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Barriers to Accessing Mental Health Services Among Emerging Adults with Co-occurring Substance Use and Mental Disorders in Coastal Kenya: A Qualitative Study

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Abstract
A substantial proportion of adults who use drugs also experience co-occurring mental health disorders. Evidence from high-income countries highlights persistent challenges in accessing mental health services among this population. However, limited empirical data exist on the barriers faced by emerging adults (EAs), aged 18–29 years, in Kenya, particularly those with substance use disorders (SUD). This study aimed to explore the barriers to mental health service access among EAs who use substances in coastal Kenya. A cross-sectional qualitative design was employed across Mombasa, Kilifi, and Kwale counties. Data were collected through nine focus group discussions (FGDs) involving 88 participants. Interviews were guided by a semi-structured protocol, audio-recorded, transcribed, and analysed thematically using NVivo 11. Findings revealed a range of individual, community, and health system barriers. Key themes included perceived stigma, negative attitudes from healthcare workers, financial constraints related to medication and transportation, limited awareness of mental health services, and a preference for traditional and faith-based healers. Participants also cited a shortage of mental health professionals and treatment facilities. To address these barriers, the study recommends multilevel interventions including community-based mental health education to reduce stigma, integration of mental health services into primary care to improve accessibility, capacity-building of health professionals to enhance responsiveness, and collaboration with traditional and faith healers to strengthen referral pathways. These strategies should be tailored to the needs of emerging adults and coordinated by stakeholders such as the Ministry of Health, NACADA, faith-based leaders, and civil society organisations.

Introduction
Mental disorders (MDs) represent a significant global public health concern. According to the World Health Organisation (2020), approximately one in eight individuals worldwide experiences a mental health disorder, making MDs a leading cause of years lived with disability. Despite their high prevalence, a substantial treatment gap persists—particularly in low- and middle-income countries (LMICs), where between 82% and 98% of individuals with mental health conditions do not receive appropriate care (Atilola, 2016; Saade et al., 2023).

In Kenya, access to mental health services remains critically limited. Kwobah et al. (2017) found that only 1.7% of individuals in a sample of 191 participants had accessed mental health services, despite 45% presenting with symptoms of mental illness. This mirrors broader trends in sub-Saharan Africa, where up to 98.8% of individuals in need of mental health care remain untreated.

Globally, individuals who use substances are at heightened risk of developing mental health disorders (United Nations Office on Drugs and Crime, 2023; World Health Organisation, 2022). Studies from high-income countries consistently report high rates of co-occurring substance use disorders (SUDs) and mental illnesses such as depression and anxiety (Ornell et al., 2021). This dual burden complicates diagnosis, treatment, and long-term recovery, underscoring the need for integrated care models. Yet, only 18% of SUD treatment programmes and 9% of mental health facilities in the United States are equipped to manage co-occurring conditions (National Institute on Drug Abuse [NIDA], 2021).

In Kenya, there is a notable paucity of data on access to mental health services among emerging adults (EAs), aged 18–29 years, who live with co-occurring SUDs and mental disorders. This evidence gap hinders the development of targeted interventions. The present study seeks to examine the barriers faced by EAs with SUDs in accessing mental health services in coastal Kenya. Findings from this research will inform policymakers and practitioners on strategies to improve service delivery and ensure equitable access to quality mental health care for this vulnerable population.

Method

Study design

This paper is part of a larger study aimed at exploring the co-occurring MDs among EAs using substances. The current research focuses on examining the barriers faced by EAs who use substances in accessing mental health services. A cross-sectional qualitative approach was used.

Study area

This study was conducted in Medically Assisted Therapy (MAT) Clinics, drug treatment centres and drop-in centres in Mombasa, Kilifi and Kwale Counties of the Coastal Kenya. The MAT clinics are government-run substance use facilities, while drop-in centres and substance use rehabilitation centres are run privately.

