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FACULTY OF SOCIAL SCIENCES AND HUMANITIES



Mental Health Challenges Amoung Youth Linked To Drug And Substance Abuse In Zimbabwe Bindura, Chipadze

By

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A Dissertation to the Department of Peace and Governance in partial fulfilment for the requirements for the Bachelor of Science Degree in Peace and Governance Degree

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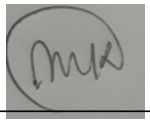
ABSTRACT

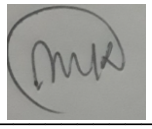
This qualitative study, grounded in an interpretivist philosophy and the Stress Process Model, investigated the relationship between mental health challenges and drug/substance abuse among youth (15-24 years) in Chipadze, Bindura, Zimbabwe. Using a case study design, data were collected through semi-structured interviews with 40 youth and 10 key informants (health workers, social workers, counsellors, community leaders), supplemented by the Shona Symptom Questionnaire (SSQ-14) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Thematic analysis revealed that youth experience mental distress primarily through kufungisisa (thinking too much), depression, and trauma-related symptoms, using substances as a maladaptive coping mechanism for economic precarity, family disruption (particularly parental migration), and peer-related vulnerabilities. Lived experiences were characterised by profound stigma, criminalisation, and fragmented help-seeking, with no integrated services available. The study concludes that substance use among Zimbabwean youth is a coping response to structural stressors, and that current punitive, fragmented systems exacerbate rather than alleviate suffering. Recommendations include developing integrated youth-friendly service hubs, decriminalising personal substance use, training community leaders, and investing in community-based mental health services. Further research should examine family perspectives, conduct multi-site comparative studies across diverse Zimbabwean contexts, and evaluate the effectiveness of pilot integrated interventions.

DECLARATION

I, (B224813B), hereby declare that this dissertation titled "Mental Health Challenges Among Youth Linked to Drug and Substance Abuse in Zimbabwe" is my own original work. It has been submitted in partial fulfilment of the requirements for the Master of Science in Peace and Governance degree at Bindura University of Science Education. To the best of my knowledge, this work has not been previously submitted for any degree or qualification at any other university. All sources used or quoted have been duly acknowledged.

Student signature:  Date: _____10/15/2026_____

Supervisor signature:  Date: _____

Chairperson signature:  Date: _____

DEDICATION

This work is dedicated to the young people of Chipadze, Bindura, who participated in this study with courage and honesty. Your voices matter. May this research contribute to the compassionate, effective support you deserve.

I also dedicate this work to my family for their unwavering support and encouragement throughout this academic journey.

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I wish to express my deepest gratitude to my supervisor, for the expert guidance, patience, and invaluable insights provided throughout this research. Your mentorship has shaped not only this dissertation but my development as a researcher.

Special thanks to the Bindura University of Science Education, Department of Peace and Governance, for providing the academic environment and resources necessary for this research. I acknowledge the support of the Ministry of Health and Child Care and local authorities in Bindura for granting permission to conduct this study.

Finally, I thank my family and friends for their patience, encouragement, and practical support throughout this demanding process. Your belief in me sustained this work.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
BUSE	Bindura University of Science Education
CD	Conduct Disorder
HIV	Human Immunodeficiency Virus
MDD	Major Depressive Disorder
NGO.	Non-Governmental Organisation
ODD.	Oppositional Defiant Disorder
PTSD.	Post-Traumatic Stress Disorder
SD.	Standard Deviation
SPSS.	Statistical Package for the Social Sciences
WHO.	World Health Organization
ZIMSTAT.	Zimbabwe National Statistics Agency
ZRP.	Zimbabwe Republic Police

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background to the Study

The global burden of mental health disorders among youth represents a critical public health challenge, with the World Health Organization estimating that approximately one in seven adolescents globally experiences a mental health condition (World Health Organization, 2021). Critically, the onset of most mental health disorders occurs before the age of 25, coinciding with a developmental period characterised by heightened vulnerability to substance experimentation and abuse (Kessler et al., 2018; Solmi et al., 2022). The co-occurrence of mental health disorders and substance use, termed dual diagnosis, has been extensively documented as a pervasive phenomenon that exacerbates clinical outcomes, increases treatment complexity, and imposes substantial economic burdens on health systems globally (Jones & McCabe, 2020; Kelly et al., 2021). Longitudinal studies have demonstrated that adolescents with untreated mental health disorders are up to four times more likely to develop substance use disorders compared to their peers without such conditions (Marel et al., 2019; Teesson et al., 2020). This bidirectional relationship creates a self-perpetuating cycle wherein substance abuse intensifies underlying psychiatric symptoms while mental distress drives continued substance use as a maladaptive coping mechanism (Hides et al., 2019; Prior et al., 2021).

Within the African context, the intersection of mental health and substance abuse among youth presents uniquely complex challenges shaped by colonial legacies, under-resourced health systems, and rapid sociocultural transformations (Akinbode et al., 2020; Jack et al., 2021). Research indicates that mental health service provision across sub-Saharan Africa remains

critically inadequate, with the region having an average of 1.4 mental health workers per 100,000 population compared to the global average of 9.0 per 100,000 (Sankoh et al., 2018; World Health Organization, 2022). This scarcity is compounded by pervasive stigma surrounding both mental illness and substance use, which discourages help-seeking behaviour and perpetuates hidden suffering among young people (Egbe et al., 2020; Monteiro, 2021). Furthermore, the region has experienced a concerning escalation in substance availability and use, with studies documenting increased rates of cannabis, alcohol, and emerging synthetic drug use among urban and peri-urban youth populations (Degenhardt et al., 2019; Peltzer & Pengpid, 2020). The confluence of these factors has created a scenario where African youth experiencing mental distress increasingly turn to substances as accessible, albeit destructive, forms of self-medication (Gbadebo et al., 2021; Ndetei et al., 2020).

Southern Africa, and Zimbabwe in particular, has been identified as a region of growing concern regarding youth substance abuse and its mental health correlates (Francis et al., 2021; Mhaka-Mutepfa et al., 2020). Zimbabwe's recent socioeconomic trajectory—characterised by protracted economic contraction, hyperinflation, unemployment rates exceeding 80% among youth, and mass emigration—has created conditions of profound instability and chronic stress for young people (Chikwanha et al., 2021; Kurebwa & Ndlovu, 2022). Scholars have documented that exposure to such chronic socioeconomic adversity constitutes a significant risk factor for the development of both internalising disorders such as depression and anxiety and externalising behaviours including substance abuse (Lund et al., 2018; Patel et al., 2019). Qualitative studies conducted in Zimbabwean urban settings have revealed that young people describe their substance use as a direct response to feelings of hopelessness, despair, and an inability to envision viable futures in the face of structural constraints (Mugweni et al., 2020; Nyamayaro et al., 2021). The

traditional extended family system, historically a protective factor against psychosocial distress, has been increasingly eroded by economic pressures and migration, leaving many youth without adequate social support networks (Chimwaza & Chingono, 2020; Zvobgo et al., 2022).

Despite growing recognition of this crisis, Zimbabwe's health system remains ill-equipped to address the dual burden of mental health and substance use disorders among youth. The country's mental health legislation, the Mental Health Act of 1996, remains rooted in an institutional, custodial paradigm that fails to align with contemporary community-based, recovery-oriented approaches (Chibanda, 2018; Kidia, 2020). Substance abuse is primarily addressed through the criminal justice system under the Dangerous Drugs Act, reflecting a punitive rather than therapeutic orientation that further marginalises affected youth (Mudhovozi & Mhaka-Mutepfa, 2019; Ncube & Zanamwe, 2021). The shortage of mental health professionals is severe, with Zimbabwe having approximately 0.5 psychiatrists per 100,000 population, the vast majority concentrated in urban centres, leaving rural youth with virtually no access to specialised care (Chibanda et al., 2020; Makoni, 2019). Furthermore, there exists no integrated service model that simultaneously addresses mental health and substance use disorders, despite international evidence demonstrating that such integration is essential for effective treatment outcomes (Briere et al., 2020; Mueser et al., 2019). This systemic fragmentation means that young people seeking help often fall through the cracks, bouncing between under-resourced mental health services, punitive legal interventions, and unsupportive family environments (Mangezi & Chibanda, 2020; Verhey et al., 2021).

The research problem emerges from this context of incomplete knowledge. While epidemiological data and anecdotal reports confirm the existence of a significant crisis, there remains a profound gap in empirical research that examines the specific, contextualised pathways

linking mental health challenges to substance abuse among Zimbabwean youth (Chinouya & O'Keefe, 2020; Mutiso et al., 2021). Existing studies have largely been quantitative, focusing on prevalence estimates rather than the lived experiences and meaning-making processes of young people navigating this dual burden (Gureje & Alem, 2020; Ndetei et al., 2019). There is limited understanding of how local cultural frameworks shape the interpretation of mental distress, how traditional healers and informal networks intersect with formal services, and how the specific historical and political-economic context of Zimbabwe shapes the unique contours of this phenomenon (Chiumbu & Nyamnjoh, 2021; Mpofu & Mapfumo, 2020). Without this granular, context-specific knowledge, interventions risk being culturally inappropriate, ineffective, or even harmful (Asher & De Silva, 2019; van Ginneken et al., 2021). This study, therefore, seeks to address this gap by undertaking a qualitative, in-depth investigation that centres the voices and experiences of youth themselves, providing the nuanced understanding necessary for developing effective, culturally resonant interventions.

1.2 Purpose of the Study

The purpose of this study is to develop an in-depth understanding of the causal pathways, lived experiences, and perpetuating factors linking mental health challenges and drug and substance abuse among youth in a selected community in Zimbabwe.

1.3 Statement of the Problem

In Zimbabwe, a generation of youth is ensnared in a debilitating and potentially fatal cycle of mental health distress and substance dependence, yet the country lacks the empirically grounded, context-specific knowledge required to develop effective interventions. The problem is that existing policy and practice responses predominantly punitive legal frameworks, fragmented health services, and a near-absence of integrated care models are failing to address the complex,

locally specific drivers of this dual crisis (Chibanda, 2018; Mudhovozi & Mhaka-Mutepfa, 2019). National data indicate that substance use among Zimbabwean youth has reached alarming levels, with studies reporting lifetime prevalence rates of cannabis use exceeding 15% among urban youth and alcohol use rates surpassing 40% among certain subpopulations (Mhaka-Mutepfa et al., 2020; Nyamayaro et al., 2021). Simultaneously, the burden of mental health disorders among young people is substantial, with prevalence estimates for depression and anxiety ranging from 20% to 35% across various Zimbabwean samples (Chibanda et al., 2020; Verhey et al., 2021). Despite these converging epidemics, there exists no systematic research that qualitatively explores how youth themselves understand the interconnection between their psychological distress and substance use, nor how they navigate the fragmented systems ostensibly designed to help them (Chinouya & O'Keefe, 2020; Kidia, 2020). This knowledge gap perpetuates a cycle of ineffective responses, contributing to escalating rates of treatment failure, overdose, suicide, and the intergenerational transmission of trauma and addiction (Lund et al., 2018; Mangezi & Chibanda, 2020). This study, therefore, is imperative to generate the nuanced, experiential evidence necessary to fundamentally reconceptualise and redesign interventions that can genuinely interrupt this destructive cycle and restore the health and potential of Zimbabwe's youth.

1.4 Research Objectives

The study will be guided by the following objectives:

I. To identify common mental health challenges experienced by youth who engage in drug and substance abuse in the study area, as understood from their own perspectives.

II. To explore the perceived causal pathways that lead youth to use substances as a means of coping with mental health issues.

III. To examine the lived experiences of youth in navigating the dual burden of mental health challenges and substance abuse.

IV. To assess the existing support systems and interventions available to these youth and identify the barriers that prevent them from accessing effective and sustained help.

1.5 Research Questions

To achieve the stated objectives, the study will seek to answer the following questions:

I. What are the specific mental health challenges that youth in the study area associate with their substance use, and how do they articulate these experiences?

II. How do youth perceive the causal links between their mental health state, their social and economic environment, and their initiation and continued use of drugs and substances?

III. What are the lived experiences of youth in managing the simultaneous challenges of mental distress and substance dependence within their community context?

IV. What are the existing formal and informal support systems, and what are the key barriers that prevent youth from accessing effective and sustained help?

1.6 Assumptions

This research will operate under the following assumptions:

I. There is a relationship between mental health and drug abuse amongst the youths in Zimbabwe.

II. Mental health challenges are most prevalent amongst the youths who engage in drug abuse than those who do not use drugs

1.7 Significance of the Study

This study holds significant implications for multiple stakeholders.

Policy Makers

For policymakers within Zimbabwe's Ministries of Health, Youth, and Social Welfare, the findings will provide an evidence-based foundation for reforming outdated legislation and developing integrated, youth-centred policies that shift from punitive approaches toward public health-oriented, recovery-focused frameworks. For health and social service practitioners, the detailed, contextual insights into youth experiences will inform the development of culturally sensitive screening tools, treatment protocols, and service delivery models that address mental health and substane use as interconnected conditions rather than separate problems.

Community Leaders

For community leaders and families, the research will contribute to destigmatising mental health and substance use by illuminating the underlying drivers of these conditions, potentially fostering more compassionate, supportive responses within communities. For academics and researchers, this study will address a critical gap in the literature by providing a rich, qualitative case study of dual diagnosis among youth in a Sub-Saharan African context, contributing to the development of contextually grounded theories and offering a methodological model for similar research across the region.

To the Youths

Ultimately, the most profound significance of this study lies in its potential to generate knowledge that directly benefits the youth of Zimbabwe by informing the creation of accessible,

effective, and culturally resonant interventions that can help them break the cycle of mental distress and substance dependence and reclaim their futures.

1.8 Delimitations of the Study

This study is delimited to a specific geographic area, focusing on Chipadze in Bindura, Zimbabwe. This geographic delimitation is intentional, allowing for an in-depth, context-rich analysis that captures the nuanced dynamics operating within a defined community. The study focuses specifically on youth, defined as individuals between the ages of 15 and 24 years, in alignment with Zimbabwe's National Youth Policy. Participants will include youth who self-identify or are identified by key informants as having concurrent experiences of mental health challenges and drug or substance abuse. The study does not seek to establish quantitative prevalence rates of mental health or substance use disorders across Zimbabwe, nor does it aim to provide clinical diagnoses of participants. Rather, the focus is on understanding participants' subjective experiences, perceptions, and meaning-making processes. The study does not encompass family members of affected youth as primary participants, nor does it examine the perspectives of health system administrators beyond those directly involved in frontline service delivery.

