KHAT DEPENDENCE: RISK FACTORS, CONSEQUENCES AND TREATMENT

Dissertation zur Erlangung des akademischen Grades des

Doktors der Naturwissenschaften (Dr. rer. nat.)

vorgelegt von

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an der Universität Konstanz

Mathematisch-Naturwissenschaftliche Sektion

Fachbereich Psychologie

Tag der mündlichen Prüfung: 21.12.2016

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Konstanzer Online-Publikations-System (KOPS)
URL: http://nbn-resolving.de/urn:nbn:de:bsz:352-1-b415e569e2a44ba64

Danksagung

An erster Stelle möchte ich mich bei Michael Odenwald bedanken. Für die großartigen Projektzeiten in Kenia und Äthiopien, die Freiheiten und das entgegengebrachte Vertrauen, viele erlebnis- und lehrreiche Jahre und die tolle Unterstützung in allen Phasen der gemeinsamen Arbeit. –Danke für das „Mitnehmen“ in diesen Bereich der Forschung!

Vielen Dank allen, die im Rahmen verschiedener Kooperationen diese Studie ermöglichten und zum Gelingen beitrugen. Danke Daktari, Maimuna, Hussein und Bernice sowie allen Mitgliedern der Tawakal Klinik in Nairobi für die Eindrücke, den Austausch, die Zusammenarbeit und das Teilnehmen am Projekt.

Danke an Thomas Elbert für das Begutachten dieser Arbeit sowie inspirierende Diskussionen in verschiedenen Kolloquien. Auch Klaus Schonauer möchte ich danken.

Von Herzen dankbar bin ich meinen großartigen Kolleginnen und Kollegen für das wundervollste Arbeitsumfeld, das man sich wünschen kann und die schönen Freundschaften, die gewachsen sind. Danke Veronika Müller, Doro Isele, Kati Dohrmann, Almut Carolus, den Johannas Fiess –Sill und –Kienle, Anke Köbach, Karl Radkte, Eva Barnewitz, Jessica Sommer, Marie-Christin Fellner, Gerd Waldhauser, Anne Schawohl, Inga Schalinski, Lotte Salmen, Heike Riedke, Maggie Schauer und Dagmar Moret für Eure Unterstützung unterschiedlichster Art.

Ein besonderer Dank nochmal an Doro, Veronika und Heike für die tolle Zeit und gemeinsame Arbeit in Äthiopien.

Auch meinen Freunden und Schwestern Daheim möchte ich danken für die Treue, das Interesse und das „immer-noch-da-Sein“ nach so viel Abwesenheit und Trubel.

Ganz besonders möchte ich auch meinen Eltern (und Oma) für die bedingungslose Unterstützung und Förderung danken, die alles ermöglichten, was bis hierher nötig und wichtig war.

Meinem Andi danke ich von Herzen für das Durchstehen aller Hochs und Tiefs, die mit meiner Arbeit in Verbindung stehen. Danke, dass du da bist und es immer warst!

Und unserem kleinen Strampelbär im Bauch bin ich dankbar für den schönsten Energie- und Motivationsschub, den man sich vorstellen kann.

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Abkürzungen

ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AC	Assessment Control
BDI	Beck's Depression Inventory
BI	Brief Intervention
CIDI	Composite International Diagnostic Interview
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders - IV
FRAMES	Feedback, Responsibility, Advice, Menu of options, Empathy, Self-efficacy
GLMM	General Linear Mixed Model
M	Mean
MI	Motivational Interviewing
PDS	Posttraumatic Diagnostic Scale
PHQ-9	Patient Health Questionnaire – 9
PTSD	Post Traumatic Stress Disorder
RC	Reliable Change
RCI	Reliable Change Index
RCT	Randomized Controlled Trial
SBI	Screening and Brief Intervention
SCID	Structured Clinical Interview for DSM
SD	Standard Deviation
SDS	Severity of Dependence Scale
SE	Standard Error
TLFB	Time-Line-Follow-Back
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Summary

Khat use has a long standing tradition in many African countries and the Arabian Peninsula. The tender leaves are chewed over hours, mostly in social settings and their stimulating effect increases concentration and productivity and leads to talkativeness and a flow of ideas. The traditional use for spiritual occasions or labor lost its relevance since mid of the 19th century with expanding trade, progressive urbanization and migration. It was replaced by motives like reduction of psychological burden, relaxation, increasing feelings of cultural identity, entertainment and fun, pressure to perform, peer pressure and social interaction. Various factors account for the development of excessive use patterns related to a number of harmful consequences for physical and mental health. There is no international regulation on khat use despite the evidence for a need for harm reduction. To date, there are no studies on khat-specific interventions.

In the present thesis, an established WHO Brief Intervention (ASSIST) was adapted for Khat use and tested for its efficacy in a randomized controlled trial with Somali refugees in Kenya. The intervention group as well as the control group were interviewed in three times of measurement concerning khat use, comorbid psychological symptoms and potential environmental factors influencing therapy success.

We found that the amount and frequency of khat use was reduced more after the intervention but also in the control group which refers to the success of the adapted intervention as well as the effects of unspecific active factors (article 1). The prevalence of comorbid symptoms of depression and PTSD was extremely high in this sample. The symptoms were reduced in both groups and we found that multiply mentally burdened participants benefit less from the intervention respective consume reduction (article 2). A lack of alternative activities, environmental khat cues and a lack of alternative coping strategies were shown to be the most relevant factors when reducing khat use (article 3).

These results are in line with current recommendations for not treating khat users as a homogenous group. An adequate treatment of khat use requires adapted intervention strategies, especially in highly burdened countries like Kenya, Ethiopia and Somalia. Comprehensive information about risks related to problematic khat use should be the first

step with focus on vulnerable groups. Trained lay persons from the community could reach many people efficiently, for example with low-threshold Brief Interventions. Using motivational strategies and increasing competence in coping strategies could prevent excessive use and reduce the need of intense treatment through highly skilled persons.

Zusammenfassung

Khatkonsum hat in vielen Ländern Afrikas und der Arabischen Halbinsel eine lange Tradition. Die zarten Blätter werden meist in Gesellschaft über Stunden hinweg gekaut und die belebende Wirkung führt zunächst zu verbesserter Konzentrations- und Leistungsfähigkeit sowie einem Rede- und Gedankenfluss. Die traditionelle Verwendung zu spirituellen Anlässen oder ausdauerndem Arbeiten verlor seit Mitte des 19. Jahrhunderts mit der Expansion von Handelswegen sowie zunehmender Urbanisierung und Flüchtlingsbewegungen mehr und mehr an Bedeutung. An ihre Stelle traten Konsummotive wie die Reduktion psychischer Belastung, Entspannung, Verstärkung kulturellen Identitätsgefühls, Unterhaltung und Spaß, Leistungsdruck, Gruppenzwang und soziale Interaktion. Unterschiedliche Faktoren führten teilweise zu extremen Konsumformen, die zahlreichen schädlichen Folgen für die körperliche und psychische Gesundheit mit sich bringen können. Zwar ist der rechtliche Umgang mit Khat international nicht einheitlich geregelt, doch legt die aktuelle Datenlage Handlungsbedarf für eine Regelung zur Verminderung der schädlichen Auswirkungen nahe. Bis dato liegen noch keine Studien zu Khat-spezifischen Interventionen vor.

In der vorliegenden Arbeit wurde eine etablierte Kurzintervention der WHO (ASSIST) für Khat adaptiert und in einer randomisiert kontrollierten Studie auf ihre Wirksamkeit bei somalischen Flüchtlingen in Kenia untersucht. Sowohl die Interventions- als auch die Kontrollgruppe wurden zu drei Zeitpunkten über Khatkonsum, komorbide psychische Symptomatik und potentielle umgebungsspezifische Faktoren, die den Therapieerfolg beeinflussen, befragt.