Study population

This study involved EAs aged 18-29 years who use substance for not less than 12 months, caregivers of the EAs (spouse, parent, sibling, or family member who have stayed with EAs during his/her active period of substance use), and the service providers (addiction counsellors, psychologists, social workers, clinicians, nurses, pharmacists, pharmaceutical technologists, laboratory technologists, and outreach workers) with not less than 12 months of a similar work.

Sample size and sampling

Study participants were recruited from MAT clinics, drop-in centres, and substance use rehabilitation facilities. A total of nine focus group discussions (FGDs) were conducted, each comprising approximately 9 to 10 participants, resulting in an overall sample size of 88 individuals.

To ensure diverse perspectives, three FGDs were held in each county, targeting three distinct participant categories: caregivers, service providers, and emerging adults. Each category was represented by one FGD per county. This structure allowed for the exploration of varied experiences and insights across different stakeholder groups.

Purposive sampling was employed to recruit participants who were well-informed and directly involved in substance use and mental health service contexts. This approach was chosen to capture rich, heterogeneous data relevant to the study's objectives.

Data collection

All focus group discussions (FGDs) were facilitated by the first author and lasted approximately 60 to 100 minutes. Two trained research assistants (RAs), with prior experience in conducting qualitative interviews, supported the sessions by taking notes and managing audio recordings. The FGDs were conducted across three drop-in centres and four government-run MAT clinics located in Mombasa, Kilifi, and Kwale counties.

Interviews were conducted in Kiswahili and English, or a combination of both, depending on participants' language preferences. To ensure confidentiality and protect participant identity, each individual was assigned a unique number for use during the discussions in place of their name.

A semi-structured interview guide was developed in both English and Kiswahili to explore participants' perceptions of the challenges and barriers to accessing mental health services among EAs who use drugs. The guide included a demographic section capturing sex, age, education level, marital status, and occupation. Its development was informed by a review of relevant literature and consultations with experienced local practitioners in substance use and mental health, each with over five years of field experience.

Data analysis

Thematic analysis was selected as the most appropriate method for this study, given its effectiveness in identifying, analysing, and reporting patterns within qualitative data (Braun & Clarke, 2006). The analysis followed the six-phase framework outlined by Braun and Clarke, ensuring a systematic and rigorous approach.

The first author led the data analysis process, beginning with familiarisation through transcription, translation, and repeated reading of the transcripts. During this phase, initial impressions and reflections were documented. Subsequently, initial codes were generated and systematically applied to relevant segments of the data. These codes were then organised into potential themes and sub-themes, with input and guidance from the co-authors to enhance analytical depth and consistency.

The development of themes was iterative, involving continuous refinement to ensure they accurately captured the underlying meanings and patterns in the data. NVivo 11 software was used to facilitate data management and coding throughout the analysis process.

Ethical considerations

Ethical approval to conduct this study was granted by the Institutional Ethics and Research Commission (IERCs) of United States International University – Africa (USIU-A), under approval number USIU-A/IERC/US127-2024. In addition, a research permit was obtained from the National Commission for Science, Technology and Innovation (NACOSTI), Licence No: NACOSTI/P/24/38249.

Before participation, all individuals were provided with a written informed consent form. The purpose of the study was clearly explained, and participants were allowed to ask questions and seek clarification. Consent was obtained only after participants demonstrated complete understanding and voluntarily agreed to take part in the study. Measures were taken to ensure confidentiality and anonymity throughout the research process.

Results

This section presents the socio-demographic characteristics of the study participants, followed by key findings on the challenges and barriers to accessing mental health services.

Of the 88 participants involved in the focus group discussions, 45 (51%) were male, indicating a relatively balanced gender distribution (see Table 1). The majority of participants were married (56%)

and 48% reported being employed. The elevated employment rate was primarily attributed to the inclusion of service providers among the participant groups.