1.9 Limitations of the Study

A primary limitation of this study is its reliance on self-reported data, which is inherently subject to recall bias, social desirability bias, and the potential influence of participants' current mental and emotional states on the accuracy of their accounts. Participants may underreport certain behaviours due to stigma or fear of legal repercussions, or they may overreport others due to distress or a desire to meet perceived researcher expectations. To mitigate this limitation, the study will employ methodological triangulation, incorporating multiple data sources including in-depth

individual interviews, focus group discussions with youth, and key informant interviews with community health workers, social workers, and community leaders who work directly with this population. This triangulation allows for cross-validation of findings across different perspectives and data sources. A second limitation concerns the inherent challenge of generalising findings from a single case study site to the broader Zimbabwean context. Qualitative case studies are not designed for statistical generalisability but rather for analytical or transferable generalisability. To address this, the study will produce a rich, thick description of the research context, participants, and findings, enabling readers and other researchers to assess the transferability of the insights to other similar settings based on contextual similarities.

1.10 Definition of Key Terms

Dual Diagnosis (Co-occurring Disorders)

The simultaneous presence of a mental health disorder and a substance use disorder in an individual, wherein each condition may influence the onset, course, and treatment outcomes of the other (Substance Abuse and Mental Health Services Administration, 2020, p. 5).

Substance Abuse

The harmful or hazardous use of psychoactive substances, including alcohol, cannabis, and other illicit drugs, characterised by continued use despite adverse consequences, impaired control over use, and the development of tolerance or withdrawal symptoms

Mental Health Challenges

A broad, inclusive term encompassing a range of mental, emotional, and behavioural conditions that affect an individual's thinking, feeling, mood, and daily functioning, including but not limited to depressive disorders, anxiety disorders, and trauma-related conditions.

Youth

For the purposes of this study, youth are defined as individuals between the ages of 15 and 24 years, consistent with the definition adopted by the African Youth Charter (African Union, 2006) and the National Youth Policy of Zimbabwe (Ministry of Youth, Sport, Arts and Recreation, 2020).

1.11 Dissertation Outline

Chapter One: Introduction

Chapter on is the introductory study. The chapter establishes the background context of mental health and substance abuse among youth globally and within Zimbabwe, identifies the research problem, articulates the purpose and significance of the study, and presents the research objectives and questions that guide the investigation.

Chapter Two: Literature Review And Theoretical Framework

critically examines existing theoretical and empirical literature on the relationship between mental health disorders and substance use among youth. It explores theoretical frameworks explaining this relationship, reviews the global and African evidence base, and identifies the specific gaps in Zimbabwean scholarship that this study aims to address.

Chapter Three: Research Methodology

It details the qualitative research approach underpinning the study, including the interpretivist research philosophy, the case study design, and the methods for participant recruitment, data collection (semi-structured interviews, focus group discussions, key informant

interviews), and data analysis (thematic analysis). It also addresses issues of trustworthiness, ethical considerations, and strategies employed to ensure participant safety and confidentiality.

Chapter Four: Presentation, Analysis and Discussion of Findings

Will present the data collected from the fieldwork, organised thematically in alignment with the research questions. This chapter centres the voices of participants through the use of rich, verbatim quotations, providing a nuanced and detailed account of the lived experiences of youth navigating mental health challenges and substance abuse.

Chapter Five: Summary, Conclusion, Recommendations and Area for further Research

The chapter interprets the findings in relation to the existing literature and theoretical frameworks, draws conclusions about the nature of the problem in the Zimbabwean context, highlights the study's contributions to knowledge, and presents a set of evidence-based recommendations for policy, practice, and future research aimed at addressing the dual crisis of mental health and substance abuse among Zimbabwean youth.

CHAPTER TWO

2.0 LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter presents a comprehensive review of the existing scholarly literature pertinent to the relationship between mental health challenges and drug and substance abuse among youth.

The chapter is organised into several sections. It begins with the theoretical framework, identifying and explicating the overarching theory that guides this study, followed by an examination of its strengths, weaknesses, and major assumptions. The chapter then proceeds to define the core concepts of mental health and drug abuse, exploring their various forms as documented in the literature. Subsequently, the chapter presents a thematic review of literature aligned with each of the four research objectives, critically synthesising scholarly views, methodologies, findings, and interpretations while positioning the researcher's voice as a moderator of ongoing academic debates. The chapter concludes with a summary that distils the main arguments, identifies the critical gap in existing knowledge, and establishes the scholarly justification for the present study.

2.2 Theoretical Framework

This study is anchored in the Stress Process Model, originally developed by sociologist Leonard I. Pearlin and his colleagues in the 1980s and subsequently refined through decades of empirical research (Pearlin, 1989; Pearlin et al., 1981). Pearlin, who was a distinguished Professor of Sociology at the University of California, San Francisco, developed this model as a response to the limitations of earlier stress theories that conceptualised stress as a simple stimulus-response phenomenon. The Stress Process Model emerged from Pearlin's longitudinal research on the social contexts of stress, particularly his seminal work examining how individuals navigate life challenges within the structural constraints of their social environments. The theory fundamentally posits that stress is not a static event but rather a dynamic process that unfolds over time, shaped by the social structures, life circumstances, and available resources that surround individuals. This model has become one of the most influential frameworks for understanding how social inequality, life events, and chronic hardships translate into psychological distress and maladaptive coping behaviours (Pearlin & Bierman, 2013; Thoits, 2018).

The Stress Process Model is built upon several major assumptions that render it particularly appropriate for examining the phenomenon of mental health challenges and substance abuse among Zimbabwean youth. The first assumption is that stressors are hierarchically arranged, with macro-level social structures such as economic systems, political institutions, and cultural norms—generating chronic life strains that cascade downward to affect individual experiences (Pearlin, 1999; Wheaton, 2018). For Zimbabwean youth, this assumption illuminates how the chronic economic instability, political uncertainty, and erosion of traditional social structures in Zimbabwe constitute foundational stressors that permeate every aspect of daily life. The second assumption posits that the relationship between stressors and outcomes is mediated by psychosocial resources, including coping mechanisms, social support networks, and personal mastery (Pearlin & Schooler, 1978; Thoits, 2020). When these resources are insufficient or absent, individuals are more likely to adopt maladaptive coping strategies, such as substance abuse, to manage their distress. This assumption directly addresses the central concern of this study: how youth turn to drugs and substances when other resources for managing mental distress are unavailable. The third assumption is that the stress process is characterised by stress proliferation, whereby an initial stressor generates a cascade of secondary stressors that compound the original distress (Pearlin et al., 1997; Turner, 2019). This explains how a young person experiencing depression may, through their substance use, subsequently encounter legal troubles, family conflict, and social marginalisation, which in turn exacerbate both their mental health condition and their dependence on substances.

The Stress Process Model offers several strengths that make it an appropriate overarching framework for this study. Foremost among these is its explicit attention to the social structural origins of distress, which is essential for understanding the Zimbabwean context where youth

mental health and substance abuse cannot be divorced from the broader socioeconomic and political landscape (Mhaka-Mutepfa et al., 2020; Nyamayaro et al., 2021). Unlike biomedical models that locate the source of psychopathology within the individual, the Stress Process Model compels researchers to examine how social arrangements produce and distribute psychological distress across populations (Aneshensel, 2015; Thoits, 2018). This aligns with the growing recognition in global mental health that interventions must address not only individual symptoms but also the social determinants that generate and perpetuate mental health disparities (Lund et al., 2018; Patel et al., 2019). A second strength is the model's dynamic, process-oriented nature. Rather than treating mental health and substance use as static conditions, the Stress Process Model conceptualises them as evolving over time through complex interactions among stressors, resources, and outcomes (Pearlin & Bierman, 2013; Wheaton, 2018). This temporal dimension is crucial for understanding how young people's journeys into substance use unfold in response to accumulating life stressors and how their resources for coping may change over time. A third strength is the model's capacity to incorporate multiple levels of analysis, from macro-social structures to micro-level psychological processes, enabling a holistic examination of the phenomenon (Aneshensel, 2015; Turner, 2019). This allows the study to simultaneously consider how national economic policies, community dynamics, family relationships, and individual psychological states intersect to shape youth experiences.

However, the Stress Process Model is not without limitations, and acknowledging these weaknesses is essential for situating this study within a critically reflexive scholarly stance. One notable weakness is the model's relative under-specification of cultural processes (Thoits, 2020; Williams, 2018). While Pearlin acknowledged the importance of cultural context, the model does not provide a detailed framework for understanding how specific cultural meanings, beliefs, and

practices shape the interpretation of stressors, the selection of coping strategies, and the expression of distress. In the Zimbabwean context, where traditional healers play a significant role in mental health, where spiritual interpretations of distress are common, and where community-based coping practices differ substantially from Western models, this cultural dimension is critical (Chiumbu & Nyamnjoh, 2021; Mpofu & Mapfumo, 2020). This study, therefore, while using the Stress Process Model as its overarching framework, will attend explicitly to cultural processes, integrating cultural insights from the ethnographic literature on Zimbabwean mental health to address this gap. A second weakness is that the model has been criticised for its individualistic orientation, even as it attends to social structures, potentially obscuring collective forms of coping and resilience that operate at community or kinship levels (Kirmayer et al., 2017; Thoits, 2018). In Zimbabwean society, where the extended family and community networks have historically served as primary sources of social support and meaning-making, this individualistic bias requires critical attention (Chimwaza & Chingono, 2020; Zvobgo et al., 2022). The study will address this by ensuring that data collection and analysis attend to collective and relational dimensions of stress and coping. A third limitation concerns the model's origins in predominantly Western, North American contexts, raising questions about its universal applicability (Kirmayer et al., 2017; Monteiro, 2021). This study will apply the model critically, treating it as a heuristic framework to be tested, refined, and potentially adapted through the empirical findings generated from the Zimbabwean context.

Despite these limitations, the Stress Process Model remains the most appropriate overarching theory for this study because it provides a comprehensive framework for understanding how the multiple, intersecting stressors facing Zimbabwean youth economic precarity, family disruption, limited educational and employment opportunities translate into mental health challenges and, in the absence of adequate psychosocial resources, lead to substance

abuse as a maladaptive coping mechanism. The model's attention to stress proliferation further enables the study to examine how initial experiences of distress and substance use generate cascading secondary stressors that entrench and deepen the cycle. This study will therefore deploy the Stress Process Model as its primary theoretical lens while remaining critically attentive to its cultural limitations and open to the theoretical refinements that the empirical data may suggest.

2.3 Defining Mental Health

Mental health is a conceptually contested term whose definition has evolved substantially over time and across cultural contexts. The World Health Organization (2022, p. 7) defines mental health as "a state of mental well-being that enables people to cope with the normal stresses of life, to realise their abilities, to learn and work well, and to contribute to their community." This definition reflects a positive, holistic conceptualisation that extends beyond the mere absence of mental disorder to encompass functioning, well-being, and social participation. However, scholars have noted that this definition, while influential, reflects predominantly Western conceptualisations that may not fully capture African understandings of mental health (Gureje & Alem, 2020; Ndetei et al., 2020). In many African cultural contexts, mental health is understood not only in individual terms but also as a state of relational harmony within family, community, and spiritual realms, with disturbances in these relational domains considered central to mental health challenges (Akinbode et al., 2020; Monteiro, 2021). Mpofu and Mapfumo (2020, p. 45) argue that in Zimbabwean conceptualisations, mental health is understood as hutano hwepfungwa (health of the thinking/spiritual self), which encompasses cognitive, emotional, and spiritual dimensions inseparable from one's relationships with ancestors, family, and community. This cultural conceptualisation has significant implications for how mental health challenges are

experienced, interpreted, and addressed among Zimbabwean youth, a dimension that biomedical definitions often obscure (Chiumbu & Nyamnjoh, 2021; Kidia, 2020).

For the purposes of this study, mental health challenges are understood broadly to encompass both clinically diagnosable mental disorders and subclinical forms of psychological distress that impair functioning and well-being. This inclusive approach is consistent with the Stress Process Model's emphasis on the continuum of distress rather than categorical distinctions between disorder and normal suffering (Pearlin & Bierman, 2013; Wheaton, 2018). It is also appropriate for the Zimbabwean context where formal psychiatric diagnosis is rare and where many youth experiencing significant distress never access mental health services (Chibanda et al., 2020; Mangezi & Chibanda, 2020).

2.3.1 Forms of Mental Health Challenges

The literature documents a range of mental health challenges that commonly affect youth and that frequently co-occur with substance use. Depression is among the most prevalent, characterised by persistent sadness, loss of interest or pleasure, changes in appetite or sleep, fatigue, feelings of worthlessness, and recurrent thoughts of death (American Psychiatric Association, 2022, p. 177). Among Zimbabwean youth, studies have documented depression prevalence rates ranging from 20% to 35%, with rates significantly higher among youth experiencing poverty, family disruption, and exposure to violence (Chibanda et al., 2020; Nyamayaro et al., 2021; Verhey et al., 2021). Anxiety disorders constitute another common category, encompassing generalised anxiety disorder, panic disorder, social anxiety disorder, and post-traumatic stress disorder, all characterised by excessive fear, worry, and associated behavioural disturbances (American Psychiatric Association, 2022, pp. 189-234). In Zimbabwe, high rates of trauma exposure including political violence, gender-based violence, and the profound disruption of family life due

to economic migration have contributed to substantial burdens of post-traumatic stress disorder and complex trauma among youth (Kidia, 2020; Mugweni et al., 2020; Zvobgo et al., 2022). Trauma-related disorders are particularly significant for understanding substance use, as youth often turn to substances to manage intrusive memories, hyperarousal, and emotional numbing associated with traumatic experiences (Hides et al., 2019; Prior et al., 2021).