Wir konnten zeigen, dass sowohl die Menge wie auch die Häufigkeit des Khatkonsums stärker durch die Intervention aber auch in der Kontrollbedingung reduziert werden konnten, was sowohl auf den Erfolg der adaptierten Behandlung wie auch die Effekte unspezifischer Wirkfaktoren hindeutet (Artikel 1). Die Prävalenz komorbider Depressions- und Traumasymptomatik ist enorm hoch in dieser Stichprobe. Die Symptome wurden ebenfalls in beiden Gruppen reduziert und es zeigte sich, dass multipel psychisch belastete Teilnehmer weniger von der Intervention bezüglich Konsumreduktion profitierten (Artikel 2). Als wichtigste umgebungsspezifische Einflussfaktoren für eine Reduktion des Konsums zeigte sich auf Grundlage einer Selbstauskunft der Klienten ein Mangel an alternativen

Beschäftigungsmöglichkeiten, eine Umgebung voller Khat-Trigger und ein Mangel an alternativen Problemlösekompetenzen (Artikel 3).

Diese Ergebnisse sind im Einklang mit aktuellen Empfehlungen, Khatkauer nicht als homogene Gruppe zu behandeln. Ein adäquater Umgang mit Khatkonsum erfordert differenzierte Interventionsstrategien, insbesondere in stark belasteten und gleichzeitig unterversorgten Ländern wie Kenia, Äthiopien oder Somalia. Flächendeckende Information und Aufklärung über problematisches Konsumverhalten, sollte mit einem Fokus auf Risikogruppen der erste Schritt sein. Geschulte Laien könnten mit niederschwelligen Interventionsangeboten, beispielweise über Kurzinterventionen, mit geringen Kosten viele Menschen erreichen. Über Motivationsarbeit und die Vermittlung von alternativen Problemlösekompetenzen könnte man exzessiven Konsum verhindern und den Bedarf an intensiver, integrativer Versorgung durch Fachkräfte gering halten.

Erläuterung von Eigenleistungen

Artikel 1 (eingereicht zur Publikation bei *ADDICTION*):

"The modified ASSIST-linked Brief Intervention for khat users: A randomized controlled effectiveness study"

Marina Widmann, Bernice Apondi, Musau Abednego, Abdulkadir Hussein Warsame, Maimuna Isse, Victoria Mutisu, Clemens Veltrup, David Ndetei, Michael Odenwald

Meine Beiträge:

- Mitwirken in der Vorbereitung der Studie, inkl. Auswahl des Mitarbeiterteams, Logistik, Trainings und Versuchspersonenrekrutierung
- Leitung der Erhebung vor Ort
- Entwicklung, kulturelle und khat-spezifische Anpassung, inkl. Koordination der Übersetzung von Studienmaterialien
- Durchführung sowie Supervision von Interviews
- Statistische Analysen
- Erstellen des Manuskripts

Artikel 2 (eingereicht zur Publikation bei *Social Psychiatry and Psychiatric Epidemiology)*:

"Comorbid psychopathology and everyday functioning in a Brief Intervention study to reduce khat use among Somalis living in Kenya: description of baseline multimorbidity, its effects of intervention and its moderation effects on substance use"

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- Statistische Analysen
- Erstellen des Manuskript

Artikel 3 *(in Vorbereitung zur Publikation)*:

"**Khat use amongst Somalis in Kenya: Aspects of lifestyle and environmental factors in consumption reduction"**

Marina Widmann, Bernice Apondi, Musau Abednego, Abdulkadir Hussein Warsame, Maimuna Isse, Victoria Mutisu, Clemens Veltrup, David Ndetei, Michael Odenwald

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- Erstellen des Manuskripts

I. Einleitung

1. Khatkonsum – eine Tradition im Umbruch

Seit Jahrhunderten wird Khat (*catha edulis*) aufgrund seiner leicht stimulierenden Wirkung konsumiert. Hauptanbau und –konsumgebiete sind die Länder im Osten Afrikas und die südwestlichen Teile der Arabischen Halbinsel (Krikorian, 1984). Die immergrünen Khatsträucher wachsen hauptsächlich im Hochland und werden je nach Höhenlage und Wasserversorgung durchschnittlich 2 – 6 m, unter optimalen Bedingungen sogar bis 25 m hoch (UNODC, 1956). Regenzeitabhängigen Ernteschwankungen und das meist namensgebende Anbaugebiet beeinflussen Verfügbarkeit, Konsistenz, Wirkung und den Marktpreis des gehandelten Khats (Gatter, 2012; Lemessa, 2001). Gesellschaftliche und wirtschaftliche Entwicklungen führten zu einem Umbruch in der Bedeutung und Verwendung des *„grünen Goldes“.*

1.1. Konsum und Wirkung

Das Kauen ist die bis heute populärste Konsumform. Die frischen Blätter und jungen, zarten Zweige werden kontinuierlich zerkaut, der austretende Saft mit den enthaltenen Wirkstoffen geschluckt und so, teilweise über Stunden hinweg von den festeren, faserigen Bestandteilen im Mund getrennt; die Rückstände werden häufig in der Backe angesammelt und nach einer Weile wieder ausgespuckt oder auch geschluckt (Kalix, 1990; Krikorian, 1983). Carrier (2007) beschreibt in seinem Buch „Kenyan Khat“ die verschiedenen Erntebereiche des Khatstrauches, der je nach Höhenlage und Wasserversorgung durchschnittlich 2 – 6 m, unter optimalen Bedingungen sogar bis 25 m hoch wächst (UNODC, 1956): Die weiter oben befindlichen, kahlen, „skelettartigen“ Äste des Baumes bilden junge, oft rötliche Triebe höchster Qualität. An den übrigen Ästen und Seitentrieben wachsen die preislich und qualitativ minderwertigeren Arten mit meist größeren Blättern und festerem Faseranteil.

Der herb bis bitterliche Geschmack wird gerne gemildert, indem Süßigkeiten, Kaugummis oder Erdnüsse gemeinsam mit den Blättern gekaut werden. Die Blätter und Zweige enthalten verschiedene Alkaloide, die stimulierende, amphetamin-ähnliche Wirkweisen besitzen: Der bedeutendste Bestandteil ist das Kathinon (S-(-)-α-Aminopropiophenon) (Kalix, 1990), sowie seine Metaboliten Kathin (S,S-(+)-Norpseudoephedrin) und R,S-(-)-Norephedrin. Sie bewirken

die Ausschüttung von Katecholaminen im zentralen und peripheren Nervensystem und somit die stimulierenden Effekte beim Menschen (Toennes, Harder, Schramm, Niess, & Kauert, 2003). Die Wirklatenzen der Bestandteile sind unterschiedlich. Laut Toennes (2013) ist die Konzentration von Kathinon wahrscheinlich 3h nach Aufnahme maximal, bei Kathin und Norephedrin erst nach ca. 12h, wenn die Konzentration von Kathinon bereits wieder abnimmt.

Innerhalb von 30-60 Minuten nach Kaubeginn sind die ersten Wirkungen spürbar. Es machen sich Erregungszustände, Euphorie, Rede- und Ideenfluss bemerkbar (Hassan, Gunaid, El-Khally, & Murray-Lyon, 2002). Nach einigen Stunden folgt ein mehr introvertierter, ruhiger Zustand, in dem das Stimmungshoch allmählich nachlässt und häufig in Ruhelosigkeit, Reizbarkeit und depressive Zustände mündet. Diese aversiven Folgen motivieren viele Khatkauer dazu, weiter und durchgehend zu konsumieren, was oft Ein- und Durchschlafprobleme und unangenehme Nachwirkungen am Folgetag mit sich bringt, ähnlich wie nach Alkoholkonsum (Hassan et al., 2002). Man hat beobachtet, dass je nach Qualität des Khats auch die Art und Intensität der unerwünschten Wirkungen stark variieren – je höher Qualität und Preis und je zarter und milder die Blätter, desto weniger Nebenwirkungen (Kennedy, 1987).

