Challenges Treating Drug Abuse and Addiction with Co-Occurring Disorders in Nairobi and Kiambu.

Prepared by: Kelvin Ateko, Mental Health Nurse
Setting: Urban outpatient/inpatient mental health and addiction services in Nairobi, Kenya (reflecting my practice experience in the last four years).

1) Executive Summary

Clients presenting with substance use disorders (SUD) in Nairobi and Kiambu often exhibit co-occurring mental health conditions (e.g., depression, anxiety, PTSD, bipolar disorder, psychosis) and medical comorbidities (e.g., HIV, TB, chronic pain). Effective treatment is hindered by a lack of integrated services, pervasive stigma, financial constraints, workforce shortages, and disjointed care pathways. This report highlights observed challenges in clinical practice and outlines actionable steps that are implementable (and scalable) within facilities.

2) Nairobi and Kiambu Context (Why Co-Occurring Care is Harder Here)

- **High comorbidity burden:** Prolonged untreated conditions lead to substance use masking underlying disorders like depression or trauma, a phenomenon known as diagnostic overshadowing.
- **Urban stressors:** Unemployment, housing instability, crime exposure, and gender-based violence (GBV) increase relapse risk and complicate follow-up care.
- **Service distribution:** Specialized treatments (psychiatry, medication-assisted therapy [MAT], trauma therapy) are concentrated in public/mission hospitals and select NGOs, with long queues and transport costs reducing adherence.
- **Stigma & culture:** Substance use and mental illness are often moralized, prompting families to seek spiritual or alternative remedies, delaying evidence-based care.
- **Legal environment:** Fear of police harassment or legal repercussions deters clients from accessing harm-reduction services.

3) Clinical and Operational Challenges Faced

A. Assessment & Diagnosis

- **Diagnostic overshadowing:** Intoxication or withdrawal symptoms can mimic primary psychiatric conditions, while psychosis or mood instability may be misattributed to substance use.
- **Limited standardized screening:** Tools such as ASSIST, AUDIT, DAST, PHQ-9, GAD-7, PCL-5, and MDQ are underutilized due to time constraints and skill gaps among staff.

- **Dual medical needs:** Coexisting HIV, TB, hepatitis, epilepsy require off-site coordination, often leading to delays.

B. Treatment Planning & Delivery

- **Fragmented pathways:** Detox, inpatient psychiatry, MAT, and psychotherapy are rarely co-located, causing referral delays and client dropouts.
- **Medication access:** Cost and stock-outs of mood stabilizers, antipsychotics, antidepressants, and anti-craving agents limit treatment, with few long-acting formulations available.
- **MAT capacity & myths:** Opioid MAT is oversubscribed and stigmatized, with misconceptions about "substituting one drug for another" deterring family support.
- **Trauma-informed care gaps:** Despite high trauma prevalence, few clinicians are trained in evidence-based therapies like EMDR or TF-CBT.
- **Suicide and violence risk:** Acute risk necessitates intensive monitoring, but limited observation capacity and safe rooms pose challenges.

C. Engagement & Retention

- **Stigma and confidentiality fears:** Clients avoid disclosure at work or school; adolescents face inconsistent caregiver consent or support.
- **Family dynamics:** Codependency and family burnout hinder relapse prevention, with structured family work being resource-intensive.
- **Follow-up barriers:** Transport costs, unstable phone access, and shifting residences lead to missed appointments and treatment drift.
- **Motivational fluctuations:** Ambivalence is common, and without ongoing motivational interviewing (MI), dropout rates increase.

D. Systems & Financing

- **Insurance limitations:** SHA and private insurance inconsistently cover detox, psychotherapy, rehab, or dual-diagnosis care, driving out-of-pocket expenses and early discharges.
- **Data & outcomes:** Patchy electronic medical records (EMR) make tracking dual-diagnosis outcomes and relapse metrics labor-intensive.
- **Workforce strain:** Shortages of psychiatrists, addiction-trained nurses, psychologists, and peer specialists increase staff burnout risk.