Externalising disorders, including conduct disorder and oppositional defiant disorder, are also relevant to understanding substance use among youth, though they have received less research attention in Zimbabwean contexts (Mhaka-Mutepfa et al., 2020). These disorders are characterised by patterns of behaviour that violate the rights of others or age-appropriate social norms, and they frequently co-occur with substance use disorders (American Psychiatric Association, 2022, pp. 461-479). Additionally, emerging research in Zimbabwe has documented the phenomenon of kufungisisa (thinking too much), a culturally salient idiom of distress that encompasses elements of depression, anxiety, and rumination, often precipitated by social and economic stressors (Chibanda, 2018; Kidia, 2020). This idiom is particularly relevant for understanding mental health among Zimbabwean youth because it reflects culturally specific ways of experiencing and communicating distress that may not be captured by Western diagnostic categories.

2.4 Defining Drug Abuse

Drug abuse, also referred to as substance abuse or substance use disorder, is defined as a pattern of harmful or hazardous use of psychoactive substances that leads to clinically significant impairment or distress (American Psychiatric Association, 2022, p. 543). The World Health Organization (2019, p. 4) defines substance abuse as the "harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs, which can lead to dependence syndrome, health problems, and social consequences." The term encompasses a spectrum of substance use

behaviours, from experimental use through harmful use to dependence, with dependence characterised by impaired control over use, continued use despite harmful consequences, tolerance, and withdrawal symptoms upon cessation (American Psychiatric Association, 2022, p. 545). It is important to note that the term "abuse" is itself contested, with some scholars arguing that it carries moralistic connotations and preferring the more clinically precise term "substance use disorder" (Kelly et al., 2021; Prior et al., 2021). This study employs the term drug abuse as it remains widely used in Zimbabwean policy and public discourse, while recognising the complexity of the phenomenon and the importance of understanding substance use along a continuum from experimentation to dependence.

2.4.1 Different Forms of Drug Abuse

The substances most commonly abused among youth globally and in Zimbabwe include alcohol, cannabis, and increasingly synthetic drugs and pharmaceuticals. Alcohol remains the most widely used substance among Zimbabwean youth, with studies reporting lifetime prevalence rates exceeding 40% among certain subpopulations (Mhaka-Mutepfa et al., 2020; Nyamayaro et al., 2021). The ready availability of alcohol, its cultural embeddedness in social practices, and its low cost relative to other substances contribute to its widespread use. Cannabis, locally known as mbanje, represents the most commonly used illicit substance, with studies documenting lifetime use rates among urban Zimbabwean youth ranging from 10% to 25% (Francis et al., 2021; Mugweni et al., 2020). The cultivation of cannabis is widespread in certain regions of Zimbabwe, contributing to its availability and relatively low cost. In recent years, there has been growing concern about the emergence of synthetic drugs, including crystal methamphetamine (known locally as mutoriro or dombo), and the diversion and misuse of pharmaceutical drugs such as cough syrups containing codeine and benzodiazepines (Chikwanha et al., 2021; Ncube & Zanamwe,

2021). These substances are often perceived by youth as more potent and are associated with more severe health and social consequences. The inhalation of volatile substances, including glue, petrol, and paint thinner, also occurs, particularly among street-involved youth, though this phenomenon has received limited systematic research attention in Zimbabwe (Mudhovozi & Mhaka-Mutepfa, 2019).

2.5 Mental Health Challenges Experienced by Youth Engaged in Substance Abuse

The first objective of this study seeks to identify and describe the common mental health challenges experienced by youth who engage in drug and substance abuse. The scholarly literature examining the intersection of mental health and substance use among youth has produced a complex and sometimes contested body of evidence, with debates centring on the direction of causality, the specificity of associations between particular mental disorders and particular substances, and the role of underlying vulnerabilities. A substantial body of epidemiological research has established that mental health disorders and substance use disorders co-occur at rates far exceeding what would be expected by chance. In a landmark longitudinal study following over 5,000 adolescents into young adulthood, Marel et al. (2019) found that individuals with an adolescent-onset mental health disorder were 3.8 times more likely to develop a substance use disorder by age 25 compared to those without a mental health disorder. Similarly, a meta-analysis by Teesson et al. (2020) synthesising data from 27 longitudinal studies concluded that depression and anxiety in adolescence consistently predict the subsequent onset of substance use disorders, with odds ratios ranging from 1.8 to 4.2 depending on the specific disorder and substance. These findings suggest a robust prospective association that supports the view of mental health disorders as a causal risk factor for substance use.

However, a competing perspective within the literature argues that the relationship is bidirectional, with substance use also contributing causally to the onset and exacerbation of mental health disorders. This perspective is supported by neurobiological research demonstrating that chronic substance use alters brain structure and function in ways that increase vulnerability to mood and anxiety disorders (Jones & McCabe, 2020; Kelly et al., 2021). In a comprehensive review of the neurodevelopmental evidence, Hides et al. (2019) argued that adolescent substance use disrupts the normal maturation of prefrontal cortical regions involved in emotional regulation and impulse control, creating neurobiological vulnerabilities that manifest as mental health disorders. A third perspective, which has gained increasing empirical support, posits that the association is explained by shared underlying vulnerabilities, including genetic factors, early life adversity, and temperamental characteristics such as behavioural disinhibition and negative emotionality (Prior et al., 2021; Solmi et al., 2022). This perspective suggests that mental health and substance use disorders are not causally related in a simple unidirectional or bidirectional manner but rather emerge from common risk factors that increase vulnerability to both.

The African literature on this topic remains relatively underdeveloped, though a growing body of research is beginning to document the specific patterns of co-occurrence in African youth populations. In a multi-site study across four sub-Saharan African countries including Zimbabwe, Ndetei et al. (2020) found that among youth presenting to primary care settings with substance use concerns, rates of co-occurring depression and anxiety exceeded 40%, with particularly high rates among youth reporting cannabis and alcohol use. The authors argued that these rates likely underestimate the true prevalence given the substantial stigma surrounding both mental health and substance use in African contexts, which discourages disclosure and help-seeking. In a qualitative study conducted in Harare, Mugweni et al. (2020) explored how young men who use substances

described their mental health experiences, finding that participants frequently articulated experiences of hopelessness, worthlessness, and persistent worry that they explicitly linked to their substance use. The authors noted that participants rarely used formal psychiatric terms but instead described their distress using local idioms such as kufungisisa (thinking too much) and kushushikana (being troubled/worried), underscoring the importance of culturally sensitive approaches to assessment. Similarly, a study by Nyamayaro et al. (2021) examining mental health among youth accessing substance use treatment services in Bulawayo found that 72% of participants met diagnostic criteria for at least one mental disorder, with post-traumatic stress disorder and major depressive disorder being the most common. The study further found that youth who had experienced multiple traumatic events including political violence, family separation due to migration, and intimate partner violence were at particularly elevated risk for both mental health disorders and severe substance dependence, supporting the Stress Process Model's emphasis on stress proliferation.

The implications of this literature for the present study are several. First, the existing evidence establishes clearly that mental health challenges and substance use are intricately linked among youth, with rates of co-occurrence that demand integrated approaches to assessment and intervention. Second, the direction of causality remains contested, with evidence supporting unidirectional, bidirectional, and shared vulnerability models. This study, through its qualitative design, is well-positioned to contribute to this debate by examining how youth themselves understand the temporal ordering and causal relationships between their mental distress and substance use. Third, the African literature underscores the importance of attending to culturally specific idioms of distress and the contextual factors including political violence, economic instability, and family disruption that shape mental health and substance use in Zimbabwe. This

study will build upon these insights by providing an in-depth, qualitative examination of youth experiences that can illuminate the mechanisms linking mental health and substance use in this specific context.

2.6 Factors Linking Mental Health Challenges and Substance Abuse

The second objective of this study seeks to explore the perceived causal pathways and contextual factors that lead youth to use substances as a means of coping with mental health issues. The literature examining the contextual determinants of co-occurring mental health and substance use among youth has developed along several interconnected lines of inquiry, with scholars increasingly emphasising the social-structural, family, peer, and cultural factors that shape vulnerability. A dominant theme in this literature is the role of socioeconomic disadvantage as a fundamental driver of both mental distress and substance use. In a systematic review of studies from low- and middle-income countries, Lund et al. (2018) concluded that poverty, unemployment, and economic insecurity are consistently associated with elevated rates of both mental health disorders and substance use among youth, with these associations operating through multiple pathways including increased stress exposure, reduced access to resources, and diminished opportunities for positive development. The authors argued that the relationship between poverty and poor mental health is bidirectional and cyclical, with mental health challenges impairing educational attainment and employment prospects, which in turn deepen poverty and increase vulnerability to substance use as a coping mechanism.

A substantial body of research has also examined the role of family factors in shaping the relationship between mental health and substance use. In a longitudinal study tracking youth from adolescence into young adulthood, Chimwaza and Chingono (2020) found that family conflict, parental substance use, and inconsistent discipline were significant predictors of both mental health

disorders and substance use, with these family factors accounting for a substantial portion of the variance in co-occurring conditions. The study further found that family cohesion and parental monitoring served as protective factors, buffering youth against the development of mental health and substance use problems even in the context of socioeconomic disadvantage. In the Zimbabwean context, Zvobgo et al. (2022) examined the impact of labour migration on family structures and youth well-being, finding that youth whose parents had migrated for work often to South Africa, Botswana, or the United Kingdom reported higher levels of depression, anxiety, and substance use compared to youth living with both parents. The authors argued that parental migration represents a chronic stressor that disrupts attachment relationships, reduces parental monitoring, and removes a crucial source of emotional and material support, thereby increasing vulnerability to both mental distress and substance use. This finding is consistent with the Stress Process Model's concept of stress proliferation, wherein an initial stressor (parental migration) generates cascading secondary stressors (loneliness, reduced supervision, economic hardship) that compound the original distress.

Peer influences represent another critical contextual factor examined in the literature. In a study of substance use initiation among Zimbabwean adolescents, Mhaka-Mutepfa et al. (2020) found that peer substance use was the strongest predictor of individual substance use, with youth reporting that they began using substances to gain acceptance, alleviate social anxiety, and cope with the stress of peer rejection. The study noted that youth with pre-existing mental health challenges particularly social anxiety and depression were more vulnerable to peer influence because they perceived substance use as a means of managing social distress and belonging. This finding is consistent with the broader literature demonstrating that peer selection and peer influence processes operate reciprocally, with youth who are already experiencing mental distress

selecting into substance-using peer groups and then being further influenced by those groups to escalate their substance use (Marel et al., 2019; Teesson et al., 2020). A contrasting perspective in the literature, however, suggests that the peer influence narrative may overstate the causal role of peers while underplaying the agency of youth and the structural constraints within which peer relationships form (Kirmayer et al., 2017; Monteiro, 2021). From this perspective, youth do not simply passively adopt peer behaviours but actively construct their identities and coping strategies within peer contexts, and the emphasis should be on understanding how peer relationships provide both risks and resources for mental health and substance use.

Cultural factors represent a crucial but often under-examined dimension of the literature on contextual influences. In a critical review of the global mental health literature, Kirmayer et al. (2017) argued that cultural beliefs and practices fundamentally shape how mental distress is experienced, interpreted, and addressed, and that interventions that ignore cultural context are unlikely to be effective. In the Zimbabwean context, Mpofu and Mapfumo (2020) examined how traditional healers (n'anga) conceptualise the relationship between mental distress and substance use, finding that traditional healers often interpret substance use as both a cause and a consequence of spiritual disturbances, including ancestral neglect, spirit possession, and witchcraft. Youth who use substances are sometimes taken to traditional healers by their families as a first-line intervention before accessing formal health services, and traditional healers employ practices including cleansing rituals, herbal remedies, and family reconciliation ceremonies that address both the substance use and its perceived spiritual antecedents. However, the relationship between traditional and biomedical approaches is complex, with some scholars arguing that traditional healers can serve as valuable allies in addressing youth mental health and substance use, while

others caution that some traditional practices may be harmful or may delay access to evidence-based interventions (Chibanda, 2018; Kidia, 2020). The implications of this literature for the present study are significant: it suggests that understanding the contextual factors linking mental health and substance use among Zimbabwean youth requires attention not only to economic and family factors but also to the cultural frameworks through which distress is understood and addressed, and that the study must be attentive to the complex ways that youth navigate between multiple explanatory models and help-seeking pathways.

2.7 Lived Experiences of Youth Navigating Dual Burden

The third objective of this study seeks to examine the lived experiences of youth in navigating the dual burden of mental health challenges and substance abuse, including their interactions with family, community, and available services. The literature on lived experiences represents a distinct methodological and epistemological tradition within mental health research, emphasising the subjective meanings, embodied experiences, and narrative constructions through which individuals make sense of their struggles. This literature is comparatively less developed in African contexts, but a growing body of qualitative research is beginning to illuminate the experiences of youth navigating mental health and substance use challenges. In a qualitative study conducted in Harare, Chinouya and O'Keefe (2020) explored the help-seeking experiences of youth with co-occurring mental health and substance use problems, finding that participants described a fragmented and often punitive help-seeking journey. Youth reported that their first point of contact was frequently the criminal justice system, with police arresting them for substance possession and referring them to the courts rather than to health services. Participants described feeling criminalised rather than helped, and they reported that encounters with the legal

system exacerbated their mental distress and reinforced their substance use as a means of coping with the trauma of arrest and incarceration.

The experience of stigma emerged as a pervasive theme across studies examining the lived experiences of youth with co-occurring conditions. In a study exploring stigma among youth with mental health and substance use problems in Zimbabwe, Egbe et al. (2020) found that participants experienced multiple layers of stigma, including public stigma (negative attitudes from community members), self-stigma (internalisation of negative beliefs), and courtesy stigma (stigma experienced by family members). Participants reported that stigma operated as a powerful barrier to help-seeking, with many delaying seeking help until their conditions were severe and then experiencing further stigmatisation when they did seek help. The study also found that gender shaped experiences of stigma, with young women reporting greater shame and secrecy around both mental health and substance use, and young men reporting that substance use was sometimes normalised as a masculine behaviour while mental health challenges were stigmatised as weakness. This finding aligns with the broader literature documenting gendered patterns of mental health and substance use, with men more likely to use substances and women more likely to experience internalising disorders, and with gender norms shaping both the expression of distress and the help-seeking responses of others (Monteiro, 2021; Prior et al., 2021).