1.2. Historische und kulturelle Bedeutung

Der Ursprung der Khatpflanze ist bis heute umstritten. Die botanische Evidenz legt u.a. aufgrund der größten Varietät der Pflanze die Herkunft aus dem Jemen nahe (Revri, 1983), alte Überlieferungen weisen auf Zentral-Asien oder Äthiopien hin (Alles, Fairchild, & Jensen, 1961; Schopen, 1978), wie auch arabische Quellen aus dem frühen 11. Jahrhundert, die jedoch ausschließlich die medizinische Verwendung beschreiben (Schopen, 1978). Früher wurde das wild wachsende Khat von speziell ernannten Khat-Erntern geschnitten, dann wurden einzelne Sträucher in privaten Gärten kultiviert, bevor Jahrhunderte später der wirtschaftliche Anbau Einzug fand. Die Bedeutung der Khat-Blätter im Alltag der Menschen zeigt sich durch die vielseitige Anwendung: Traditionell wurde Khat damals z.B. im Rahmen der sogenannten *„wadaja“* – Zeremonie gekaut, die sowohl für Individuen mit persönlichen Problemen wie Krankheiten oder Konflikte, als auch für Gruppen bei Hungersnöten oder anderen gesellschaftlichen Krisen abgehalten wurde. Neben der traditionell äthiopischen Kaffeezeremonie gab es bei diesen Ritualen je nach Wohlstand des Gastgebers Verpflegung

für die geladenen Teilnehmer und Khat als wichtigster Bestandteil in ausreichenden Mengen. Nachdem Kaffee gereicht wurde und verschiedene Erzählungen und Verse über Heilige zitiert wurden, zirkulierte ein großes Bündel Khat und wurde über Stunden bis Tage hinweg gekaut. Sobald die Teilnehmer einen gewissen Trancezustand erreicht hatten, in ständiger Begleitung der Gebete, wurde gemeinsam, in häufiger Wiederholung um Problemlösung gebeten. So lange, bis das Khat zur Neige ging und die Zeremonie schließlich mit dem Satz beendet wurde *„chatu endallaqa azachen hulla yelaq" („da das Khat zu Ende ist, mögen auch all unsere Sorgen zu Ende sein") (Gebissa, 2010)*. Als Begründung für die Verwendung von Khat wird die größere Nähe zu den angebeteten Heiligen, sowie die verbesserte Ausdauer und Klarheit für deren Verehrungszeremonien beschrieben (Gebissa, 2004). Obwohl Frauen nicht prinzipiell von diesen Ritualen ausgeschlossen wurden, gab es exklusiv für sie Zeremonien, in denen frauenspezifische Probleme thematisiert wurden, wie zum Beispiel Heirat, Geburt, Schwangerschaft oder Kinderlosigkeit (Gebissa, 2010).

Im Alltag der ländlichen Bevölkerung, hauptsächlich im Kontext der Landwirtschaft beginnt der Tag typischerweise mit einem kurzen, gemeinsamen „Augenöffner", dem *„igabana"* mit ein paar Blättern aus dem eigenen Garten, um einen Energieschub für den anstehenden Arbeitstag zu bekommen, sowie in den müden Nachmittagsstunden –vergleichbar mit dem in vielen Kulturkreisen üblichen, morgendlichen und nachmittäglichen Kaffee. Khat und Kaffee werden in vielen historischen Quellen gemeinsam verwendet. Sie teilen den geografischen wie auch philologischen Ursprung sowie ihre frühe Verwendung bei Religiösen und Gelehrten für Gebete und das Studium; und beide Drogen wurden zu wichtigen Bestandteilen der jemenitischen und äthiopischen Gesellschaft (Kennedy, 1987).

Auch im kenianischen Nationalmuseum wird der traditionelle Wert der Blätter in verschiedenen Stämmen beschrieben. Khat war sowohl frisch als auch getrocknet z.B. als Mitgift bei Hochzeiten gerne gesehen, um *„Leuchten und Glanz in die Feier und Glück für die Frischvermählten und Gäste zu bringen"* (Gebissa, 2004) oder bei Beerdigungen, *„um die Trauer zu teilen"* (Kennedy, 1987). Die bis heute soziale Bedeutung des Khat-Kauens ist vielfach dokumentiert und beschrieben (Krikorian, 1984).

Aus dem späten 13. bis 14. Jahrhundert finden sich Dokumente, die das Khatkauen im Jemen beschreiben. Damals wurden die Blätter auch in getrockneter Form als Tee konsumiert, zunächst aus demselben, traditionell religiösen Anlass wie in Äthiopien, jedoch auch, um auf

langen Reisen wach und leistungsstark zu bleiben und zu Arbeitszwecken die Konzentrationsfähigkeit aufrecht zu erhalten (Rice, 2009): *"[Khat] had the singular properties of enlivening the imagination, clearing the ideas, cheering the heart, diminishing sleep, and taking the place of food."* (Burton, Mitte 19.Jh, zitiert nach Rice, 2009).

Etwas später wurden auch einige kritische Haltungen beschrieben: *"Like nicotine, it does not seem to be a drug. It is much worse than nicotine, however, in its ultimate effects, for it definitely reduces strength and vigor, and addicts who are deprived of it lose their ability to think clearly without it; they tremble and sweat and are very difficult to cure."* (Coon, 1945).

Bis zum Ende des 19. Jahrhunderts wurde Khat sowohl in städtischen wie auch ländlichen Gebieten hauptsächlich zu besonderen Anlässen konsumiert (Gebissa, 2004) und war aufgrund begrenzter Verfügbarkeit und Transportmöglichkeiten hauptsächlich der wohlhabenden Elite vorbehalten (Gatter, 2012; Gebissa, 2004; Kennedy, 1987). Es wurde bei gemeinsamen Kausitzungen Wert auf eine statusbezogene Sitzordnung gelegt, was bei weniger wohlhabenden und ländlichen Zusammenkünften weniger eine Rolle spielt (Kennedy, 1987). Auch die Dauer der Sitzungen war ein Zeichen von Wohlstand: Bauern und Ärmere trafen sich kürzer und weniger häufig, um sich wieder der Arbeit widmen zu können (Schopen, 1978; Weir, 1985).

Sowohl damals wie auch mit der späteren Ausdehnung auf alle gesellschaftlichen Schichten bis heute war der soziale Aspekt des Konsums zentral: *(…) ideal places of peaceful relaxation (…) where the cares and problems of daily existence can be forgotten during a period of pleasurable conversation and comradship."* (Kennedy, 1987). Der Ablauf einer gemeinsamen Khatsitzung, die oft vom frühen Nachmittag (oft nach dem Freitagsgebet) bis abends andauert, folgt meist demselben Muster: Zunächst kommt man in lebendiger, geselliger Atmosphäre zusammen, tauscht Neuigkeiten und Klatsch aus und erzählt Geschichten und Witze. Die Gespräche werden dann oft konzentrierter: Gesellschaftliche Themen aus Politik, Wirtschaft, geschäftlichen Interessen, Religion und Geschichte werden fokussiert in der Gruppe diskutiert. In ländlichen Gebieten stehen Debatten um Ländereien und Preise der landwirtschaftlichen Güter und die Planung familiärer und gemeinnütziger Veranstaltungen meist im Vordergrund. Die Stimmung wird dann langsam ruhiger, die Themen werden privater, Gespräche lassen nach und die Teilnehmer sind mehr in sich gekehrt, bevor der Heimweg angetreten wird. Oft treffen sich bestimmte Gruppen mit gemeinsamen Interessen.

Somit bieten diese Treffen die wichtige Gelegenheit, Netzwerke aufzubauen und geschäftliche wie private Kontakte zu knüpfen, die in der Regel allerdings Männern vorbehalten sind. Auch Frauen pflegen jedoch, ihre eigenen Khattreffen abzuhalten. Hierbei steht der Unterhaltungsaspekt und der sozialer Austausch mehr im Vordergrund und es werden geringere Mengen an Khat gekaut (Kennedy, 1987).

