health issues, be able to deliver basic psychosocial support, and be able to make referrals to clinics and mental health professionals if needed. As they learn more about mental health problems, they will be better able to recognize mental health concerns and intervene at the early level, including in underserved and rural communities where mental health services might be unavailable or limited.

Extension officers should also engage very closely with health care workers, social workers, community leaders and families to raise awareness about mental health and alleviate stigma in their communities. Extension officers can educate the public through outreach, awareness and community engagement programs to encourage seeking mental health support and following treatment. Their engagement may help build trust between communities and healthcare providers, facilitate patient referrals, and support patients to seek appropriate levels of care.

Extension officers also need to be well-resourced, well-supervised, and well-referral to be able to effectively fulfil their role in providing mental health support and linking into communities. Continuous capacity building workshops, information materials and organized referral guidelines should be provided by the government or healthcare institutions to help extension officers keep track of vulnerable people in the community and follow up. Extension officers can play an important role in strengthening the continuum of care, bolstering the psychosocial support systems and supporting the improvement of the mental health of clients with common mental health disorders, if mental health services are strengthened.

5.4.4Recommendations for further research

Further studies are recommended to investigate the long-term effectiveness of the stepped-up care model in addressing common mental health disorders in various health care systems. To evaluate patient outcomes, future research is needed to examine how stepped-up care impacts mental health over a longer term, reduces relapse rates, and enhances quality of life. Comparative research between the rural and urban clinics may also reveal greater understanding of contextual factors that affect the implementation and success of the model.

There is also a need for research that is more focussed on the experiences and perspectives of the various stakeholders involved in stepped-up care, such as patients, carers, social workers, nurses and policy makers. These types of studies could be helpful in identifying areas of inadequate service delivery, communication issues, and challenges to effective collaboration in multi-disciplinary teams. Additionally, more studies are needed to explore how training and capacity building interventions affect practitioners' competence and confidence in the use of stepped-up care principles in actual clinical practice.

Furthermore, the effect of resource availability (e.g., medication supply systems, staffing levels and supervisory arrangements) on successful implementation of stepped-up care models should be explored in future studies. New interventions could include digital health tools, community-level interventions and task shifting to enhance service provision in resource-poor environments. These areas, with enhanced evidence base, will help to foster more effective, contextually appropriate and sustainable mental health care systems.

5.4.5 Social work based recommendations

Social work recommendations for the effective and efficient implementation of the stepped-up care model include: enhancing the professional role of social workers in mental health service provision. Training needs in psychosocial assessment, counselling, case management, crisis intervention and referral systems are needed, to enable social workers to identify and respond to the different levels of mental health need. There should be a greater emphasis on continuous professional development and supervision to develop confidence and competence in using the stepped-up care approach in clinical and community settings.

Social workers are also encouraged to have a person-in-environment and strengths-based orientation towards clients. This includes evaluating the person's symptoms as well as their family, social, cultural and economic environment which can affect how they feel. Treatment plans must be implemented in a way that empowers active involvement in the family/carers and community support systems for recovery, to minimise risk of relapse and continuity of care. Advocacy is also important, enabling social workers to rectify issues like medication supply, stigma and access to services.

In addition, social workers need to strengthen partnerships with other multi-disciplinary teams such as community health workers, nurses, psychologists and psychiatrists for coordinated

stepped-up care delivery. Progress monitoring and timely decision making regarding care escalation strongly relies on improved documentation, tracking tools and attendance at case review meetings. Social workers should also undertake community outreach and mental health education to combat stigmatisation and encourage early help-seeking. These stepped-up social work roles will enhance the effectiveness, availability and sustainability of care for those with common mental health disorders.

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APPENDIX ONE: Data Collection: Semi structured Interview Guide

Project Title: EXPERIENCES OF MENTAL HEALTH PRACTITIONERS IN PROVIDING THE STEPPED UP CARE MODEL FOR COMMON MENTAL HEALTH DISORDERS IN PRIMARY HEALTH CARE IN HARARE, ZIMBABWE

SECTION A: Background Information

1. Can you tell me about yourself including your role, experience and area of work?

2. Can you describe your involvement in providing stepped up care to clients with common mental health disoders?

SECTION B: Experiences of Mental Health Practitioners In Providing Stepped Up Care For Depression

1. What are the common experiences of mental health practitioners in providing stepped up care?

2. What challenges do mental health practitioners face in providing stepped up care services?

3. How do these challenges affect their performance and wellbeing?

SECTION C: Copying Strategies and Support

1. What copying mechanisms are commonly used by mental health practitioners in providing stepped up care?

2. What support systems are currently in place for staff?

3. How effective are these support systems?

APPENDIX 2: FOCUS GROUP DISCUSSION QUESTIONS

SECTION A: CHALLENGES AND BARRIERS

1. What are the common challenges that mental health practitioners face when providing stepped up care for common mental health disoders?

2. What training gaps affect your ability to provide stepped up care?

3. What barriers exist in your organization when trying to refer clients to higher levels of care?

SECTION B: EFFECTIVENESS AND SUSTAINABILITY

1. What do you understand by the different levels of care in treating common mental health disorders?

2. As a professional, when do you think it is necessary to step up care for a patient with a common mental health disorder?

4. What types of interventions are involved when stepping up care for common mental health?

SECTION C: COPYING STRATEGIES

1. What strategies do you use to overcome challenges when providing stepped up care?

2. How do you handle situations where referral systems are slow or ineffective?

3. What strategies do you use to support patients who are reluctant to accept higher levels of care?

APPENDIX 3: Consent Form

Consent to take part in research.

I voluntarily agree to take part in this research by Nissi . P.Binton , student at Bindura University of Science Education. Your information is vital in the progression of this research and my academics therefore, your cooperation is greatly appreciated. I agree to my interview

being audio recorded and l have read and understood the nature of the research, its objectives, prons and cons.

The research is voluntary which means no payment or remunerations are going to be made. Ethical considerations will be prioritized for your privacy especially confidentiality .You are encouraged to drawback if you feel uncomfortable. Above all none of the information provided during the interview will be published to anyone even to you directly. .Therefore, the information gathered will be used for academic purposes only.

Signature of Research Participant……..

Name……..

Date……

Signature of Researcher……..

Name…….

Date……..

CITY OF HARARE

All correspondence to be addressed to the
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Ref:- 3/7

Your Ref:-

CITY HEALTH DEPARTMENT
ROWAN MARTIN BUILDING
D.H.S.S
30 APR 2026
D.H.S:

30 April 2026

Nissi Patricia Binton
15999 Kuwadzana 1
HARARE

Dear Nissi Patricia Binton

RE: APPLICATION FOR PERMISSION TO CONDUCT A STUDY TITLED: EXPERIENCES OF MENTAL HEALTH PRACTITIONERS IN UTILIZING THE STEPPED UP CARE MODEL FOR COMMON MENTAL HEALTH DISORDERS IN PRIMARY HEALTH CARE IN HARARE

I refer to the above subject matter.

Permission has been granted for you to conduct a study titled **Experiences of mental health practitioners in utilizing the stepped up care model for common mental health disorders in primary health care in harare**

Please note that you will be expected to share your study findings with the City Health Department through the Director's office.

Do Not Hesitate to contact the Ethics Committee for any Assistance you may require.

Yours Faithfully

pp

DIRECTOR OF HEALTH SERVICES
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