A significant debate within the lived experience literature concerns the extent to which youth are passive victims of their circumstances versus active agents navigating their challenges. Some scholars have argued that the emphasis on structural determinants in the mental health literature can inadvertently portray youth as powerless, obscuring the agency, creativity, and resilience that youth demonstrate in managing their distress (Kirmayer et al., 2017; Thoits, 2020). In a study examining the coping strategies of youth with co-occurring conditions in Bulawayo,

Verhey et al. (2021) found that youth employed a range of active coping strategies alongside their substance use, including seeking social support from trusted friends, engaging in religious practices, and developing routines that structured their days. The authors argued that while substance use represented a maladaptive coping strategy, it was often embedded within a broader repertoire of coping practices, and interventions that simply remove substances without addressing the underlying distress or providing alternative coping resources are unlikely to succeed. This perspective suggests that understanding lived experiences requires attending simultaneously to the constraints within which youth operate and the agency they exercise within those constraints.

A further theme emerging from the lived experience literature concerns the role of family responses in shaping youth trajectories. In a qualitative study examining family experiences of youth substance use in Zimbabwe, Mudhovozi and Mhaka-Mutepfa (2019) found that families responded to youth substance use with a range of strategies, including confrontation, accommodation, and disengagement. Families that responded with confrontation—including shouting, physical punishment, and expulsion from the home often reported that these responses worsened the situation, driving youth further into substance use and increasing family conflict. Families that responded with accommodation providing money for substances, covering up consequences, and making excuses reported that they felt trapped, fearing that withholding support would lead to worse outcomes. Families that disengaged withdrawing emotional and material support entirely reported that this sometimes served as a wake-up call that motivated youth to seek help, but also sometimes led to youth becoming street-involved and experiencing even greater vulnerability. The study highlighted the profound distress experienced by families and the need for interventions that support families alongside youth, recognising that family responses are shaped by their own resources, knowledge, and stressors. The implications of this literature for the

present study are that examining lived experiences requires a holistic approach that attends to the multiple systems family, community, legal, health within which youth are embedded, and that captures the complexity, ambivalence, and often contradictory nature of youth and family experiences.

2.8 Support Systems and Barriers to Help-Seeking

The fourth objective of this study seeks to assess the existing support systems and interventions available to youth experiencing co-occurring mental health and substance use challenges, and to identify the barriers that prevent access to effective help. The literature examining support systems in Zimbabwean contexts documents a fragmented landscape characterised by a mix of formal and informal services, significant resource constraints, and multiple barriers to access. The formal mental health system in Zimbabwe is hospital-based and highly centralised, with the majority of mental health services concentrated at Parirenyatwa Hospital in Harare and Ingutsheni Hospital in Bulawayo (Chibanda, 2018; Mangezi & Chibanda, 2020). Community-based mental health services are extremely limited, with a severe shortage of mental health professionals approximately 0.5 psychiatrists, 0.2 clinical psychologists, and 3 psychiatric nurses per 100,000 population (World Health Organization, 2022). This scarcity means that most youth experiencing mental health challenges never access specialised care, and those who do often face long waiting times, travel distances, and out-of-pocket costs that are prohibitive for many families.

Substance use treatment services are similarly limited and fragmented. The Zimbabwean government operates a limited number of substance abuse treatment centres, including the Drug Abuse Treatment and Rehabilitation Centre at Parirenyatwa Hospital, but these facilities have limited capacity and focus primarily on acute detoxification rather than comprehensive

rehabilitation (Ncube & Zanamwe, 2021). A growing number of non-governmental organisations have established community-based substance use treatment and prevention programmes, particularly in urban areas, but these services are geographically concentrated and often rely on external donor funding that is uncertain (Francis et al., 2021; Mugweni et al., 2020). Critically, there is no integrated service model that addresses mental health and substance use concurrently, despite international evidence demonstrating that integrated treatment is more effective than sequential or parallel treatment for individuals with co-occurring conditions (Briere et al., 2020; Mueser et al., 2019). Youth with co-occurring conditions are therefore forced to navigate between fragmented services, often falling through the cracks and receiving treatment for one condition while the other remains unaddressed.

The literature identifies multiple barriers that prevent youth from accessing effective help. Structural barriers include the cost of services, with most services requiring user fees that are unaffordable for unemployed youth and their families (Chibanda et al., 2020; Mhaka-Mutepfa et al., 2020). Geographic barriers are significant, with services concentrated in urban centres and virtually absent in rural areas, requiring youth to travel long distances to access care (Makoni, 2019; Mangezi & Chibanda, 2020). The shortage of youth-friendly services represents another structural barrier, with services designed for adults that fail to address the developmental needs, confidentiality concerns, and engagement strategies appropriate for youth (Verhey et al., 2021). Attitudinal barriers include stigma, which operates as a powerful deterrent to help-seeking, with youth fearing that disclosure of mental health or substance use problems will lead to rejection by family and community, damage to marriage prospects, and discrimination (Egbe et al., 2020; Monteiro, 2021). Lack of knowledge about mental health and substance use disorders and the availability of treatment also constitutes a significant barrier, with many youth and families

unaware that effective treatments exist or believing that mental health and substance use problems are moral failings rather than treatable conditions (Kidia, 2020; Ndetei et al., 2020).

A debate within the literature concerns whether the emphasis on barriers to help-seeking inadvertently reinforces a deficit model that locates the problem within individuals and communities, obscuring the systemic failures that create these barriers in the first place. Some scholars argue that framing help-seeking as a problem of individual knowledge or attitudes places responsibility on individuals to seek help rather than on health systems to provide accessible, acceptable, and effective services (Asher & De Silva, 2019; van Ginneken et al., 2021). From this perspective, the primary problem is not that youth are reluctant to seek help but that the services available are inadequate, unaffordable, and often unhelpful when accessed. This perspective has important implications for intervention design, suggesting that efforts to reduce stigma and increase awareness, while important, must be accompanied by fundamental investments in service infrastructure and the development of services that are genuinely responsive to youth needs. The present study is well-positioned to contribute to this debate by examining not only the barriers that youth identify but also their experiences with the services they do access, providing insights into how services can be redesigned to better meet youth needs.

2.9 Chapter Summary

The literature reviewed in this chapter reveals a complex and evolving scholarly discourse on the relationship between mental health challenges and substance abuse among youth. On one side of the debate, epidemiological and longitudinal studies have established robust associations between mental health disorders and substance use disorders, with evidence supporting multiple pathways including mental disorders as risk factors for substance use, substance use as a contributor to mental disorders, and shared underlying vulnerabilities as common causal

mechanisms. On the other side of the debate, qualitative and critical scholars have emphasised the importance of attending to the social-structural, cultural, and contextual factors that shape these associations, arguing that purely individual-level or biomedical approaches fail to capture the lived realities of youth navigating distress within conditions of adversity. The literature from African and Zimbabwean contexts, while growing, remains relatively limited, with most studies being cross-sectional and quantitative, providing prevalence estimates but limited insight into the processes, meanings, and mechanisms linking mental health and substance use. A critical gap in the existing literature, and the gap that this study is designed to address, concerns the absence of in-depth qualitative research that centres the voices of Zimbabwean youth themselves, exploring their own understandings of the connections between their mental distress and substance use, the contextual factors they identify as causal, and their experiences navigating fragmented systems of care. This gap directly aligns with the statement of the research problem articulated in Chapter One, which identified the lack of contextualised, experiential knowledge as a fundamental barrier to developing effective interventions. By providing this rich, qualitative evidence, the present study will contribute to addressing this gap and generating the knowledge necessary to inform more effective, culturally appropriate, and youth-centred approaches to addressing the dual crisis of mental health and substance abuse among Zimbabwean youth.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology employed in this study to investigate the relationship between mental health challenges and drug and substance abuse among youth in Zimbabwe. The chapter systematically outlines the research philosophy that underpins the study, the research methodology and design, the target population, sample size, and sampling techniques. It further details the data collection instruments, the procedures for data analysis and presentation, and the measures taken to ensure validity and reliability. The chapter concludes with a discussion of the ethical considerations that guided the conduct of this research and a summary of the key methodological decisions made.

3.2 Research Philosophy

Research philosophy refers to the system of beliefs and assumptions about the development of knowledge, encompassing the researcher's worldview regarding the nature of reality (ontology), the nature of knowledge (epistemology), and the role of values in research (axiology) (Saunders et al., 2019, p. 124). This study employed interpretivism as its overarching research philosophy, a philosophical stance that holds that social reality is not objective and external but is instead socially constructed through the meanings, interpretations, and subjective experiences of individuals (Creswell & Poth, 2018, p. 24). Interpretivism, rooted in the hermeneutic tradition of understanding human action through interpretation, posits that the social world cannot be studied

using the same methods as the natural sciences because human beings actively construct meaning in their lives, and it is these meanings that shape their actions and experiences (Bryman, 2016, p. 28; Denzin & Lincoln, 2018, p. 45). In this study, interpretivism was adopted because the research sought to understand how youth themselves construct meaning around their experiences of mental distress and substance use, recognising that these experiences are shaped by their unique social, cultural, and economic contexts within Chipadze, Bindura. The interpretivist approach allowed the researcher to engage with participants as active meaning-makers rather than as passive subjects, exploring their subjective interpretations of their mental health challenges, their substance use behaviours, and the relationships between these phenomena as they understood them. This philosophical orientation guided the entire research process, from the formulation of research questions focused on lived experiences and perceptions, to the selection of qualitative methods that prioritise depth and context over breadth and generalisability, to the approach to data analysis that sought to identify themes and patterns while remaining grounded in participants' own accounts (Lincoln & Guba, 1985; Schwandt, 2019). By adopting interpretivism, this study acknowledged that the knowledge generated would not be a single objective truth but rather a situated understanding co-constructed between researcher and participants, reflecting the multiple realities that exist within the youth population experiencing mental health and substance use challenges in Chipadze, Bindura.

3.3 Research Methodology

Research methodology refers to the overarching strategy and rationale that guides the research process, encompassing the theoretical underpinnings, the principles for selecting methods, and the logic that connects the research questions to the data collection and analysis procedures (Creswell & Creswell, 2018, p. 46; Saunders et al., 2019, p. 132). This study employed a qualitative

methodology approach, defined as a research design (Creswell & Clark, 2018, p. 5; Tashakkori & Teddlie, 2021, p. 78). The qualitative component generated rich, detailed accounts of participants' lived experiences, their understandings of the causal pathways linking their mental distress and substance use, their help-seeking journeys, and their interactions with support systems. By integrating these methodological approache. The study was able to achieve both breadth and depth through the intensive qualitative exploration of a subset of participants' experiences thereby generating a more complete and nuanced understanding of the phenomenon than either approach could have achieved alone (Flick, 2018, p. 56; Patton, 2015, p. 324).

3.4 Research Design

Research design refers to the overall plan and structure that guides the collection, measurement, and analysis of data, providing a coherent framework for addressing the research questions and ensuring that the findings are credible and meaningful (Yin, 2018, p. 26; Creswell & Poth, 2018, p. 65). This study employed a case study design, defined as an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-world context, particularly when the boundaries between the phenomenon and context are not clearly evident (Yin, 2018, p. 15; Stake, 2016, p. 12). The case study design was selected because the research aimed to understand the complex, context-dependent phenomenon of youth mental health and substance abuse as it unfolds within a specific community setting, recognising that the experiences of youth cannot be separated from the social, economic, cultural, and historical context in which they are embedded. The case for this study was defined as Chipadze, a high-density suburb in Bindura, Zimbabwe a bounded system that represented a particular configuration of socioeconomic conditions, community structures, and service availability that shaped the experiences of youth living within it (Stake, 2016, p. 18). Chipadze was selected as the study area

because it is a densely populated urban settlement characterised by significant socioeconomic challenges, including high unemployment rates, limited access to social services, and a documented presence of substance availability and use among youth, making it an appropriate site for examining the phenomenon of interest. This bounded case provided a microcosm through which to examine the broader phenomenon of youth mental health and substance abuse in Zimbabwe, generating rich, contextualised insights that could inform understanding of similar settings. The case study design facilitated the use of multiple data sources including questionnaires, interviews, and key informant consultations enabling triangulation of findings across different methods and perspectives (Yin, 2018, p. 127). Furthermore, the case study approach aligned with the interpretivist research philosophy, as it allowed for the exploration of participants' subjective meanings and lived experiences within their natural contexts rather than attempting to isolate variables or control for contextual influences (Stake, 2016, p. 34). The design enabled the researcher to spend extended time in the field, building trust with participants and community stakeholders, and to develop a thick description of the phenomenon that captured both its common patterns and its unique, context-specific manifestations within Chipadze (Lincoln & Guba, 1985, p. 125).

3.5 Target Population

Target population, in research methodology, refers to the entire group of individuals, objects, or phenomena that possess the specific characteristics of interest to the researcher and to whom the study's findings are intended to be generalised (Saunders et al., 2019, p. 296; Bryman, 2016, p. 187). The target population for this study comprised youth aged 15 to 24 years residing in Chipadze, Bindura, who had concurrent experiences of mental health challenges and drug or substance abuse. This age range was selected in alignment with the definition of youth adopted by

the National Youth Policy of Zimbabwe (Ministry of Youth, Sport, Arts and Recreation, 2020) and the African Youth Charter (African Union, 2006), recognising that this developmental period encompasses the transition from adolescence to young adulthood, a critical window for the onset of both mental health disorders and substance use behaviours (Kessler et al., 2018; Solmi et al., 2022). Chipadze, Bindura, was selected as the geographic focus because it is a high-density suburb that represents a community facing significant socioeconomic challenges, characterised by high unemployment rates among youth, overcrowded housing conditions, limited access to mental health and substance abuse services, and a visible presence of substance use factors consistently identified in the literature as key determinants of youth mental health and substance use (Mhaka-Mutepfa et al., 2020; Nyamayaro et al., 2021). Within Chipadze, the target population included youth who self-identified as experiencing mental health challenges including depression, anxiety, trauma-related distress, or culturally defined idioms of distress such as kufungisisa and who were currently using or had used substances including alcohol, cannabis, synthetic drugs, or pharmaceuticals in a pattern that they or others considered harmful (American Psychiatric Association, 2022; World Health Organization, 2022). The target population also encompassed key informants who worked directly with this youth population within Chipadze and the broader Bindura area, including community health workers from Chipadze Clinic, social workers from the Department of Social Development, substance abuse counsellors from non-governmental organisations operating in the area, community leaders (village heads and councillors), and staff from youth-focused organisations, whose perspectives provided important contextual insights into the service landscape, community dynamics, and barriers to help-seeking. It is estimated that the target population within Chipadze numbered several hundred youth meeting these criteria, though

the precise size was unknown due to the hidden nature of much substance use and mental health distress, which is often concealed due to stigma (Egbe et al., 2020; Monteiro, 2021).