Sowohl in Kenia als auch Somalia wurde der Khatkonsum erst in den 1960er Jahren durch Expansion und Ausbau der Handelswege nach der Unabhängigkeit bzw. Wiedervereinigung zum weit verbreiteten Gesellschaftsphänomen (Gatter, 2012).

In der traditionellen Medizin fand Khat bei Kopfschmerzen, Erkältungen, Schmerzen, Arthritis, Fieberzuständen und Depressionen Anwendung. Gelehrte wandten es außerdem bei Diabetes und Bluthochdruck an (Kennedy, Teague, Rokaw, & Cooney, 1983) und noch heute wird es beispielsweise in Äthiopien bei Grippe, Husten, Gonorrhö, Asthma und anderen Lungenproblemen eingesetzt (Lemessa, 2001). Aufgrund des hohen Gehalts an Vitamin C (Ascorbinsäure) und anderen Inhaltsstoffen wie Kalzium, Beta-Karotin und Eisen (z.B. Getahun & Krikorian, 1973; N. Patel, 2000) werden auch die positiven Einsatzmöglichkeit in Mangelgebieten anerkannt. Die kontroversen Diskussionen um positive und negative Effekte sind wohl so alt wie die Kau-Tradition selbst und wurden bereits im 16. Jahrhundert diskutiert (Kennedy, 1987).

Heute wird Khat vom Jemen über das Saudi Arabische Hochland bis nach Israel konsumiert und angebaut; außerdem in Äthiopien, Somalia, dem Südsudan, Kenia, Uganda über Mosambik bis Südafrika. Über Migrationsbewegungen und Handel verbreitete sich Khat auch nach Algerien, Marokko und die USA. Der Lufttransport machte später das Expandieren nach Europa, hauptsächlich über die Niederlande und Großbritannien weiter nach Deutschland, Frankreich, Norwegen und Schweden möglich (Gatter, 2012).

1.3. Ökonomische Bedeutung und staatliche Regulierung

In den vergangenen Jahrzehnten, nach Ende des zweiten Weltkrieges stieg die Khatpruduktion in Ostafrika und der Arabischen Halbinsel deutlich an. Heute Ist der Khatsektor einer der bedeutendsten Wirtschaftszweige z.B. im Jemen, Äthiopien und Kenia und verdrängt teilweise besorgniserregend die Lebensmittelproduktion aufgrund der viel höheren Gewinnspanne,

was Khat auch den Namen *„Cash Crop“* einbrachte (Gatter, 2012; Klein, Beckerleg, & Hailu, 2009). Schon in den 1970er Jahren brachte der Khatanbau fünfmal mehr Ertrag als Kaffee und etwa zwanzigmal mehr als Getreide und andere Lebensmittel (Weir, 1985) – bis 2010 verzeichnete Gatter (2012) eine zunehmende Verdrängung der Lebensmittelversorgung zugunsten des Khatanbaus. Für über ein Drittel der Bevölkerung im Jemen trägt der Khatsektor zu Existenzsicherung bei – sei es im Anbau, Transport oder weiteren Handel (Gatter, 2012). In Äthiopien, Kenia und dem Jemen trägt Khat für etwa 15 Millionen Menschen zur Existenzgrundlage bei (Anderson, Beckerleg, Hailu, & Klein, 2007; Gatter, 2012).

Zahlen zur Prävalenz von Khatkonsum variieren sehr stark und hängen vor allem vom sozioökonomischen Status, Geschlecht, ethnischem Hintergrund der untersuchten Gruppen und der geografischen Lage ab. In Ländern, wo Khat traditionell angebaut und konsumiert wird werden sehr hohe Raten über alle gesellschaftlichen Schichten hinweg berichtet, wohingegen sich in „jungen“ Konsumländern neue Formen und Untergruppen mit eigenen Konsummotiven entwickelten (Odenwald, Klein, & Warfa, 2015).

Debatten um den rechtliche Umgang mit Khat bestehen seit jeher und sind bis heute sehr heterogen (Krikorian, 1984). Obwohl Kathin und Kathinon in den Tabellen I und II der Konvention über psychotrope Substanzen von 1971 gelistet sind, ist Khatkonsum in vielen Ländern nicht rechtlich geregelt. Meist ist entweder eine nicht-regulierunde „laissez-faire“ Haltung oder ein striktes Verbot vorherrschend. Differenzierte staatliche Richtlinien fehlen bislang, u.a. aufgrund der noch immer unzureichend eindeutigen Datenlage über die schädlichen Folgen von Khat (Nutt, King, & Phillips, 2010; Odenwald, Klein, & Warfa, 2010; WHO Expert Committee on Drug Dependence, 2006). Legal sind die Blätter z.B. in Kenia, Somalia, Jemen, Äthiopien und Dschibuti, verboten in Eritrea, Madagaskar, Ruanda, im Sudan und Tansania und den meisten Ländern Europas. Erst 2013 wurde Khat in den Niederlanden und Mitte 2014 in Großbritannien illegal.

Es gibt bereits einige Beispiele für größtenteils erfolglose Versuche, Khatkonsum zu verbieten, da es meist an notwendigen Folge- und Ausgleichsmaßnahmen mangelt(e) (Gatter, 2012; Warfa et al., 2007).

1.4. Gesundheitliche Folgen des Konsums

1.4.1. Physisch

Mittel- und Langfristig lassen sich bei exzessivem Konsum eine Reihe negativer Auswirkungen auf Gesundheit und Wohlbefinden beobachten, die mittlerweile auch wissenschaftlich sehr gut belegt sind: Die häufigsten Beschwerden zeigen sich im gastrointestinalen System, was vermutlich an den astringenten und absorptionsverlangsamenden Eigenschaften der im Khat enthaltenen Tannine liegt (WHO, 1980). Angefangen bei der Mundgesundheit werden oft Mundtrockenheit (auch bereits während des Kauens), Karies, Zahnfleischrückgang und Parodontitis berichtet (El-Wajeh & Thornhill, 2009); in Fallberichten wurden auch Mundkarzinome mit Khatkonsum in Zusammenhang gebracht (Soufi, Kameswaran, & Malatani, 1991) und Gastritis, Magenschmerzen und –geschwüre, Konstipation und Darmverschlüsse häufig gefolgt von Gewichtsverlust berichtet eine Vielzahl der Konsumenten (A. Al-Motarreb, Al-Habori, & Broadley, 2010; Cox & Rampes, 2003). Beeinträchtigungen des zentralen Nervensystems zeigen sich über Schwindel, Konzentrationsprobleme, Ein- und Durchschlafprobleme, Kopfschmerzen, eingeschränkte motorische Koordinationsfähigkeit sowie tremorartige und stereotype Bewegungsformen (Cox & Rampes, 2003; Kalix, 1984), was durch die Wirkung der Kathinone erklärt wird, die sowohl qualitativ als auch quantitativ denen der Amphetamine ähnelt (Kalix, 1984). Kardiovaskulär hängt Khatkonsum mit erhöhtem Blutdruck, Tachykardie, Arrhythmien, Herzrasen, Gefäßverengung – was u.a. in Tierversuchen mit Kathinon nachgewiesen wurde (A. L. Al-Motarreb & Broadley, 2003), Ischämie und laut Fallberichten auch Infarkten, Lungenödemen und Hirnblutungen zusammen (Giannini, Burge, Shaheen, & Price, 1986). Stoffwechsel- und Hormonsystem betreffend werden Hyperthermie, Perspiration und Hyperglykämie beschrieben (Cox & Rampes, 2003) und es gibt zahlreiche Berichte zu Beeinträchtigungen der Leberfunktion (A. Al-Motarreb et al., 2010). Auch die Reproduktionsfähigkeit und Sexualfunktionen verändern sich unter intensivem Khatkonsum. Bei Männern werden Spermatorrhoe, Impotenz, Veränderungen der Libido und Probleme beim Urinieren berichtet (Cox & Rampes, 2003). Interessanterweise scheint sich bei Männern wie bei Frauen die Libido nach Khatkonsum zu erhöhen, bei Männern allerdings zu 60% gefolgt von einer verringerten sexuellen Funktion im Gegensatz Frauen, die zu 80% eine gesteigerte Leistungsfähigkeit berichteten (Elmi, 1983). Es zeigten sich bei Frauen, die während

Schwangerschaft und Stillzeit Khat konsumieren ein geringeres Geburtsgewicht der Babys, vermehrt Totgeburten und Komplikationen beim Stillen (Cox & Rampes, 2003).