Table 1: Socio-Demographic Characteristics of the Participants (N = 88)

Characteristic	Frequency (n)	Percentage (%)
Gender	Male: 45	51%
	Female: 43	49%
Age Group	18 – 24: 12	14%
	25 – 34: 44	50%
	35 – 44: 14	16%
	45 – 54: 10	11%
	55+: 8	9%
Marital Status	Single: 34	39%
	Married: 49	56%
	Divorced:3	3%
	Widowed: 2	2%
Educational Level	No Education: 5	6%
	Primary Level: 29	33%
	Secondary Level: 23	26%
	Certificate Level: 2	2%
	Diploma Level: 21	24%
	Bachelor's Level: 8	9%
Occupation Level	Unemployed: 24	27%
	Employed: 42	48%
	Self-employed: 22	25%

Challenges and Barriers to Accessing Mental Health Services

Thematic analysis revealed several critical barriers affecting access to mental health care among EAs with co-occurring depressive and anxiety disorders and SUD. These barriers spanned individual, community, and systemic levels.

Key themes included perceived stigma, which discouraged help-seeking behaviour, and negative attitudes among healthcare providers, which further alienated EAs from formal care systems. Participants also reported accessibility and financial constraints, including the high cost of medication, transportation, and inpatient services, as significant deterrents.

Additionally, the study highlighted a shortage of qualified mental health professionals and treatment facilities, particularly in underserved regions. Cultural beliefs and practices, including reliance on traditional and faith-based healers, were also identified as influential factors shaping care-seeking preferences. Finally, limited awareness and understanding of mental health issues among participants contributed to delayed or avoided engagement with available services.

The following section provides a detailed discussion of each of these barriers and their implications for service delivery and policy reform.

Perceived stigma and discrimination

The FGDs revealed that perceived stigma and discrimination significantly hindered access to mental health services among EAs who use substances. Participants described stigma as manifesting in multiple forms—both external and internal. Notably, many EAs appeared to internalise negative societal attitudes, resulting in self-stigmatisation. This self-directed stigma contributed to feelings of shame, fear of judgement, and reluctance to seek professional help. In addition, participants reported

experiencing discriminatory attitudes from community members and healthcare providers, which further discouraged engagement with mental health services.

> *"Sometimes we find that clients stigmatise themselves, such as being afraid to access services from service providers. This self-stigma can create barriers to accessing services."* (Kilifi FGD Service Providers P2).

However, sometimes the stigma and discrimination may arise from those close to them.

> *"Another thing is the discrimination; once he is known to have a mental illness, people will discriminate against him; no one wants to support him or follow up on his clinical visit until he is fully recovered. The minute he is known to be mentally ill, he will be isolated and suffer alone. There is no family support, community support, or parental support."* (Kwale FGD Service Provider P1).

Healthcare Provider Negative Attitudes as a barrier to access and quality of care

Participants across all FGDs consistently highlighted negative attitudes among healthcare professionals as a significant barrier to accessing mental health services. Stereotypes and judgemental perceptions held by some providers not only discouraged help-seeking but also compromised the quality of interactions and the overall therapeutic experience. Stigma within the healthcare system can be as damaging as community-level stigma, further marginalising individuals in need of support.

> *"For Barrier, I feel our attitudes sometimes can send clients away. When a person who has mental health issues comes in or someone who is using drugs, then we treat them like they are not human beings. This one smell awful, and you start closing your nose. Do you think that youth will come back to you again?"* (Mombasa FGD Service Providers P7).

> *"We also tend to have this behaviour thinking that we know more, we are superior we don't listen to them attentively thinking that he is just an addict who does not even know himself so many times we tend to impose our ideas onto them on how they should live instead of listening to them trying to understand them where they are coming from and know how best you can help them make them feel heard but most of the times as providers we don't do that we tend to stigmatise them see them as people who are in lower status than us like what can he tell me? which they don't appreciates so that one will hinder them from coming back to you."* (Kilifi FGD Service Providers P11).

One important point raised by EAs in terms of barriers to going for care is the low trust levels between them and health care providers. They mentioned that they feel very discouraged from going for care when they realise that there is no guarantee of confidentiality. They felt that their information might sometimes be mishandled, either intentionally or unintentionally. For instance, the participants mentioned gossiping and the risk of exposure of personal information when therapists have written their notes as one of the reasons why they would not go for mental health services.