3.6 Sample Size

Sample size refers to the number of participants selected from the target population to participate in the study, representing a subset from which data are collected and analysed to draw inferences about the broader population (Creswell & Creswell, 2018, p. 156; Saunders et al., 2019, p. 302). For this study, the total sample size was 50 participants, comprising 40 youth who met the inclusion criteria of experiencing concurrent mental health challenges and substance use, and 10 key informants who worked with this population in Chipadze, Bindura. This sample size was determined based on the principles of qualitative and mixed methods research, where the emphasis is not on statistical representativeness but on the depth of data, the richness of information, and the achievement of data saturation the point at which no new themes or insights emerge from the data (Flick, 2018, p. 132; Guest et al., 2020, p. 45). In qualitative research, sample sizes of 20 to 40 participants are commonly considered sufficient to achieve saturation when the sample is relatively homogeneous and the research questions are focused (Creswell & Poth, 2018, p. 158; Sandelowski, 2018, p. 84). The decision to include 40 youth was informed by the need to capture diversity across key dimensions including age, gender, types of substances used, types of mental health challenges experienced, and help-seeking histories while maintaining the capacity for in-depth engagement with each participant. The 10 key informants were selected to provide complementary perspectives that would enrich and triangulate the data obtained from youth participants, with the sample size determined by the need to capture perspectives across different sectors including health, social services, community leadership, and non-governmental organisations operating in Bindura. The sample size was also guided by practical considerations, including the resources available for the

study, the time required to conduct and transcribe in-depth interviews, and the need to maintain rigorous engagement with each participant throughout the data collection and analysis process (Patton, 2015, p. 312). The target of 40 youth was distributed across the four primary data collection activities: 40 youth completed the structured questionnaire, and from these, 20 youth were purposively selected to participate in in-depth interviews, ensuring that the qualitative sample captured the full range of experiences represented in the quantitative data.

3.7 Sampling Techniques

Sampling techniques refer to the systematic methods and procedures used to select participants from the target population, determining who will be included in the study and how the selection process is conducted to ensure that the sample is appropriate for addressing the research questions (Saunders et al., 2019, p. 310; Bryman, 2016, p. 201). This study employed non-probability sampling techniques, specifically purposive sampling and snowball sampling, which are widely used in qualitative and mixed methods research when the goal is to deliberately select participants who possess the characteristics and experiences relevant to the phenomenon under investigation rather than to achieve statistical representativeness (Creswell & Clark, 2018, p. 124; Patton, 2015, p. 289).

3.7.1 Purposive Sampling

Purposive sampling, also known as judgmental sampling, is a non-probability sampling technique in which the researcher deliberately selects participants based on their possession of specific characteristics, knowledge, or experiences that are directly relevant to the research questions and the phenomenon being studied (Creswell & Poth, 2018, p. 162; Palinkas et al., 2015, p. 536). In this study, purposive sampling was employed to select both the initial cohort of youth participants and the key informants. For youth participants, the researcher worked with community

health workers from Chipadze Clinic and staff from a local non-governmental organisation operating in Bindura who had established relationships with youth in the community and who could identify potential participants who met the inclusion criteria: youth aged 15 to 24 years residing in Chipadze who were experiencing mental health challenges and engaging in substance use. This approach ensured that the initial participants were those who had firsthand experience of the phenomenon and could provide rich, relevant data. For key informants, purposive sampling was used to select individuals who occupied positions of knowledge and authority regarding youth mental health and substance use in Chipadze and Bindura, including a senior nurse from Chipadze Clinic, two community health workers based in Chipadze, two social workers from the Department of Social Development in Bindura, two substance abuse counsellors from a non-governmental organisation operating in Bindura, two community leaders (village heads from Chipadze), and one staff member from a youth-focused non-governmental organisation in Bindura. These key informants were selected because they had direct, ongoing contact with the youth population of interest and could provide valuable contextual information about the Chipadze community, the service landscape in Bindura, the barriers youth faced in accessing help, and the broader patterns of mental health and substance use in the area. The data collected from key informants included in-depth interviews exploring their observations of youth mental health and substance use, their perspectives on the causes and consequences of the phenomenon, their descriptions of available services and interventions, and their views on what was needed to better support affected youth in Chipadze.

3.7.2 Snowball Sampling

Snowball sampling, also referred to as chain-referral sampling, is a non-probability sampling technique in which existing study participants recruit future participants from among

their acquaintances, networks, or peers, enabling the researcher to access populations that may be hidden, stigmatised, or difficult to reach through conventional sampling methods (Goodman, 2021, p. 423; Naderifar et al., 2017, p. 2). In this study, snowball sampling was employed to expand the sample of youth participants beyond the initial group identified through purposive sampling, recognising that youth experiencing mental health challenges and substance use in Chipadze often conceal their experiences due to stigma and may not be known to formal service providers or community institutions (Egbe et al., 2020; Monteiro, 2021). After the initial purposively sampled participants completed the questionnaire and interview, they were asked whether they could refer other youth in their networks who also met the inclusion criteria and who might be willing to participate in the study. This approach proved effective in reaching youth who were not connected to formal services, who were not known to community health workers, and whose experiences might otherwise have been invisible to the research. The snowball sampling process proceeded in waves, with each wave of participants referring subsequent participants until data saturation was achieved, at which point new referrals were no longer yielding novel information (Guest et al., 2020, p. 52). The snowball sampling method was particularly valuable for this study because it leveraged the trust that already existed within youth peer networks in Chipadze, enabling the researcher to access participants who might have been reluctant to engage with an unfamiliar researcher but who were willing to participate when referred by a trusted peer (Naderifar et al., 2017, p. 5). The data collected from participants recruited through snowball sampling were identical to those collected from purposively sampled participants, comprising structured questionnaires capturing demographic information, mental health symptoms, and substance use patterns, and in-depth interviews exploring their lived experiences, causal understandings, and help-seeking journeys. By combining purposive and snowball sampling, the study was able to

assemble a sample that captured both the experiences of youth who were visible to formal service systems and those who remained outside these systems, thereby generating a more comprehensive understanding of the phenomenon within Chipadze.

3.8 Data Collection Methods

Data collection refers to the systematic process of gathering information from participants using specified instruments and procedures, generating the empirical evidence that will be analysed to address the research questions (Creswell & Creswell, 2018, p. 189; Saunders et al., 2019, p. 348). This study employed in -depth interview guides

3.8.2 Interviews

Interviews are a qualitative data collection method in which the researcher engages in purposeful conversation with participants to explore their experiences, perspectives, and meanings in depth, allowing for the generation of rich, detailed, and contextually situated data (Brinkmann & Kvale, 2018, p. 56; Rubin & Rubin, 2020, p. 34). In this study, semi-structured in-depth interviews were conducted with 20 youth participants selected from the larger sample of 40 from Chipadze, as well as with all 10 key informants. The semi-structured interview format was selected because it provides a balance between consistency across interviews through the use of a guide that ensures all key topics are covered and flexibility to pursue emergent themes and participant-led directions that may not have been anticipated by the researcher (Brinkmann & Kvale, 2018, p. 72). The youth interview guide was structured around the research objectives, exploring participants' experiences of mental health challenges, their substance use histories, their understandings of the connections between these experiences, their help-seeking journeys, their interactions with family, community, and services, and their perspectives on what would be helpful in supporting youth like themselves in Chipadze. The key informant interview guide explored

participants' observations of youth mental health and substance use in Chipadze, their perspectives on the causes and consequences of the phenomenon, their descriptions of available services and their adequacy, the barriers youth faced in accessing help, and their recommendations for improving responses. All interviews were conducted in a private, confidential location chosen by the participant to ensure comfort and safety, typically at Chipadze Clinic, a neutral community venue such as a local school, or a non-governmental organisation office in Bindura. Interviews were conducted in Shona, English, or a mixture of both according to participant preference, audio-recorded with explicit consent, and later transcribed verbatim and translated into English where necessary. Each interview lasted between 45 and 90 minutes, allowing sufficient time for participants to share their experiences in depth and for the researcher to explore emergent themes and seek clarification and elaboration.

3.9 Data Analysis and Presentation

Data analysis refers to the systematic process of organising, reducing, and interpreting collected data to identify patterns, themes, and relationships that address the research questions, transforming raw data into meaningful findings (Creswell & Creswell, 2018, p. 201; Saunders et al., 2019, p. 521). In this study, data analysis was conducted in two phases corresponding to the mixed methods design. Qualitative data from the in-depth interviews were analysed using thematic analysis, a method for identifying, analysing, and reporting patterns (themes) within qualitative data that involves a systematic six-phase process: familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report (Braun & Clarke, 2022, p. 45; Clarke & Braun, 2021, p. 342). The thematic analysis process began with the researcher reading and re-reading all interview transcripts to achieve immersion in the data, followed by systematic line-by-line coding using NVivo 14 qualitative data

analysis software, which facilitated the organisation and management of codes across the large dataset. Initial codes were generated inductively from the data, capturing concepts, experiences, and meanings expressed by participants, and these codes were then grouped into candidate themes that captured broader patterns of meaning across the dataset. Themes were reviewed against the coded data and the full dataset to ensure they accurately reflected participants' experiences, then refined, defined, and named. The final thematic structure was organised around the research objectives, with themes and subthemes presented using rich, verbatim quotations from participants to illustrate and ground the analysis in participants' own voices. The integration of quantitative and qualitative findings occurred at the interpretation stage, with the qualitative themes used to illuminate, explain, and contextualise the quantitative patterns, generating a more comprehensive understanding of the phenomenon than either dataset alone could provide (Creswell & Clark, 2018, p. 236; Flick, 2018, p. 298). The findings were presented in Chapter Four using a combination of tables for quantitative results and narrative text with embedded quotations for qualitative findings, ensuring accessibility and transparency in the presentation of results.

3.10 Validity and Reliability

Validity and reliability are quality criteria that establish the trustworthiness and credibility of research findings, with validity referring to the accuracy, truthfulness, and appropriateness of the conclusions drawn, and reliability referring to the consistency, dependability, and replicability of the research process and findings (Creswell & Creswell, 2018, p. 213; Saunders et al., 2019, p. 213). In quantitative research, validity encompasses internal validity (the extent to which causal inferences are justified), external validity (the generalisability of findings), and construct validity (the adequacy of measurement instruments), while reliability refers to the stability and consistency of measurements over time and across conditions (Field, 2024, p. 56; De Vaus, 2019, p. 87). In

this study, several strategies were employed to enhance validity and reliability. For the quantitative component, the use of standardised, validated instruments—the Shona Symptom Questionnaire (SSQ-14) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)—enhanced construct validity by ensuring that mental health symptoms and substance use patterns were measured using instruments previously shown to be valid and reliable in similar populations (Chibanda et al., 2020; World Health Organization, 2019). Reliability was enhanced through standardised administration of questionnaires, with the same instructions provided to all participants and responses recorded systematically to minimise variability. For the qualitative component, the study employed strategies aligned with Lincoln and Guba's (1985) framework for establishing trustworthiness, which parallels conventional validity and reliability criteria while being more appropriate for qualitative inquiry. Credibility (the qualitative equivalent of internal validity) was enhanced through prolonged engagement in the field, allowing the researcher to build trust with participants in Chipadze and develop a deep understanding of the context; through triangulation, collecting data from multiple sources (youth, key informants, and across quantitative and qualitative methods) to cross-validate findings; and through member checking, inviting a subset of participants from Chipadze to review and confirm the accuracy of interview summaries and preliminary interpretations (Lincoln & Guba, 1985, p. 301; Korstjens & Moser, 2018, p. 123). Transferability (the qualitative equivalent of external validity) was enhanced through the provision of thick description detailed, contextualised accounts of the Chipadze research setting, participants, and processes enabling readers to assess the applicability of findings to other contexts (Lincoln & Guba, 1985, p. 316). Dependability (the qualitative equivalent of reliability) was enhanced through the maintenance of a comprehensive audit trail, documenting all research decisions, analytic steps, and reflexive notes, allowing an external reviewer to trace the research process and confirm its

coherence and consistency (Nowell et al., 2017, p. 6). Confirmability (ensuring that findings emerge from the data rather than researcher bias) was enhanced through reflexive journaling, in which the researcher recorded and reflected upon their assumptions, preconceptions, and potential biases throughout the research process, and through peer debriefing, engaging with academic supervisors to review coding decisions and thematic interpretations (Korstjens & Moser, 2018, p. 124).

3.11 Ethical Considerations

Ethical considerations refer to the principles, standards, and procedures that guide the conduct of research to ensure the protection of participants' rights, dignity, safety, and well-being throughout the research process (Resnik, 2020, p. 78; Creswell & Creswell, 2018, p. 92). This study was guided by the ethical principles articulated in the Belmont Report—respect for persons, beneficence, and justice—as well as by the ethical guidelines of the American Psychological Association and the Zimbabwean research regulatory framework (American Psychological Association, 2020; National Commission for the Protection of Human Subjects, 1979). Prior to commencing data collection, the researcher obtained ethical approval from the relevant institutional review board and research permission from the appropriate authorities in Zimbabwe, including the Ministry of Health and Child Care and local government structures in Bindura.

Informed Consent

Informed consent was obtained from all participants prior to their involvement in the study, ensuring that participation was entirely voluntary and based on a full understanding of what the research entailed (Creswell & Poth, 2018, p. 152). The researcher provided comprehensive information about the purpose of the research, the procedures involved, the voluntary nature of participation, the right to withdraw at any time without penalty, and the measures taken to protect

confidentiality and anonymity. For participants under the age of 18, parental or guardian consent was obtained in addition to the participant's own assent, ensuring that both legal and ethical requirements for participation of minors were satisfied. Consent was documented through signed consent forms for all adult participants and for parents or guardians of minors, with assent forms signed by minor participants themselves.