1.4.2. Psychisch

Psychologische Folgen bei moderatem Konsum reichen von übersteigertem Redefluss, Hyperaktivität über Schlaflosigkeit, Ängstlichkeit, Reizbarkeit, Unruhe zu gesteigertem aggressivem Verhalten (Cox & Rampes, 2003; Griffiths et al., 1997). Obwohl die langfristigen Zusammenhänge zwischen Khatkonsum und Aggression nur dürftig belegt ist, gibt es zahlreiche Berichte über gewalttätiges, aggressives Verhalten bei Khatkauern (Cox & Rampes, 2003; Giannini & Castellani, 1982; Odenwald et al., 2005). Auch schwerwiegende Stimmungsschwankungen und Depressionen, teilweise mit Suizidalität wurden häufig berichtet (z.B. Hassan et al., 2002; Nielen, van der Heijden, Tuinier, & Verhoeven, 2004).
Khat-induzierte Psychosen und kurze psychotische Episoden werden diskutiert und vor allem bei exzessivem, langjährigem Konsum berichtet (K. Bhui & Warfa, 2010; Dhadphale, Mengech, & Chege, 1981; M. Odenwald et al., 2009; Yousef, Huq, & Lambert, 1995). Aber wie auch bei anderen psychologischen Folgestörungen fehlen ausreichend kontrollierte Langzeitstudien zu psychotischen Störungen. Khatkonsum wird bislang als verstärkender oder auslösender Faktor bei bereits genetisch oder durch das Umfeld vulnerablen Personen gesehen (Odenwald, 2007; Odenwald et al., 2005).
Zum Abhängigkeitspotential der Blätter gibt es zahlreiche Hinweise aus Verhaltensbeobachtungen, die sowohl psychologische aus auch physiologische Aspekte der Abhängigkeit nahe legen (Odenwald, Warfa, Bhui, & Elbert, 2010). Auch wissenschaftlich gibt es bereits einige Evidenz für das psychologische Abhängigkeitspotential: Die Skala für Abhängigkeitsschwere *(„Severity of Dependence Scale", SDS*) wurde für Khat angepasst und positive Zusammenhänge zwischen den Scores und Khat-Alkaloid Konzentrationen in Speichel gefunden (S. Kassim, Hawash, Johnston, & Croucher, 2012; S. Kassim, Islam, & Croucher, 2010). Die Werte aus dem Fragebogen waren vergleichbar mit denen einer schwer heroinabhängigen, behandlungsbedürftigen Gruppe jemenitischer Khatkauer in Großbritannien (S Kassim & Croucher, 2006). In einer Gruppe jemenitischer Khatkauer, ebenfalls in Großbritannien lebend, fanden S. Kassim, Croucher, and Al'absi (2013), dass etwa ein Drittel der Teilnehmer die Diagnosekriterien für eine Abhängigkeit laut ICD oder DSM erfüllten. In nicht repräsentativen Gruppen mit einem großen Anteil psychotischer Teilnehmer

in Somalia und mit somalischen Flüchtlingen in Kenia wurden noch höherer Prävalenzen von 84-100% gefunden (Odenwald et al., 2012; Widmann et al., 2014).

Trotz dieser langen Liste an möglichen gesundheitlichen Folgen legt die aktuelle, wissenschaftliche Evidenz nahe, dass die individuellen gesundheitlichen sowie sozialen Schäden durch Khatkonsum geringer sind als bei anderen Substanzen mit Missbrauchspotential und bei moderatem, gelegentlichen Konsum kaum negative Auswirkungen zu erwarten sind (Nutt et al., 2010; Pennings, Opperhuizen, & van Amsterdam, 2008).

1.5. Warum kauen Menschen Khat? Lebensgefühl versus Abhängigkeit

Die vielseitigen angenehmen Aspekte des Khatkonsums wurden bereits weiter oben im geschichtlichen Kontext beschrieben. Gatter untersuchte im Jemen Gründe, warum Menschen in der heutigen Zeit Khat kauen. Die am häufigsten genannten waren *„it gives strength", „makes more alert", „relieves depression", „I like it", „because my friends chew"* und *„for social interaction"*, sowohl bei Männern wie auch bei Frauen (Gatter, 2012). Klein (2007) und S.L. Patel (2008) beschreiben ähnliche Muster bei Somalis, die in Großbritannien leben. Khatkauen trage zu einem Identitätsgefühl und sozialem Wohlbefinden bei. In einer äthiopischen Studie wird die Stabilisierung von Emotionen als ein Grund für den Khatkonsum genannt (Alem, Kebede, & Kullgren, 1999) und auch in unseren Studien berichteten die Teilnehmer von den positiven Aspekten des gemeinsamen Kauens in geselliger Runde, wo man sich trifft, um Neuigkeiten und Probleme auszutauschen. In früheren Untersuchungen fanden sich auch positive Zusammenhänge zwischen traumatischer Belastung und der Menge an konsumiertem Khat –d.h. je belasteter die Menschen in fremden Umgebungen sind, desto wichtiger wird der Aspekt der Gemeinschaft und sich-austauschen-könnens mit Anderen gleicher Herkunft (Odenwald et al., 2009; Widmann et al., 2014).

Diese Beobachtungen und wissenschaftlichen Erkenntnisse unterstützen die Hypothese des funktionalen Konsums auch für Khat. Durch die immer stärker werdenden Flüchtlingsbewegungen und aversiven Lebensumständen, denen die Menschen in Gastländern oft ausgesetzt sind, ist es kaum möglich, adäquate soziale, medizinische und

psychologische Versorgung zu leisten. Diese Umstände schaffen eine lukrative Grundlage für eine Erweiterung des Khathandels, was in der allgegenwärtigen, rasant ausbreitenden Verfügbarkeit und Popularität deutlich wird.

In gebildeteren Bevölkerungsschichten wird Khat häufig zu Lern- und Konzentrationszwecken konsumiert und es zeigen sich Zusammenhänge zwischen Bildungsstand und Konsummenge (Alem et al., 1999). Bei jungen Khatkauern an Universitäten in Äthiopien werden auch Zusammenhänge von Konsum und dem Initiieren von sexuellen Aktivitäten berichtet (Kebede et al., 2005; Tura, Alemseged, & Dejene, 2012) und in anderen Untersuchungen mit Studenten zeigen sich „Entspannung & Unterhaltung“ und „soziale Gründe“ als meistgenannte Konsummotive (Kassaye, Sherief, Fissehaye, & Teklu, 1999).

Sowohl unsere persönlichen Erfahrungen im Feld als auch neuere Untersuchungen zu Konsumformen und -gewohnheiten zeigen immer extremer werdende Muster wie z.B. *„binge-chewing“* (kontinuierliches Kauen für 24h und länger). Auch Kombinationen mit anderen Substanzen, um den Khateffekt zu verstärken oder wieder abzumildern werden berichtet (Odenwald, Hinkel, et al., 2007; Omolo & Dhadphale, 1987; Tulloch, Frayn, Craig, & Nicholson, 2012; Zein, 1988).