> *"There are also those counsellors, if you go to see her just when you leave, she turns to the other counsellors, aah, you see that girl, that girl is an addict. You understand, instead of her helping you, she criticises you, now those criticisms also hurt people very much."* (Kwale FGD Emerging Adult P8).

> *"We've reached the point where I can't just surrender to a therapist or a psychologist because at the end of the day, when you get my shit on paper, that paper, if you leave it there at the office, your secretary will still go through it, so there's no oath of secrecy. It is better to trust my fellow drug user, I will go and share with him that I am going through this and that, and he will be genuine with me, you understand?"* (Kwale FGD Emerging Adult P11).

Accessibility and Cost are key barriers to ensuring proper mental health care

Participants consistently identified accessibility and financial constraints as major obstacles to seeking care for both substance use and mental health issues. Many reported being unable to afford consultation fees, medication, or the high costs associated with admission to rehabilitation centres and mental health units. These economic barriers significantly limited their ability to access timely and appropriate treatment.

> *"I feel that these services they are not aah, they are partly accessible and eh on a larger scale more are not accessible because if you look like it is, giving an example of this rehabilitation and methadone centre or drug treatment centre they are supposed to serve the whole county, but they are situated in Kombani"* (Kwale FGD Service Provider P4)

> *"You take your child to the hospital, but you do not have the fee, you want to get sessions for the child to get counselling services from professionals to counsel the child on how to help himself to get out of the drug addiction. You find the fees are high, for one session, you can be told its 2000, 1500, or1000 its too much when you can't afford transport to take the child to the hospital, you can't afford food, challenges to see a doctor in a government hospital, you lack medicine to give your patient, you know your child has this, but you do not have medicine to treat your child."* (Mombasa FGD Caregivers P8)

> *"The medicines are costly and most parents in Malindi cannot afford. For example, drugs like Clopixol Acuphase or Clopixol Depot are almost 2,000. In the hospitals, these medicines are not available; they will be prescribed, and you must purchase them from the chemist. Those that are there are Benzhexol, Tegretol, which are the minor medications, but those medications that can be prolonged until he is fine, it will require the parent to spend a lot of money, and there is no organisation that gives these drugs for free."* Kilifi FGD Caregiver F4

Participants also highlighted difficulties in reaching these mental health centres since they were far. Additionally, our participants noted that transport costs to attend sessions regularly were prohibitive. The services were seen to involve lots of travel, which added an extra burden on the families and caregivers of emerging adults using drugs.

> *"The health facility is far from where you stay, and for you to reach it, you need transport, which you probably don't have"* (Kwale FGD Emerging Adults P10).

> *Kilifi is vast, making it high time for them to establish a reputable institution like Mathare or Port Reitz. The distance from Malindi to Port Reitz is considerable, and even to Mathare, it is too far."* (Kilifi FGD Service Providers P4).

> **"***Accessibility is an issue. One, you know, the cost of treating someone, whether it is a substance use disorder or even mental illnesses, is prohibitive"* (Mombasa FGD Service Providers P4).

Inadequate mental health professionals and facilities

Participants consistently reported that the health system lacks sufficient personnel, infrastructure, and resources to meet the rising demand for mental health services among EAs who use drugs. All three counties—Mombasa, Kilifi, and Kwale—were noted to have a severe shortage of mental health professionals and treatment facilities. Additionally, some participants observed that existing facilities were limited in scope, only addressing limited services to mental health conditions.

> *"In my opinion, the current number of rehab facilities is insufficient, necessitating a government proposal or strategic plan to establish new branches at an affordable price."* (Kilifi FGD Service Providers P1).

However, the challenge was not just the shortage of facilities but the lack of facilities that may address the special needs of specific sub-populations. For instance, it was noted that in all three counties, there was a shortage of resources to address the needs of adolescents and women.

> *There is lack of adolescent friendly centres because there was this aspect of creating adolescent friendly places where they can access all services under one roof so that we can avoid trauma and stigmatisation if such centres are set up where these adolescents can comprehensively receive all services I think they can always seek for help sometimes we stigmatise them so much we are like now you what is your problem?....if they can get such services I think we can kerb the addiction and mental illness* (Kilifi FGD Service Providers P9).