4) Reflections from Current Practice

- **Case-mix (last 6–12 months, non-identifying patterns):**
    - High prevalence of alcohol, cannabis, and polysubstance use; rising stimulant (non-prescription) use among young adults.
    - Frequent co-occurring major depression, generalized anxiety disorder (GAD), PTSD, and bipolar spectrum; episodic psychosis linked to cannabis/high-potency products.
    - Medical comorbidities: recurrent gastritis/liver issues in alcohol users; HIV/TB in a subset of opioid/stimulant users, undetected diabetes, hypertension and even other serious skeletal injuries.
- **Observed bottlenecks:**
    - Long waits for psychiatric review post-detox; difficulty aligning therapy with MAT/medical clinic schedules.
    - Fluctuating family engagement—caregivers attend admission but fade during therapy/relapse-prevention phases.
    - Limited crisis beds for dual-diagnosis relapse with suicidality; safety planning often occurs outpatient.
- **What has worked for us:**
    - **Standardized intake bundle:** ASSIST/AUDIT + PHQ-9 + GAD-7 + brief trauma screen at first contact, repeated at 4–6 weeks to differentiate substance-induced vs. primary disorders.
    - **Mini-MDT huddles (weekly):** Counselor, nurse, psychiatrist (on-call), and peer specialist review complex cases, documenting clear care plans.
    - **Warm referrals:** Named contacts at nearby MAT/psychiatry/medical clinics, with clients receiving a date, location, and phone number.
    - **Family sessions:** Two structured meetings (education + boundaries + relapse plan) before intensive phase discharge.
    - **Crisis protocol:** Brief safety plans, means-restriction counseling, and 48-hour phone check-ins post-crisis.

5) Recommendations (Practical, Near-Term)

- Embed integrated screening with ASSIST/AUDIT/DAST + PHQ-9/GAD-7/PCL-5 at intake; train staff to interpret and repeat post-detox.
- Formalize dual-diagnosis pathways (detox ↔ psychiatry ↔ MAT ↔ therapy) with a one-page client/family pathway sheet.
- Enhance trauma-informed practice with short trainings on grounding, stabilization, and EMDR/TF-CBT referrals.
- Ensure medication continuity by tracking stock, developing a low-cost formulary, and securing reliable suppliers for anti-craving agents and long-acting antipsychotics.
- Involve peers by recruiting trained support workers for engagement, group facilitation, and follow-up calls.
- Offer a 3-session family module (psychoeducation; boundaries/enabling; relapse warning signs + crisis plan).
- Integrate brief MI into every contact, using text prompts for adherence and cravings check-ins.
- Navigate finances by maximizing SHA/insurer benefits and creating sliding-scale bundles for psychotherapy + psychiatry.
- Capture data with simple EMR templates for diagnoses, substances, risk, attendance, and outcomes; conduct monthly audits.
- Build community links for safe use education, naloxone training, and supplies where lawful.

6) Longer-Term System Improvements (Advocacy Points)

- Develop co-location or hub-and-spoke models integrating detox, psychiatric review, MAT, and counseling.
- Expand capacity with scholarships/CPD for addiction psychiatry, trauma therapy, and case management, plus burnout prevention supervision.
- Launch public education to reduce stigma and promote early help-seeking, including employer support for return-to-work.

- Engage policy/insurance to ensure consistent coverage for dual-diagnosis admissions, MAT, and psychotherapy.

7) Ethical & Safety Considerations in Nairobi

- Protect confidentiality and obtain informed consent during inter-facility coordination.
- Manage suicide risk with clear protocols, 24/7 emergency numbers, and family briefings on red flags.
- Practice cultural humility, respecting spiritual supports while guiding toward evidence-based care.
- Prioritize non-coercive, dignity-focused care with harm reduction principles.

8) Conclusion

Treating SUD with co-occurring disorders in Nairobi requires an integrated, trauma-informed, family-inclusive approach. Despite systemic gaps, our facility has advanced through standardized screening, multidisciplinary collaboration, warm referrals, and structured family work. Scaling these interventions, alongside advocacy for financing and capacity, can reduce relapse, enhance safety, and improve client functioning and family well-being.

Appendices

- **Intake toolkit:** ASSIST/AUDIT/DAST, PHQ-9, GAD-7, PCL-5, MDQ quick guides.
- **One-page client pathway:** Detox → Psychiatric review → MAT (if indicated) → Individual/Group therapy → Family module → Relapse plan.
- **Relapse prevention card:** Trigger–Thought–Craving–Action plan + emergency contacts.