2. Somalia, Migration und Khat

Somalia führt aktuell die Liste der instabilsten Staaten der Welt an (Foreign Policy, 2016) und es zählt weltweit zu den Ländern mit den größten Flüchtlingsbewegungen. Aktuell gibt es insgesamt etwa 1.1 Millionen somalische Flüchtlinge, von denen ca. 150.000 als intern Vertriebene gelten und knapp 400.000 in Kenia leben, wie in Abbildung 1 veranschaulicht (UNHCR, 2016b). Hinzu kommt noch eine Vielzahl an Flüchtlingen ohne legalen Aufenthaltsstatus.

Über die vergangenen Jahrzehnte hinweg prägten Bürgerkrieg, Trockenheit und Hungersnöte das Land. Nach dem Sturz des Diktators Barre 1991 fanden militärische Konflikte zwischen verschiedenen Milizen, Clans und radikal religiösen Gruppierungen unter Eingreifen der umliegenden Länder und der internationalen Gemeinschaft statt. Seit 2000 gab es zwar eine international anerkannte Übergangsregierung, allerdings gelang es dieser nicht, die Situation

zu befrieden und allgemein in Somalia Akzeptanz zu finden. Seit 2012 wurde sie durch eine föderale Regierung ersetzt, die vielleicht der Beginn in Richtung Befriedung und Stabilisierung bedeutet, doch noch immer ist der Alltag der Menschen von bewaffneten Auseinandersetzungen, vor allem zwischen Regierung (mit internationaler Unterstützung) und der radikalislamischen Terrorgruppe al-Shabaab und anderen geprägt. Unter internationalem Mitwirken wird an der Umsetzung des politischen Programmes zur Stabilisierung und zum Neuaufbau des Staates gearbeitet und für Ende 2016 sind Neuwahlen vorgesehen.

Zusätzlich zur politischen Lage zwangen lange Perioden von Trockenheit und darauf folgenden Hungersnöte viele Menschen, ihre Heimat zu verlassen. Die letzte Hungersnot 2011/12 forderte über eine Viertel Million Todesopfer und 2014 waren noch immer über 1 Million Menschen kritisch ungenügend mit Wasser und Nahrung versorgt. Weitere 2 Millionen werden als belastet eingestuft und fast eine Viertel Million Kinder unter 5 Jahren gelten als akut unterversorgt (FSNAU & FEWSNET, 2014).

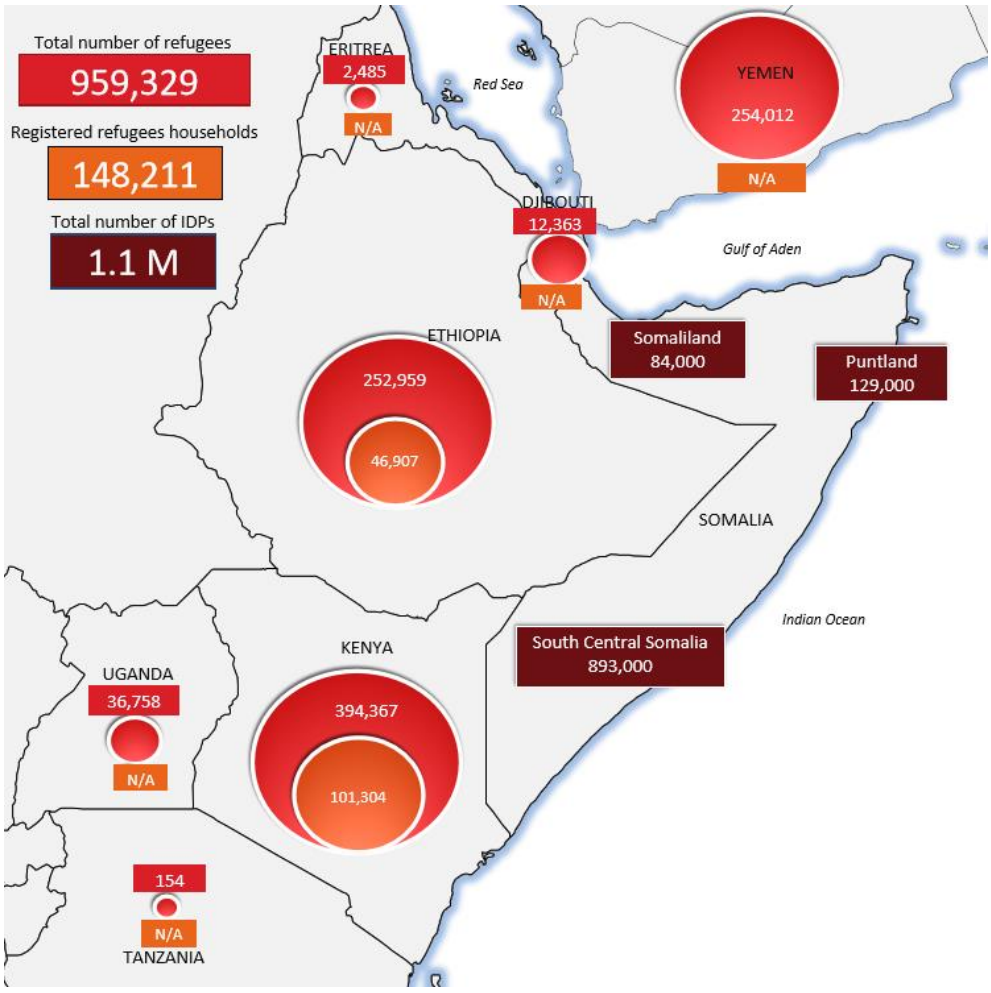


Abbildung 1. Migration aus Somalia, Quelle: UNHCR (2016).

2.1. Somalische Flüchtlinge in *„klein Mogadishu“* Eastleigh / Nairobi

Eastleigh –auch *„little Mogadishu“* genannt- ist ein Stadtteil von Nairobi, der Hauptstadt Kenias und wird zu einem großen Teil von Somalis bewohnt. Es gilt als pulsierendes *„Business-center“* der Stadt und das Bild der Hauptstraßen ist geprägt von grauen Beton-Hochhäusern, in die zahlreiche kleine Geschäfte gepfercht sind. Man findet oft auf weniger als 10 Quadratmetern vollgeladene Stoff- und Kleidungsgeschäfte, Läden für Haushalts- und Schreibwaren, Apotheken, *„shoe-shinern“* und kleine Restaurants. Im fließenden Übergang sind Verkaufsstände an die Gebäude angebaut oder die Verkaufsware ist auf Decken ausgelegt oder an praktisch faltbaren Hängevorrichtungen zur Schau gestellt. Durch kleine freigelassene Gässchen tummeln sich die Menschenmassen, lautstark verhandelnd und ständig begleitet vom lauten Hupen und den ratternden Motoren des allgegenwärtigen Verkehrsstaus.

An vielen Orten finden sich ganze Reihen von Khatständen, die Tisch an Tisch die frischen Bündel, gut geschützt in Bananenblätter oder Zeitungspapier eingewickelt zum Verkauf anbieten. Die gängigsten Namen für Khat sind hier *„miraa“* und *„veve“* und die Geschäfte oder Stände, wo man die begehrten Blätter erwerben kann, sind oft mit außen angebrachten Bananenblättern markiert. Man erhält beispielsweise das sogenannte *„Giza“* mit kurzen, zarten Stängeln, kleineren Blättern und einer rötlichen Färbung, das grünere *„Kangeta“* mit längeren, festeren Stängeln oder *„Magoca“*, das lediglich in Form loser Blätter in kleinen Plastiktüten verkauft wird.