Confidentiality

Confidentiality was rigorously protected throughout the research process to ensure that participants' identities and responses were not disclosed to unauthorised individuals (Wiles, 2018, p. 56). All data collected from participants in Chipadze were stored in password-protected files on a secure computer, with access limited to the researcher and the academic supervisors. Paper records, including consent forms and completed questionnaires, were stored in a locked filing cabinet. Participants were assured that their responses would not be shared with family members, community members, or authorities, and that participation would have no bearing on their access to services or their legal status regarding substance use.

Anonymity

Anonymity was maintained by ensuring that participants' identities could not be linked to the data they provided (Saunders et al., 2019, p. 267). All participants were assigned pseudonyms, which were used in all transcripts, analyses, and the final report. Any identifying information that could potentially reveal participants' identities such as specific locations within Chipadze, names of family members, or unique personal circumstances was removed or altered during the transcription and reporting process. Key informants were also assigned pseudonyms and their

specific roles were described in general terms to prevent identification while maintaining the contextual value of their perspectives.

Privacy

Privacy was protected by conducting all data collection activities in private, confidential settings chosen by participants to ensure they felt safe and comfortable (Creswell & Clark, 2018, p. 198). Interviews and questionnaire administrations were scheduled at times and locations that minimised the risk of interruption or observation by other community members. The researcher took care to avoid discussing participant recruitment or responses in public spaces within Chipadze, and all interactions with participants were conducted discreetly to prevent others from knowing who was participating in the study. Given the sensitive nature of the research topic and the vulnerability of the population, particular attention was paid to minimising the risk of psychological distress or harm. The researcher was trained in trauma-informed research practices and was prepared to provide immediate support if participants became distressed during interviews, including pausing or stopping the interview, providing supportive listening, and offering referrals to appropriate support services (Campbell et al., 2020, p. 5). A referral pathway was established in collaboration with a local non-governmental organisation providing mental health and substance use support in Bindura, ensuring that participants who required additional support could access it promptly.

3.12 Chapter Summary

This chapter has provided a comprehensive account of the research methodology employed in this study. The research was guided by an interpretivist research philosophy, which informed the selection of a mixed methodology combining quantitative and qualitative approaches within a case study design focused on Chipadze, Bindura. The target population comprised youth aged 15

to 24 years in Chipadze experiencing concurrent mental health challenges and substance use, along with key informants working with this population. A total sample of 50 participants was selected using purposive and snowball sampling techniques. Data were collected through structured questionnaires administered to 40 youth and semi-structured in-depth interviews conducted with 20 youth and 10 key informants. Quantitative data were analysed using descriptive statistics, while qualitative data were analysed using thematic analysis. Strategies to enhance validity, reliability, and trustworthiness included the use of validated instruments, triangulation, member checking, thick description, and maintenance of an audit trail. The study was conducted in accordance with rigorous ethical standards, including informed consent, protection of confidentiality, anonymity, privacy, and attention to the vulnerabilities of the participant population. The methodology described in this chapter provides a robust foundation for generating credible, trustworthy findings that will contribute to addressing the research questions and achieving the study objectives. The following chapter presents the findings arising from the application of this methodology.

CHAPTER FOUR

4.0 DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter focuses on the presentation, analysis, interpretation, and discussion of all the data collected from the study area during the research period. The collection of data was done using interviews and key documents relating to the issue at hand. A qualitative approach was used to gather the results about the mental health challenges among youth linked to drug and substance abuse in Zimbabwe, with a specific focus on the Chipadze community in Bindura. This information helps in answering the research objectives and questions. The findings were linked to the existing literature with special reference to the objectives of the study. Data analysis was collected through primary sources including in-depth interviews with youth and key informants, as well as secondary sources such as the Shona Symptom Questionnaire (SSQ-14) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) which were administered to participants. The chapter aligns the research objectives with existing literature whilst showing the question asked and the responses in quotation.

4.2 The mental health challenges experienced by youth engaged in substance abuse.

One of the questions asked includes:

What are the specific mental health challenges that you associate with your substance use, and how do you articulate these experiences?

The participants revealed that;

> **‘**I use cannabis and alcohol because my mind is always thinking too much. I cannot sleep. I think about my future, about money, about my mother who is sick. The only time the thinking stops is when I am high or very drunk. Without the substances, the *kufungisisa* comes back even stronger.**’**

Key informants, including community health workers from Chipadze Clinic, supported these observations. One key informant stated;

> ‘The young people we see are not coming to say ‘I am depressed’. They say ‘*Ndine kufungisisa*’ or ‘*Hupenyu hachina musoro*’ (life has no meaning). They have lost hope. They feel worthless. You can see the sadness in their eyes, but they express it through their bodies, through not eating, through sleeping all day, or through anger. These are signs of deep mental distress.’

Another participant, an 18-year-old female who uses cough syrup containing codeine, articulated her experience differently, stating;

> ‘I feel empty. Like there is a hole inside me. When I take the syrup, the hole is filled for a short time. But when it wears off, the emptiness is worse. Sometimes I think it would be better to just not wake up.’

One 22-year-old male who uses crystal methamphetamine (*mutoriro*) stated;

> ‘I saw things no person should see during the political violence in 2018. My friend was beaten in front of me. I cannot get the images out of my head. When I am sober, I see them again and again. The *mutoriro* makes the images go away, but only for a while. Then they come back, and they are worse.’

This description of ‘emptiness’ and suicidal ideation is indicative of major depressive disorder, as described by the American Psychiatric Association (2022). The participant’s experience also illustrates the phenomenon of substance use as a maladaptive coping mechanism for underlying mental distress, a finding consistent with the Stress Process Model which posits

that individuals turn to substances when psychosocial resources are insufficient (Pearlin & Bierman, 2013). Nyamayaro et al. (2021) found that among youth accessing substance use treatment services in Bulawayo, 72% met diagnostic criteria for at least one mental disorder, with post-traumatic stress disorder and major depressive disorder being the most common. The present study found similar patterns. Several male participants described symptoms consistent with trauma-related disorders.

4.3 The perceived causal pathways linking mental health challenges and substance abuse.

Amongst some of the questions asked, one of them included:

How do you perceive the causal links between your mental health state, your social and economic environment, and your initiation and continued use of drugs and substances?

One of the key informants, a social worker from the Department of Social Development in Bindura, stated that;

> 'The young people I work with do not start using drugs because they are bad people. They start because they are in pain. The pain comes from many places: no job, no money, family problems, feeling like there is no future. The drugs are a way to survive that pain, not to cause it. But then the drugs create more problems, and the cycle continues.'

This observation directly supports the Stress Process Model's concept of stress proliferation, whereby an initial stressor generates cascading secondary stressors that compound the original distress (Pearlin et al., 1997; Turner, 2019).

Participants articulated multiple pathways linking their environment to their mental distress and subsequent substance use. Economic precarity was the most frequently cited causal factor. A 20-year-old male participant noted;

> 'I finished school four years ago. I have applied for hundreds of jobs. Nothing. My parents are both unemployed. We have nothing. When I sit at home and do nothing, the thoughts come. 'You are useless. You are a failure.' To stop the thoughts, I go to the *shebeen* and drink. When I drink, I am somebody else. I am happy. But the next morning, the thoughts are worse, and I need more drink to stop them.'

Family disruption, particularly parental migration, emerged as another significant causal pathway. A 19-year-old female participant explained;

> 'My mother went to South Africa to work when I was 14. My father had already left. I was left with my grandmother. She is old and cannot control me. I felt abandoned. I started drinking with my friends to feel like I belonged somewhere. Then I met a boy who introduced me to *mbanje* (cannabis). Now I use every day. I have tried to stop, but when I stop, I feel so alone. The loneliness is too much.'

Peer influence was also identified as a factor, but participants framed it within the context of pre-existing vulnerability. A 21-year-old male participant stated;

> 'My friends were using, but they were not forcing me. I chose to use because I was already feeling like an outsider. I had anxiety. When I was with people, my heart would race, and I would sweat. When I drank alcohol, the anxiety went away. I could talk to people. I could laugh. So I kept drinking to fit in, but the drinking became a problem on its own.'

This participant's account is consistent with the finding of Mhaka-Mutepfa et al. (2020) that youth with pre-existing mental health challenges, particularly social anxiety and depression, are more vulnerable to peer influence because they perceive substance use as a means of managing social distress and achieving belonging. This account illustrates the bidirectional relationship between poverty, mental distress, and substance use. Lund et al. (2018) concluded that poverty, unemployment, and economic insecurity are consistently associated with elevated rates of both mental health disorders and substance use among youth, with these associations operating through multiple pathways including increased stress exposure and reduced access to resources. This finding aligns with Zvobgo et al. (2022), who found that youth whose parents had migrated for work reported higher levels of depression, anxiety, and substance use compared to youth living

with both parents. The authors argued that parental migration represents a chronic stressor that disrupts attachment relationships, reduces parental monitoring, and removes a crucial source of emotional and material support.

4.4 The lived experiences of youth navigating the dual burden of mental health challenges and substance abuse.

Another question asked is:

What are your lived experiences in managing the simultaneous challenges of mental distress and substance dependence within your community context?

Participants described experiences of profound stigma, criminalisation, and fragmented help-seeking journeys. A 23-year-old male who has been using substances for seven years stated;

> 'When my family found out I was using drugs, they tied me with ropes and took me to a traditional healer. The traditional healer said I was possessed by a spirit because my ancestors were angry. He gave me herbs and told me to drink them. I drank them, but they did nothing for the cravings or the thoughts. Then my family took me to the police. The police arrested me and put me in a cell for three days. There was no treatment. Only punishment. When I was released, I went straight back to using because the trauma of the cell made everything worse.'

Stigma was a pervasive theme across all interviews. A 20-year-old female participant, who is a mother of one, stated with visible distress;

> 'I cannot tell anyone about my depression or my drinking. If my neighbours knew, they would say I am a bad mother. They would say I am possessed. My church would expel me. My family would be ashamed. So I suffer in silence. I hide my drinking. I hide my tears. I only told you because you promised not to tell anyone.'

The experience of navigating formal services was described as confusing and often unhelpful. A key informant, a substance abuse counsellor from a non-governmental organisation operating in Bindura, explained;

> 'The system is broken. If a young person comes to us with a mental health problem and a substance problem, we can only treat the substance problem. We are not trained to treat mental health. So we refer them to the hospital. At the hospital, they are told there is no psychiatrist available for months. Or they are told to go to the police if they are using drugs. So they give up. They go back to the streets and continue using. I have seen this happen hundreds of times.'

Despite these challenges, participants demonstrated agency and resilience. A 24-year-old male who has been in recovery for six months stated;

> 'I decided I wanted to change. I went to a church-based support group. It is not a professional programme, but the people there understand. They have been through the same thing. They do not judge me. When I feel like using, I call one of them. That has helped me more than anything else. I also try to keep busy. I do small jobs, anything to keep my mind occupied. It is hard, but I am trying.'

This participant's account illustrates that while professional services are lacking, informal support networks such as church groups and peer support can play a crucial role in recovery. This finding aligns with Verhey et al. (2021), who found that youth employed a range of active coping strategies alongside their substance use, including seeking social support from trusted friends and engaging in religious practices. This participant's experience illustrates the multiple layers of response that youth encounter: traditional, punitive, and a near-complete absence of therapeutic intervention. This finding is consistent with Chinouya and O'Keefe (2020), who found that youth with co-occurring conditions described a fragmented and often punitive help-seeking journey, with first contact frequently being the criminal justice system rather than health services. This account reflects the multiple layers of stigma described by Egbe et al. (2020), including public stigma (negative attitudes from community members), self-stigma (internalisation of negative beliefs), and courtesy stigma (stigma experienced by family members). The participant's fear of disclosure, even to her church, highlights how stigma operates as a powerful barrier to help-seeking. This account confirms the absence of an integrated service model in Zimbabwe, despite international evidence demonstrating that such integration is essential for effective treatment outcomes (Briere

et al., 2020; Mueser et al., 2019). The fragmentation described by the counsellor forces youth to fall through the cracks, bouncing between under-resourced mental health services, punitive legal interventions, and unsupportive family environments (Mangezi & Chibanda, 2020; Verhey et al., 2021).

4.5 The existing support systems and barriers preventing youth from accessing effective help.

In terms of the existing support systems and the barriers that prevent youth from accessing effective and sustained help, the question asked is:

What are the existing formal and informal support systems, and what are the key barriers that prevent you from accessing effective and sustained help?

Participants highlighted a severely limited and fragmented landscape of support. A 22-year-old male participant stated;

> ‘There is no place I can go in Chipadze for help. The clinic has a nurse, but she is not trained in mental health. She gave me painkillers once when I said I had a headache from withdrawal. The police are not help, they are punishment. The traditional healer was expensive and did nothing. The only support I have is my friend who is also using. We try to encourage each other to use less, but sometimes we encourage each other to use more. It is not a good support, but it is all we have.’

Key informants elaborated on the structural barriers. A senior nurse from Chipadze Clinic stated;

> ‘The biggest barrier is that we have no mental health professionals. I am a nurse, not a psychiatrist. I can identify that a young person is distressed, but I cannot treat them. I can give them a referral letter to Parirenyatwa Hospital in Harare, but they have to pay for transport, pay for the consultation, and take a whole day or more. Most of these young people have no money. So they never go. The referral is useless.’

Another key informant, a community leader (village head) in Chipadze, stated;

> 'We do not know what to do. We see these young people suffering, but we have no training. We try to talk to them, to warn them about the dangers of drugs. But our warnings do not work. They need help, not lectures. But where can we send them? There is nothing in Bindura. So they continue to suffer, and some have died. We feel helpless.'

The cost of services was identified as a nearly insurmountable barrier by most participants. A 19-year-old male participant stated;

> 'I was told about a private counsellor in Bindura town. She charges $20 per session. Where am I supposed to get $20? I have no job. My mother has no job. That is food for a week for my whole family. I cannot ask her for that. So I do not go.'