> *"We have places where these people are being treated, but the challenge is most of those sites are for males only, the majority... if we have an issue with a female client that can only be treated as an outpatient service"* (Kwale FGD Service Providers P9).

Inadequate awareness of mental healthcare

Participants expressed concerns on a widespread lack of awareness and understanding of mental health among EAs with SUD, their caregivers, and even some service providers. This knowledge gap was seen as a major barrier to accessing care, particularly for those experiencing co-occurring depressive and anxiety disorders. Limited mental health literacy contributed to delayed help-seeking and underutilisation of available services.

> *"Also, aaah* ***...****one of the gaps towards the service providers is that they don't have the right capacity to root out some of these mental disorders affecting the community, so there is a need for the government and other private institutions to train and further capacity build these service providers"* (Kilifi FGD Service Providers P1).

> *"At the community-level, there is a need to educate people because they don't know if they can get mental health treatment at the referral hospital; it's only a few people who know, but the majority don't know if such services exist, and it is a need at the community-level."* (Kilifi FGD Caregiver P4).

> *"Most of the people in the community…still do not know about mental illnesses, so they end up not being able even to seek the necessary help that the person needs because first of all they don't see it as something that can be treated."* (Kilifi FGD Service Providers P3).

It was also noted that sometimes the patients and their caregivers may be aware of the mental health problems but have no knowledge of where to get the relevant services.

> *"Someone is affected by drugs, they don't know what to do, they are wondering what way, what next, until someone becomes a psychiatric patient, it's when they will say Hey, this is now serious, let's go to the hospital. So, the knowledge, first, there is a knowledge gap in terms of the awareness of issues related to mental health and substance abuse in the community"* (Mombasa FGD Service Providers P1).

Preference for traditional and faith-based healers

Cultural beliefs—including the attribution of mental illness to witchcraft—were identified as significant barriers to accessing formal mental health care. As a result, many EAs with SUD, depression, and anxiety disorders preferred seeking help from traditional and faith-based healers. While these practices are deeply rooted in community norms, they often delay engagement with evidence-based medical treatment and limit access to timely, professional care.

> *"Especially our Kilifi community and for instance in Malindi people have the mentality ah that these children have been bewitched, so there is a need to educate our people, there is an enormous need to educate society and especially those who have mental disorders most of them do not attempt to report*

because they think they have been bewitched but majority is SUD (substance use disorder), besides Bipolar and others" (Kilifi FGD Caregiver P4).

"Another challenge I can say is from the family. The family can see that their person has become mentally ill, but they will say he has been bewitched, and instead, they will not take him to see a doctor or give him medication. If you tell them that this issue is not to be dealt with at home support, instead they continue supporting their person with traditional treatment despite the person continuing to suffer" (Kwale FGD Service Providers, P 7).

"For those who come from rural it's an issue for them to accept that this person has mental problems, first this one has been witchcraft, so they will try the local ways where they are and by the time they come to realise that that you know there is more than just being than being witchcraft and this is when they have come to uh…" (Mombasa FGD Service Providers P4).

Discussions

This study's results indicate that EAs who present with co-occurring substance use and mental problems experience numerous barriers to accessing mental health services, including costs, shortage of personnel, stigma, and lack of awareness, among others. These results concur with what has been previously reported, although all the previous studies focused on access to mental health services in general (Kwobah et al., 2023). In an earlier study in Kenya, some of the challenges reported include a shortage of personnel, lack of awareness among health care workers, stigma and low levels of awareness in the community (Kumar et al., 2021). This implies that several of the challenges observed within the current study are not unique to drug users but to the general population in Kenya. This calls for an urgent need to enhance the mental health services within the Kenyan context.