Unmittelbar neben jedem Khatstand findet man eine Gelegenheit, Erdnüsse oder Süßigkeiten zu kaufen, sie sorgfältig in kleine, aus Altpapier gerollte Tütchen verpackt sind. Der Khatverkauf ist größtenteils von Männern dominiert, wohingegen die Frauen für die zugehörigen Erdnüsse zuständig sind. Ein Bündel Khat kostet zwischen 150 und 250 KSh, was in etwa dem Preis einer warmen Mahlzeit in einem lokalen Straßenimbiss entspricht. Die großen Khatlieferungen, meist aus dem Kenianischen Hochland *„Meru“*, werden um die Nachmittagszeit gegen 16:00 Uhr erwartet. Die kleinen Plätze, wo der Truck, vollgepackt mit den fest geschnürten Paketen Tag für Tag eintrifft, sind schon Stunden vor Ankunft eine erwartungsvolle, teils aggressive Unruhe zu beobachten, bis sich bei der Ankunft Scharen von Menschen um den Pick-up drängen.

Eastleigh´s Einwohnerzahl stieg in den vergangenen Jahren rasant an; sie wird aktuell auf 300 – 500.000 Menschen geschätzt (Lindley, 2007; Micheni, 2010). Auch die Infrastruktur

entwickelte sich unheimlich schnell. Innerhalb weniger Jahre wurden zahlreiche Verkehrswege asphaltiert und die provisorischen Straßen aus grauer Erde und Steinen ohne Kanalisation, die sich an Regentagen in Schlammbahnen verwandelten sind nun zumindest in einigen Hauptstraßen verbessert worden. Das Müll- und Abwassersystem ist allerdings noch immer sehr dürftig und so sind die Straßen, Geschäfts- und Wohngebiete noch immer von Müll, stinkenden Kloaken und generell unhygienischen Bedingungen umgeben.

Viele der über 400.000 somalischen Einwanderer in Kenia leiden und der Feindseligkeit der kenianischen Bevölkerung. Sie werden selten als hilfebedürftige Flüchtlinge anerkannt, sondern eher als Terrorgefahr generalisiert (Jaji, 2014) und sie werden als wirtschaftliche Bedrohung angesehen, würden den Staat viel Geld kosten, Arbeitsplätze und Märkte einnehmen, die den Einheimischen zustünden. Lokale Geschäftsleute zeigen sich besorgt über die mangelnde wirtschaftliche Regulation seitens der Regierung: *'Eastleigh businesses are strong competitors that shouldn't be ignored. If things continue this way, one day Eastleigh will really be the main commercial centre of Nairobi'* (aus einem Interview mit einem kenianischen Geschäftseigentümer). Allerdings ist die Kluft zwischen Arm und Reich groß und der Wohlstand entscheidet darüber, wieviel Schutz und Sicherheit man sich kaufen kann. Reiche Geschäftsfamilien profitieren von korrupten Verwaltungen, ärmere Flüchtlinge leiden unter konstanter Schikane und Diskriminierung (Campbell, 2006). Laut der Anti-Korruptionsvereinigung „Transparency International" ist Korruption in Kenia nach wie vor ein großes Problem, vor allem repräsentiert durch Polizeibeamte. Ein Drittel aller Befragten, mussten in den vergangenen 12 Monaten Bestechungsgelder bezahlen und 70% der Bevölkerung sind unzufrieden mit der staatlichen Bekämpfung der Korruption (TI, 2015). Auch in unserer Projektzeit klagten viele Mitarbeiter über willkürliche Verhaftungen und gewaltsames Eindringen in Wohnungen durch Beamte. Außerdem seien sie deren Willkür ausgesetzt, müssten Bestechungsgelder bezahlen und monate- bis jahrelange Wartefristen auf Pässe und andere Dokumente in Kauf nehmen, die es den jungen Menschen ermöglichen, Zugang zu Bildungseinrichtungen zu erhalten.

Diese langen Wartezeiten und aversiven Umstände, gefolgt oder kombiniert mit sehr hohen Quoten an Arbeitslosigkeit machen es wiederum noch attraktiver, vor allem für junge Menschen, Beschäftigung, Orientierung und Gesellschaft beim Khat-Kauen, Anti-Regierungsgruppierungen oder radikalislamischen Organisationen zu suchen. Die Bandenkriminalität, durch die tägliche Angriffe in Eastleigh zu verzeichnen sind, verstärken die

alltägliche Unsicherheit, sich frei auf der Straße bewegen zu können und es kommt häufig zu frustrierenden, verängstigenden, teilweise traumatisierend gewalttätigen Auseinandersetzungen. Die Tendenz zu erhöhtem, exzessivem Khatkonsum konnten wir in früheren Studien bereits zeigen (Widmann et al., 2014).

2.2. Versorgungsnotstand

Zusätzlich zu den politischen Schwierigkeiten in Somalia und Kenia und den Naturkatastrophen, stellt die Versorgungslücke sowohl im physischen als auch psychischen Bereich ein großes Problem dar (Alkan & Ali, 2001). Die Gruppe der somalischen Flüchtlinge in Kenia ist durch die jahrelangen traumatischen Erfahrungen in Krieg und Hungersnöten und die Umstände, unter denen sie beispielsweise in Eastleigh leben, besonders stark belastet. Dadurch, dass weder in der Heimat, noch im Gastland eine adäquate Versorgung stattfand und -findet, können Praktiken wie Anketten, Festbinden und Wegsperren beobachtet werden (Odenwald et al., 2005; Onyut et al., 2009; Silove et al., 2008). Die sogenannte *„ Mental Health Treatment Gap“* (mhGAP) erfährt seit einigen Jahren zwar vermehrt wissenschaftliche Aufmerksamkeit, doch sind die Zustände in den meisten Entwicklungsländern noch weitgehend unverändert (Demyttenaere et al., 2004; Saxena, Thornicroft, Knapp, & Whiteford, 2007). Die Versorgungslücke für substanzbezoge Erkrankungen ist mit bis zu achtzig Prozent besonders hoch (Kohn, Saxena, Levav, & Saraceno, 2004).

Der Mangel an finanziellen Ressourcen und ausgebildetem Fachpersonal legt nahe, dass Versorgungskonzepte zur Behebung dieser Missstände effizientere Behandlungsstrukturen erfordern.

3. Interventionsansatz der WHO ASSIST-linked Brief Intervention

Die Weltgesundheitsorganisation (WHO) entwickelte und evaluierte ein Kurzinterventionspaket, das auf eine individuelle Risikoeinschätzung aufbaut, mit dem Ziel, den Substanzkonsum zu stoppen oder zu reduzieren: Die *„ASSIST-linked Brief Intervention“.* Die Intervention besteht aus den Elementen *ASSIST (Alcohol, Smoking and Substance Involvement Screening Test)* Fragebogen zur Bestimmung des persönlichen Risikos, der

Kurzintervention und dem Selbsthilfemanual (R. Humeniuk, Dennington, & Ali, 2008; Humeniuk R. E., 2010; R. E. Humeniuk, Henry-Edwards, Ali, Poznyak, & Monteiro, 2010; WHO, 2002). Die Wirksamkeit von Screenings mit Kurzinterventionen für Alkoholkonsum in medizinischen Grundversorgungseinrichtungen ist gut belegt (O'Donnell et al., 2014), wobei die Evidenz für andere Substanzen schwächer ist (Saitz, 2014; Matthew M Young et al., 2014).

3.1. ASSIST Fragebogen

Der *ASSIST* Fragebogen prüft die Kriterien eines Substanzmissbrauchs gemäß internationaler Diagnosekriterien. Mit neun Fragen, die jeweils für alle Substanzgruppen erfragt werden, wird ein Summenwert errechnet, der den Teilnehmer in geringes, mittleres oder hohes Risiko einstuft, bestimmte Folgen des Konsums zu erleiden.

Nach ausführlichen Diskussionen in Expertenrunden für Khatkonsumenten wurde der ASSIST adaptiert: Khat wurde inklusive verschiedener Subtypen in die Liste der Substanzen mit aufgenommen. Außerdem erarbeiteten wir zusammen mit erfahrenen Konsumenten, Experten und basierend auf wissenschaftlicher Literatur eine Liste möglicher Folgen des Khatkonsums und ein Schema für niedrigen, mittleren und schweren Khatkonsum. Dabei orientierten wir uns an den höheren Cut-Off Werten, wie sie bei Alkohol verwendet werden.