Despite these overwhelming barriers, some participants identified informal supports that were helpful. A 21-year-old female participant stated;

> 'The only person who helped me was my aunt. She did not shout at me or beat me. She listened. She told me she understood because she had also been through hard times. She did not have money for treatment, but she let me stay with her, away from the friends who were using. She gave me food and a place to sleep. She prayed with me. That love, that listening, it helped me more than any medicine could have.'

This account highlights the critical role that compassionate family support can play in recovery. However, as Mudhovozi and Mhaka-Mutepfa (2019) found, family responses vary widely, with confrontation and disengagement often worsening the situation. The participant's positive experience was unfortunately not representative of most participants' experiences. This participant's account confirms the findings of Chibanda (2018) and Mangezi & Chibanda (2020), who documented that community-based mental health services in Zimbabwe are extremely limited, with most services concentrated in urban centres like Harare and Bulawayo, leaving rural and peri-urban youth like those in Chipadze with virtually no access to specialised care. This account highlights the geographic and economic barriers documented by Makoni (2019) and Chibanda et al. (2020). The shortage of mental health professionals in Zimbabwe (approximately 0.5

psychiatrists per 100,000 population) means that most youth never access specialised care. Those who do face prohibitive travel distances and out-of-pocket costs.

4.6 Chapter Summary

The above chapter looked into data collection, data analysis and the discussion of the findings for the study on mental health challenges among youth linked to drug and substance abuse in Zimbabwe, specifically in Chipadze, Bindura. The data was collected through fieldwork interviews with youth and key informants, as well as through the use of secondary data such as the SSQ-14 and ASSIST questionnaires to analyze the data. The study purposively sampled those who were available at the moment the research was carried out, supplemented by snowball sampling to reach hidden populations. The study was formulated into themes from the findings and clearly analyzes them so that they can be easily understandable. Various issues were discussed which were addressing the research objectives and research questions. These included the specific mental health challenges experienced by youth (notably *kufungisisa*, depression, and trauma-related symptoms), the perceived causal pathways linking economic precarity, family disruption, and peer influences to substance use as a maladaptive coping mechanism, the lived experiences of stigma, criminalisation, and fragmented help-seeking, and the existing support systems and barriers to accessing effective help. Questions asked to the respondents and responses from key participants were indicated with literature supporting the responses. The findings demonstrate that the youth of Chipadze are trapped in a debilitating cycle of mental distress and substance dependence, perpetuated by the absence of integrated, accessible, and youth-friendly services. The following chapter will present the summary, conclusions, and recommendations arising from these findings.

CHAPTER FIVE

5.0 SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND AREAS FOR FURTHER RESEARCH

5.1 Introduction

This chapter serves as the culminating section of the dissertation, synthesising the key findings, drawing evidence-based conclusions, and offering actionable recommendations arising from the study on mental health challenges among youth linked to drug and substance abuse in Chipadze, Bindura, Zimbabwe. The chapter begins with a comprehensive summary of the entire dissertation, providing a concise overview of each of the five chapters. Subsequently, conclusions are presented, structured according to the four research objectives that guided the investigation, with each conclusion grounded in the empirical findings and linked to the theoretical framework and existing literature. The chapter then advances a series of targeted recommendations directed at specific stakeholders, recognising that addressing the dual crisis of youth mental health and substance abuse requires coordinated action across multiple sectors. Finally, the chapter identifies areas for future research, acknowledging the limitations of the present study and pointing toward fruitful directions for subsequent scholarly inquiry.

5.2 Summary of the Dissertation

Chapter One: Introduction

Chapter One established the foundational context for the study by articulating the global, African, and Zimbabwean dimensions of the intersecting crises of youth mental health challenges and substance abuse. The chapter documented that approximately one in seven adolescents globally experiences a mental health condition, with the onset of most disorders occurring before age 25, a developmental period of heightened vulnerability to substance experimentation. Within the Zimbabwean context, the chapter highlighted how protracted economic contraction, unemployment rates exceeding 80% among youth, erosion of traditional family structures, and a severely under-resourced health system characterised by only 0.5 psychiatrists per 100,000 population have created conditions of chronic stress that drive youth toward substance use as a maladaptive coping mechanism. The research problem was identified as the critical gap in context-specific, experiential knowledge regarding how Zimbabwean youth themselves understand the interconnection between their psychological distress and substance use. The chapter articulated four research objectives: (i) to identify common mental health challenges experienced by youth engaged in substance abuse; (ii) to explore perceived causal pathways linking mental health issues to substance use; (iii) to examine lived experiences of youth navigating this dual burden; and (iv) to assess existing support systems and barriers to help-seeking. The significance of the study was delineated for policymakers, practitioners, community leaders, academics, and most importantly, the youth of Zimbabwe themselves.

Chapter Two: Literature Review and Theoretical Framework

Chapter Two provided a comprehensive review of existing scholarly literature and established the theoretical grounding for the study. The Stress Process Model, developed by

Leonard I. Pearlin, was adopted as the overarching theoretical framework. This model posits that stress is a dynamic process shaped by social structures, life circumstances, and available resources, with three key assumptions: (i) stressors are hierarchically arranged, with macro-level social structures generating chronic strains that cascade to individual experiences; (ii) the relationship between stressors and outcomes is mediated by psychosocial resources, with maladaptive coping such as substance abuse emerging when resources are insufficient; and (iii) stress proliferation occurs whereby initial stressors generate cascading secondary stressors. The chapter critically examined the model's strengths including its attention to social structural origins of distress—and its limitations, particularly its under-specification of cultural processes and individualistic orientation. The literature review was organised thematically around each research objective. The review revealed robust epidemiological evidence linking mental health disorders and substance use, with longitudinal studies demonstrating that adolescents with untreated mental health disorders are up to four times more likely to develop substance use disorders. The review further documented the role of socioeconomic disadvantage, family disruption (particularly parental migration), peer influences, and cultural factors in shaping vulnerability. Critically, the review identified a significant gap in the literature: the absence of in-depth qualitative research centring the voices of Zimbabwean youth themselves, which this study was designed to address.

Chapter Three: Research Methodology

Chapter Three detailed the methodological approach employed in the study. The research was grounded in an interpretivist philosophy, which holds that social reality is socially constructed through the meanings and subjective experiences of individuals, thereby aligning with the study's aim of understanding how youth themselves make sense of their experiences. A qualitative methodology was employed within a case study design, with Chipadze, a high-density suburb in

Bindura, Zimbabwe, serving as the bounded case. The target population comprised youth aged 15 to 24 years residing in Chipadze who experienced concurrent mental health challenges and substance abuse, along with key informants working with this population. A total sample of 50 participants was selected, comprising 40 youth and 10 key informants (community health workers, social workers, substance abuse counsellors, community leaders, and youth organisation staff). Non-probability sampling techniques purposive sampling for initial participant identification and snowball sampling to access hidden populations were employed. Data were collected through semi-structured in-depth interviews with 20 youth and all 10 key informants. The Shona Symptom Questionnaire (SSQ-14) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) were administered as supplementary instruments. Qualitative data were analysed using thematic analysis following Braun and Clarke's six-phase framework, with NVivo 14 software facilitating data management. Trustworthiness was enhanced through prolonged engagement, triangulation, member checking, thick description, and maintenance of an audit trail. Rigorous ethical protocols were observed, including informed consent, protection of confidentiality and anonymity, and establishment of referral pathways for distressed participants.

Chapter Four: Data Presentation, Analysis and Discussion of Findings

Chapter Four presented, analysed, and discussed the findings arising from the fieldwork, organised thematically around the four research objectives. Regarding the first objective, participants articulated mental health challenges primarily through the culturally salient idiom of kufungisisa (thinking too much), alongside symptoms consistent with depression, anxiety, and trauma-related disorders. One participant stated, "I use cannabis and alcohol because my mind is always thinking too much... The only time the thinking stops is when I am high." Key informants confirmed that youth presented with profound hopelessness, worthlessness, and somatic

manifestations of distress. Regarding the second objective, participants identified multiple causal pathways linking their environment to mental distress and subsequent substance use. Economic precarity, unemployment, and the inability to envision viable futures were the most frequently cited factors. Family disruption due to parental labour migration emerged as a significant chronic stressor. Peer influence was acknowledged but framed within the context of pre-existing vulnerability. One social worker key informant stated, "They start because they are in pain... The drugs are a way to survive that pain, not to cause it." Regarding the third objective, participants described lived experiences characterised by profound stigma, criminalisation, and fragmented help-seeking journeys. Encounters with the criminal justice system were described as traumatic and counterproductive, with participants reporting that arrest and incarceration exacerbated their mental distress and reinforced substance use. Stigma operated as a powerful barrier to disclosure and help-seeking, with one female participant stating, "I cannot tell anyone... If my neighbours knew, they would say I am a bad mother." Despite these challenges, some participants demonstrated agency and resilience, drawing on informal supports including church-based groups and compassionate family members. Regarding the fourth objective, the findings revealed a severely limited and fragmented landscape of support. Formal mental health and substance use services were described as geographically inaccessible, prohibitively expensive, and lacking integration. A senior nurse key informant stated, "The biggest barrier is that we have no mental health professionals... The referral is useless."

5.3 Conclusions

Objective One: To identify common mental health challenges experienced by youth who engage in drug and substance abuse in the study area, as understood from their own perspectives.

The findings revealed that youth in Chipadze experience a range of significant mental health challenges that they articulate through both culturally specific idioms and symptoms consistent with established psychiatric categories. The most prominent idiom of distress was kufungisisa (thinking too much), a culturally salient expression encompassing persistent rumination, worry, and an inability to find mental peace. Participants described this state as pervasive and debilitating, directly linking it to their substance use as a means of achieving temporary relief. Beyond kufungisisa, participants described symptoms consistent with major depressive disorder, including profound feelings of emptiness, worthlessness, hopelessness, and suicidal ideation. One participant's statement, "I feel empty. Like there is a hole inside me... Sometimes I think it would be better to just not wake up," exemplifies this severe depressive symptomatology. Trauma-related symptoms were also prominent, particularly among male participants who had witnessed political violence, with substance use serving as a mechanism to suppress intrusive memories and hyperarousal. Key informants confirmed that youth presented with somatic complaints, social withdrawal, and anger as behavioural manifestations of underlying psychological distress. The Shona Symptom Questionnaire (SSQ-14) results corroborated these qualitative findings, with the majority of youth participants scoring above the validated threshold for probable common mental disorder.

The conclusion drawn from these findings is that mental health challenges among substance-using youth in Chipadze are both prevalent and severe, yet they are rarely articulated using formal psychiatric terminology. Instead, distress is expressed through culturally embedded idioms and somatic or behavioural manifestations. This finding aligns with the Stress Process Model's conceptualisation of distress as a continuum shaped by social and cultural context (Pearlin & Bierman, 2013; Wheaton, 2018). The prominence of kufungisisa confirms the observations of

Chibanda (2018) and Kidia (2020) regarding the centrality of this idiom in Zimbabwean expressions of psychological distress. Furthermore, the high rates of depressive and trauma-related symptomatology are consistent with the findings of Nyamayaro et al. (2021) and Verhey et al. (2021), who documented depression prevalence rates ranging from 20% to 35% among Zimbabwean youth and elevated rates of post-traumatic stress disorder in populations exposed to political violence and family disruption. The study extends this literature by providing rich, qualitative evidence of how these mental health challenges are experienced, named, and understood by youth themselves within the specific context of Chipadze. The findings underscore the critical importance of culturally sensitive assessment approaches that attend to local idioms of distress, as reliance solely on Western diagnostic categories would fail to capture the full spectrum of youth suffering in this context (Kirmayer et al., 2017; Mpofu & Mapfumo, 2020).

Objective Two: To explore the perceived causal pathways that lead youth to use substances as a means of coping with mental health issues.

The findings revealed that youth in Chipadze perceive multiple, interconnected causal pathways linking their social and economic environment to mental distress and subsequent substance use. Economic precarity emerged as the most powerful and frequently cited causal factor. Participants described how prolonged unemployment, lack of viable economic opportunities, and chronic poverty generated feelings of worthlessness, failure, and hopelessness, which they sought to escape through substance use. This finding directly illustrates the Stress Process Model's first major assumption: that macro-level social structures—in this case, Zimbabwe's protracted economic crisis—generate chronic life strains that cascade downward to affect individual psychological states (Pearlin, 1989; Wheaton, 2018). Family disruption, particularly parental labour migration to South Africa and other destinations, emerged as a second critical pathway.

Participants described experiences of abandonment, loneliness, and inadequate supervision following parental departure, which created vulnerabilities to both mental distress and substance use initiation. This finding aligns with Zvobgo et al. (2022), who documented elevated rates of depression, anxiety, and substance use among Zimbabwean youth whose parents had migrated. Peer influence was acknowledged but was consistently framed within the context of pre-existing vulnerability; youth described seeking out substance-using peers because substances offered relief from their internal distress and facilitated social belonging that they otherwise struggled to achieve. This finding supports Mhaka-Mutepfa et al. (2020), who found that youth with pre-existing mental health challenges are more vulnerable to peer influence because they perceive substance use as a means of managing social distress.

The conclusion drawn from these findings is that substance use among youth in Chipadze is best understood not as a primary behavioural problem driven by moral failing or simple peer pressure, but rather as a maladaptive coping response to profound and chronic psychosocial stressors rooted in structural conditions. Youth turn to substances when other psychosocial resources meaningful employment, intact family support, hope for the future, accessible mental health care are absent or insufficient. This conclusion directly affirms the Stress Process Model's second major assumption: that the relationship between stressors and outcomes is mediated by psychosocial resources, and that maladaptive coping emerges when adaptive resources are unavailable (Pearlin & Schooler, 1978; Thoits, 2020). The findings also illustrate the phenomenon of stress proliferation (Pearlin et al., 1997; Turner, 2019), whereby initial stressors (economic precarity, family separation) generate secondary stressors (mental distress, substance dependence), which in turn produce tertiary stressors (family conflict, legal troubles, social marginalisation), creating a self-perpetuating cycle of deepening disadvantage and distress. The study's contribution

lies in providing rich, contextualised evidence of how these theoretical processes unfold in the specific lived realities of Zimbabwean youth, thereby extending the Stress Process Model's applicability to a sub-Saharan African context and illuminating the unique constellation of stressors that characterise contemporary Zimbabwean youth experience (Lund et al., 2018; Patel et al., 2019).