The current findings also align with the global literature (Priester et al., 2016), in an integrative review of barriers to accessing mental health services among people with co-occurring mental disorders and SUD, concluded that there were two types of barriers to treatment access, i.e. personal characteristics barriers and structural barriers (Priester et al., 2016). This integrative review highlights personal characteristics issues like those reported by the current study, including stigma and cultural beliefs. Additionally, it identifies structural barriers, such as personnel shortages and high treatment costs, which are also consistent with the current study's findings. These results highlight the need to ensure that services provided by treatment and rehabilitation centres are more client-centred.

Superstition, cultural beliefs, and the preference for traditional and spiritual healers continue to pose significant barriers to accessing formal mental health services across various African countries, including Malawi, Sudan, and Zambia (Abubakar et al., 2013; Ali & Agyapong, 2015; Chilale et al., 2017; Munakampe, 2020). These findings underscore the need to critically examine the importance of collaborating with traditional and faith-based healers in reducing mental health stigma, raising awareness, addressing substance use, and promoting timely access to care. Engaging these community figures in mental health advocacy may offer culturally grounded pathways to improve service uptake.

A significant gap in the clinical services seems to be the lack of capacity of health care workers to address the mental health needs of the emerging adults who present with comorbid mental health and substance use problems. There is a pressing need for capacity-building initiatives that build health care workers with skills to carry out early identification and management of mental health problems among drug users. This training also needs to incorporate aspects that address the negative attitudes, stereotypes, and stigmatising beliefs among the healthcare professionals so that they can provide a setting that encourages EAs who use drugs to come for care when needed. Studies from other parts of the world indicate that when evidence-based and targeted interventions are implemented, there

can be a reduction of stigma in the health care settings. For instance, in a study conducted in Nepal following an implementation of a carefully designed intervention, health care workers 'Willingness to interact with a person with mental illness increased from 54% pre-training to 81% at 16 months. Observed clinical competency increased from 49% pre-training to 93% at 16 months"(Kohrt et al., 2020).

Access and affordability remain critical barriers to care. To address these, the integration of mental health services into primary care is essential. This approach allows for early intervention within accessible and familiar health settings, particularly for individuals who may not seek specialised care. Additionally, community-based mental health education can improve mental health literacy, reduce stigma, and empower emerging adults to seek help. Training non-specialists and peers to deliver low-intensity psychological support—using tools like WHO's Problem Management Plus (PM+) and Problem Management and Alcohol Plus (PM+A)—can further expand reach (Cai et al., 2025; Fuhr et al., 2021). Evidence-based Cognitive Behavioural Therapy models, including relapse prevention, the Community Reinforcement Approach (CRA), and Behavioural Couple Therapy (BCT), should also be considered to support recovery and long-term wellbeing (Morin et al., 2017).

Taken together, these findings underscore the need for a coordinated, multilevel response that incorporates culturally responsive, youth-friendly, and evidence-based interventions to improve access to mental health services for emerging adults in Kenya.

Limitation

The study participants were recruited from MAT clinics, drop-in centres and substance abuse rehabilitation and treatment centres where they were undergoing substance use treatment. The recruitment process missed out on participants who were actively using substances but not enrolled in a substance use treatment facility, limiting the study findings and transferability to other contexts. Additionally, the study's geographical area was selected from coastal Kenya; hence, the study findings can only be contextualised within those counties, limiting the generalizability to other regions outside the study settings.

Conclusions

Emerging adults with co-occurring substance use and mental health disorders face major barriers to care, including stigma, cost, limited awareness, and workforce shortages. Addressing these challenges the study recommends four key strategies: community-based mental health education to improve awareness and reduce stigma; integration of mental health services into primary care to enhance accessibility and early intervention; capacity-building for healthcare professionals to improve diagnostic and therapeutic competencies; and collaboration with traditional and faith-based healers to foster culturally sensitive care and bridge gaps between biomedical and community-based approaches.

Embedding a stepped care model within these interventions ensures that support is matched to need from low-intensity approaches like PM+ and PM+A to CBT-based relapse prevention, CRA, and BCT for more complex cases. Policy reforms at national and county levels are essential to scale these solutions and close the treatment gap for EAs living with co-occurring substance use and mental health challenges in Kenya.

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