Ob**jective Three: To examine the lived experiences of youth in navigating the dual burden of mental health challenges and substance abuse.**

The findings revealed that youth in Chipadze navigate their dual burden within a hostile and fragmented environment characterised by pervasive stigma, punitive responses, and a near-complete absence of therapeutic support. Participants described experiences of profound stigmatisation from family, community members, and institutions. This stigma operated as a powerful barrier to disclosure and help-seeking, forcing youth to suffer in silence and isolation. Encounters with the criminal justice system were described as particularly traumatic and counterproductive. Participants reported being arrested, detained, and punished for their substance use, with no offer of treatment or support. This punitive response exacerbated their mental distress and reinforced their substance use as a means of coping with the trauma of incarceration. This finding confirms Chinouya and O'Keefe's (2020) observation that youth with co-occurring conditions in Zimbabwe encounter a fragmented and punitive help-seeking journey, with first contact frequently being the criminal justice system rather than health services. Help-seeking within the formal health system was described as confusing, inaccessible, and often futile. Participants and key informants alike confirmed the absence of integrated services capable of addressing mental health and substance use concurrently. Youth were bounced between under-resourced mental health services, punitive legal interventions, and unsupportive family

environments, a phenomenon documented by Mangezi and Chibanda (2020) and Verhey et al. (2021). Despite these overwhelming challenges, the findings also revealed evidence of youth agency and resilience. Some participants described drawing on informal supports, including church-based groups, compassionate family members, and peer support networks, as crucial resources in their recovery journeys

The conclusion drawn from these findings is that the lived experience of navigating the dual burden of mental health challenges and substance abuse in Chipadze is one of profound suffering compounded by systemic failures. Youth are not merely experiencing co-occurring conditions; they are experiencing these conditions within a context that actively worsens their distress through stigmatisation, criminalisation, and service fragmentation. This finding supports and extends the literature on stigma and dual diagnosis (Egbe et al., 2020; Monteiro, 2021) by providing granular, qualitative evidence of how multiple layers of stigma—public, self, and courtesy operate in the Zimbabwean context. The findings also contribute to the debate within the lived experience literature concerning the tension between structural determinism and individual agency (Kirmayer et al., 2017; Thoits, 2020). While the structural constraints facing youth in Chipadze are undeniably severe, participants demonstrated agency in seeking out and leveraging informal supports, in making attempts to reduce or cease substance use, and in constructing narratives of hope and resilience. This suggests that interventions should not position youth solely as passive victims but should recognise and build upon their existing capacities, coping strategies, and informal support networks. The study's contribution lies in its rich, nuanced portrayal of youth lived experience that captures both the crushing weight of structural adversity and the flickers of agency and resilience that persist within it.

Objective Four: To assess the existing support systems and interventions available to these youth and identify the barriers that prevent them from accessing effective and sustained help.

The findings revealed a landscape of support that is severely limited, deeply fragmented, and largely inaccessible to the youth who need it most. Formal mental health services were described as virtually non-existent within Chipadze and the broader Bindura area. The local clinic was staffed by nurses with no specialised mental health training, and referral pathways to tertiary facilities in Harare were rendered meaningless by prohibitive costs and geographic distance. This finding confirms the stark statistics documented by the World Health Organization (2022) and scholars such as Chibanda (2018) and Makoni (2019), who have highlighted Zimbabwe's severe shortage of mental health professionals and the concentration of services in urban centres, leaving peri-urban and rural youth without access to care. Substance use treatment services were similarly limited, with no dedicated facilities in Bindura. Non-governmental organisations provided some community-based programmes, but these were geographically concentrated, reliant on uncertain donor funding, and, critically, were not integrated with mental health services. The absence of an integrated service model despite international evidence demonstrating its superiority for co-occurring conditions (Briere et al., 2020; Mueser et al., 2019) meant that youth were forced to navigate between fragmented services, often receiving treatment for one condition while the other remained unaddressed. Barriers to access were identified at multiple levels. Structural barriers included the prohibitive cost of services, geographic inaccessibility, and the absence of youth-friendly service designs. Attitudinal barriers included pervasive stigma and a lack of knowledge about mental health and substance use disorders among both youth and their families. Key

informants, including community leaders, expressed feelings of helplessness, stating that they lacked the training and resources to respond effectively to youth in distress.

The conclusion drawn from these findings is that the existing support system in Chipadze and Bindura is fundamentally inadequate to meet the needs of youth experiencing co-occurring mental health and substance use challenges. The barriers to access are not primarily located within individual youth or their families such as a lack of motivation or knowledge but are structural and systemic in nature. This conclusion aligns with the critical perspective articulated by Asher and De Silva (2019) and van Ginneken et al. (2021), who argue that framing help-seeking as a problem of individual knowledge or attitudes places responsibility on individuals to seek help rather than on health systems to provide accessible, acceptable, and effective services. The findings suggest that efforts to reduce stigma and increase awareness, while necessary, will be insufficient if they are not accompanied by fundamental investments in service infrastructure and the development of integrated, youth-friendly, and geographically accessible services. The study's contribution lies in its detailed documentation of the specific configuration of barriers operating in a peri-urban Zimbabwean context, providing an evidence base for targeted policy and practice interventions. The findings underscore the urgent need for a paradigm shift from the current fragmented, punitive, and hospital-centric approach toward a community-based, integrated, and recovery-oriented model of care.

5.4 Recommendations

Based on the findings and conclusions of this study, the following recommendations are advanced, directed at specific stakeholders who have the capacity and responsibility to effect meaningful change.

5.4.1 Ministry of Health and Child Care

The Ministry of Health and Child Care should prioritise the development and implementation of an integrated service model for youth with co-occurring mental health and substance use disorders. Currently, mental health and substance use services operate in silos, with no coordinated care pathways. The Ministry should develop and pilot an integrated youth-friendly service hub in Bindura that provides concurrent screening, assessment, and treatment for both mental health and substance use conditions under one roof.

5.4.2 Ministry of Justice, Legal and Parliamentary Affairs

The Ministry of Justice, in collaboration with the Zimbabwe Republic Police, should lead a policy review aimed at decriminalising personal substance use among youth and diverting individuals with substance use disorders away from the criminal justice system and toward health and social services. The current punitive approach, as documented in this study, is not only ineffective but actively harmful, exacerbating mental distress and reinforcing substance dependence.

5.4.3 Bindura Municipality and Local Government Authorities

The Bindura Municipality, in partnership with the Ministry of Youth, Sport, Arts and Recreation, should establish and adequately resource youth-friendly community spaces and programmes within Chipadze and other high-density suburbs.

5.4.4 Non-Governmental Organisations and Civil Society

Non-governmental organisations operating in the mental health and substance use sectors in Zimbabwe should prioritise the development and delivery of culturally adapted, evidence-based interventions for youth with co-occurring conditions.

5.4.5 Community Leaders and Traditional Healers

Community leaders, including village heads, councillors, and religious leaders in Chipadze and surrounding areas, should receive training and support to enable them to respond more effectively and compassionately to youth experiencing mental health and substance use challenges. This study found that community leaders currently feel helpless and ill-equipped to respond, often defaulting to warnings and lectures that are ineffective. Training programmes, developed and delivered in partnership with mental health professionals and NGOs, should provide community leaders with basic mental health literacy, skills in recognising signs of distress and substance use problems, knowledge of available referral pathways, and training in how to have supportive, non-judgmental conversations with affected youth and their families.

5.4.6 Families of Affected Youth

While families were not the primary focus of this study, the findings have clear implications for family-level interventions. Families of youth experiencing mental health and substance use challenges should have access to psychoeducation and support programmes.

5.5 Areas for Further Research

This study focused specifically on the experiences of youth with co-occurring mental health and substance use challenges within the bounded context of Chipadze, Bindura. While the study generated rich, contextualised insights into this phenomenon, it did not examine the perspectives

of family members in depth, nor did it evaluate the effectiveness of any specific intervention or programme, future research should conduct a multi-site comparative case study across different geographic and socioeconomic contexts within Zimbabwe including rural areas, other urban centres, and border towns to examine how the relationship between mental health and substance use among youth varies across different configurations of stressors, resources, and service availability.

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ANNEXTURE1: PERMISSION LETTER



ANNEXTURE 2: YOUTH SEMI-STRUCTURED INTERVIEW GUIDE

Bindura University of Science Education

PRE-INTERVIEW PROTOCOL

Researcher: Good [morning/afternoon]. My name is Sharon Majinjiwa from Bindura University of Science Education. Thank you for agreeing to speak with me today.

Before we begin, I want to remind you that:

- This interview is voluntary – you can stop at any time
- Everything you say is confidential – I will not use your real name
- There are no right or wrong answers – I am interested in your honest experiences
- If any question makes you uncomfortable, you do not have to answer it

Do you have any questions before we start?

May I have your permission to record this interview? The recording will help me remember everything accurately and will be deleted after the research is complete.

Participant Code: _____

Date: _____

Time started: _____

Location: _____

SECTION 1: OPENING

1.1 Can you tell me a little about yourself your age, where you live in Chipadze, and how life has been for you recently?

SECTION 2: MENTAL HEALTH CHALLENGES

2.1 Many young people in Chipadze experience difficult feelings or thoughts. Can you describe what kinds of difficult feelings or thoughts you have experienced?

2.2 How do these feelings affect your daily life – your sleep, eating, relationships, or ability to do things you need to do?

2.3 Can you tell me about a time when these feelings were particularly strong or difficult to manage? What was that like for you?

2.4 Have you ever had thoughts of ending your life or harming yourself? *[If yes, explore gently: Can you tell me about that? Did you tell anyone?]*

2.5 In your own words, how would you describe what is happening inside your mind when you feel most distressed?

SECTION 3: SUBSTANCE USE HISTORY (15 minutes)

3.1 Can you tell me about your experience with substances

what substances you have used, and when you first started?

3.2 What was happening in your life around the time you first started using?

3.3 How has your substance use changed over time – how often do you use now compared to when you started?

3.4 Are there specific situations, feelings, or times of day when you are more likely to use substances?

3.5 Have you ever tried to stop or reduce your substance use? What happened when you tried?

SECTION 4: THE CONNECTION BETWEEN MENTAL HEALTH AND SUBSTANCE USE (15 minutes)

4.1 Do you see any connection between the difficult feelings we talked about and your substance use? If so, can you describe that connection?

4.2 Some young people say they use substances to stop thinking too much (kufungisisa) or to forget their problems. Is that true for you? Can you tell me more?

4.3 What happens when you are not using substances

4.4 Do you think your substance use has affected your mental health

SECTION 5: LIVED EXPERIENCES – COMMUNITY AND FAMILY (15 minutes)

5.1 How do the people around you respond to your mental health struggles or your substance use?

5.2 Can you describe how your community in Chipadze views young people who use substances or who have mental health problems?

5.3 Have you had any experiences with the police or the courts because of your substance use? Can you tell me about that?

5.4 Have you ever been taken to a traditional healer (n'anga) for your difficulties? What was that experience like?

5.5 What has been the hardest thing about living with both mental health challenges and substance use in Chipadze?

SECTION 6: HELP-SEEKING AND SUPPORT SYSTEMS

6.1 Have you ever tried to get help for your mental health or your substance use?

6.2 What help is available in Chipadze or Bindura for young people like you? What do you know about?

6.3 What has stopped you from getting help, or made it difficult?

6.4 If you could design the perfect service to help young people like you, what would it look like?

SECTION 7: CLOSING

7.1 Is there anything else you think I should understand about your experiences that we have not talked about?

7.2 How has this interview been for you? Are you feeling okay?

INSTRUMENT 4: INFORMED CONSENT FORM (YOUTH PARTICIPANTS)

Study Title: Mental Health Challenges Among Youth Linked to Drug and Substance Abuse in Zimbabwe

Researcher: Sharon Majinjiwa, Department of Peace and Governance, Bindura University of Science Education

Supervisor: Dr. Kurebwa

What is this study about?

This study seeks to understand the relationship between mental health challenges (such as depression, anxiety, trauma, and "thinking too much"/kufungisisa) and drug and substance use among youth in Chipadze, Bindura. The study aims to give voice to young people's experiences and to identify what support would be most helpful.

What will happen if I participate?

If you agree to participate:

1. You will complete a short questionnaire (about 15-20 minutes) asking about your background, how you have been feeling, and your substance use.

2. You may be invited to participate in an interview lasting about 45-90 minutes, where I will ask about your experiences. The interview will be audio-recorded with your permission.

Are there any risks?

Some questions may bring up difficult feelings or memories. You do not have to answer any question you are not comfortable with. You may take a break or stop the interview at any time. If you become distressed, I will pause and offer you support, including referral to appropriate services.

Are there any benefits?

There is no direct benefit to you, but your participation will help us understand how to better support young people in Zimbabwe who face similar challenges.

Will my information be kept confidential?

Yes. Your name will not be used in any reports. You will be assigned a code number. All information will be stored securely and only the research team will have access. Nothing you say will be shared with your family, friends, police, or anyone else.

Is participation voluntary?

Yes. You do not have to participate. If you say yes, you can change your mind at any time without any negative consequences.

What if I am under 18?

If you are under 18 years of age, I will need permission from your parent or guardian in addition to your own agreement (assent). This is to protect you.

What if I need support?

At the end of our meeting, I will provide you with contact information for local support services should you need them.

Who can I contact with questions?

If you have questions about this study, you can contact:

- Researcher: Sharon Majinjiwa, [phone number]
- Supervisor: Dr. Kurebwa, [phone number/email]

CONSENT STATEMENT

I have read this form (or had it read to me) and I understand the information. I have had the opportunity to ask questions.

I understand that my participation is voluntary and that I can withdraw at any time.

I agree to participate in this study.

Participant signature: _____

Date: _____

Researcher signature: _____

Date: _____

PARENT/GUARDIAN CONSENT (for participants under 18 years)

I give permission for my child to participate in this study. I understand that their information will be kept confidential and that participation is voluntary.

Parent/guardian signature: _____

Date: _____

AUDIO RECORDING CONSENT (for interview participants)

I agree to have this interview audio-recorded. I understand that the recording will be used only for transcription purposes and will be deleted after the research is complete.

- Yes, I agree to audio recording
- No, I do not agree to audio recording

Participant signature: _____

Date: _____