3.2. Die Kurzintervention

Die wichtigsten Theorien und Modelle, die dieser Intervention zugrunde liegen sind zum einen das transtheoretische Modell von Prochaska and DiClemente (1983), das davon ausgeht, dass es zu keiner Verhaltensänderung kommen kann, bevor der Teilnehmer eigene Motivation zur Veränderung generiert hat. Außerdem die Motivierende Gesprächsführung (Miller & Rollnick, 2004) als therapeutische Grundhaltung mit den Eckpfeilern „Menschen bei der Verhaltensänderung unterstützen“, „Empathie“, „ Diskrepanz und Ambivalenz durch offene Fragen schaffen“, „mit Widerstand ´tanzen´“, „Reflektierendes Zuhören und Zusammenfassen“ sowie das „FRAMES“ Modell (als Teil der motivierenden Gesprächsführung) mit den Elementen „Feedback“, „Verantwortung überlassen“, „Rat geben“, „die Wahl lassen“, „Empathie“ und „Selbstwirksamkeit“.

Auch bei der Intervention waren einige Khat-spezifische Anpassungen notwendig. Ebenfalls nach ausgiebigem Austausch mit lokalen und internationalen Experten ergaben sich folgende neun Schritte:

1. Den Teilnehmer fragen, ob er interessiert ist, seinen Risikowert aus dem Fragebogen zu erfahren, um die Entscheidung über das weitere Vorgehen dem Klienten zu überlassen und somit Widerstand abzubauen.
2. Individuelles Feedback zum Risikolevel geben und den damit verbunden möglichen Folgen.
3. Fragen, wie besorgt der Klient nun über seinen Wert ist. Mit einer offenen Frage am Ende fördert man das eigene Verbalisieren von Nachteilen und Veränderungsgedanken.
4. Gute und schlechte Seiten am Khatkonsum erfragen und den Klienten dazu bringen, beide Seiten gründlich zu bedenken und damit Diskrepanz erzeugen
5. Vor- und Nachteile zusammenfassen mit Betonung der weniger guten Aspekte unter Anerkennung der Erlebnisse sowie durch die Fokussierung auf den kognitiven Konflikt.
6. Fragen, wie besorgt der Teilnehmer nun über die negativen Aspekte ist. Mit offenen Fragen werden Veränderungsgedanken gefördert.
7. Rat darüber geben, wie das Risiko gesenkt werden kann, weitere Schäden zu erleiden indem eine Verbindung zwischen Konsumreduktion und Schadensreduktion geknüpft wird. Dabei empathisch sein und den Klienten nicht verurteilen
8. Dem Teilnehmer die Wahl und letztendliche Entscheidung über sein Verhalten überlassen.
9. Selbsthilfe-Manual aushändigen, zusammen mit der Feedback Seite. Vertrauen in die Fähigkeiten des Klienten ausdrücken.

Die Atmosphäre sollte von Anfang bis Ende von Partnerschaft, Akzeptanz, Mitgefühl und dem Wachrufen neuer Gedanken geprägt sein.

3.3. Selbsthilfemanual

Das Manual besteht aus einer Zusammenstellung genereller Informationen zu Substanzkonsum und einigen therapeutischen Bestandteilen, wie zum Beispiel Tabellen und

Listen in die tagebuchähnliche Beobachtungen des Konsums oder Vor- und Nachteile festgehalten werden können.

Auch am Selbsthilfemanual wurden einige Änderungen vorgenommen: Beispiele und Bilder wurden für Khat angepasst und Informationen zu möglichen Risiken und Schäden, die mit Khatkonsum in Zusammenhang stehen wurden mit aufgeführt.

4. Ziele der Dissertation

Die Ziele dieser Untersuchungen sind der Gewinn eines differenzierteren Verständnisses von Khatkonsummustern und -motiven, um angepasste, durchführbare Behandlungsstrategien zu entwickeln, evaluieren und implementieren. In Ländern wie Kenia, Äthiopien und Somalia, wo durch Kriege, Naturkatastrophen und politische Instabilität eine hohe Prävalenz und gleichzeitig extreme Unterversorgung für psychische Erkrankungen und funktionalen Konsum herrschen ist der Bedarf an effizienten und leicht umsetzbaren Behandlungen immens. Der hier dokumentierte Teil soll zunächst als Vorbereitung für eine multizentrische Studie in diesen Ländern dienen und Hinweise auf verschiedene Konsummuster und die Wirksamkeit einer effizienten Kurzintervention liefern.

Die vorliegende Arbeit beschreibt den Prozess, die Erfahrungen und die Wirksamkeit der kulturellen und substanzspezifischen Anpassung der *„ASSIST-linked Brief Intervention“* bei Somalischen Flüchtlingen in Kenia für Khat mit Berücksichtigung von Multimorbidität, umgebungsspezifischen Einflussfaktoren und der Bewertung der Teilnehmer.

Der erste Artikel konzentriert sich auf die Wirksamkeit der angepassten Screening-Kurzintervention bezüglich Menge und Frequenz des Khatkonsums im Zeitraum von drei Monaten über drei Messzeitpunkte hinweg.

Im zweiten Artikel wird auf Multimorbidität eingegangen. Genauer gesagt, wie sich die Symptomatik einer Depression, PTSD und khat-psychotische Symptome im Verlauf der Behandlung verändern und ob sie den Interventionseffekt beeinflussen. Außerdem wird der Therapieeffekt bezüglich funktionaler Zeit und Konsumzeit beschrieben.

Im dritten Teil werden die Meinungen der Teilnehmer über die Intervention und deren einzelnen Teile beschrieben und verschiedene umgebungsspezifische Faktoren, die nach Meinung der Klienten zur Reduktion des Konsums beitrugen oder diesen erschwerten. Hierbei wird auch besonders auf die Thematik *„Khat-kauen als lifestyle“* eingegangen.

Insgesamt kann so ein umfassender Eindruck einer ersten khat-spezifischen Kurzintervention bei Somalis in Kenia, mit Rücksicht auf kulturelle Hintergründe und aktuelle umgebungs-spezifische Einflussfaktoren dargestellt werden. Er bietet eine Grundlage für die

Weiterentwicklung praxisrelevanter Forschung und die Implementierung nachhaltiger Versorgung und einem differenzierten Umgang mit (un)problematischem Khatkonsum.

II Artikel

5. The Modified ASSIST-linked Brief Intervention for Khat Users: A Randomized Controlled Effectiveness Study[1]

[1] Eingereicht zur Publikation bei ADDICTION

5.1. Abstract

Background and aims: The traditional consumption of the stimulant khat (*catha edulis*) leaves in countries around the Horn of Africa have profoundly changed in the recent decades and excessive use has emerged which is related to the development of dependence. The aim of this study was to test the effectiveness of Brief Intervention to reduce khat use.

Methods: In this randomized controlled trial 330 male Somali khat users from the community were either assigned to Screening and Brief Intervention (161) or Assessment-only Control group (169). We adapted the World Health Organization's Alcohol, Smoking and Substance Involvement Screening Test-linked Brief Intervention (ASSIST-linked BI) to khat and Somali culture. Trained local counselors administered two intervention sessions (t1, t2) to the intervention group and one session to the control group after two months (t3). We assessed amount and frequency of khat use with the Time-Line-Follow-Back method. We used partial matching to correct baseline differences and mixed effect models to test group differences.

Results: Over all 12 weeks (t1 – t2 – t3) and from t1 to t2 khat use amount and frequency significantly declined ($p < .001$) and the intervention group showed a greater reduction in amount and frequency (all group x time effects with $p \leq .030$). From t2 to t3 there was no further reduction and no group differences were found.

Conclusion: Khat use amount and frequency in the community can be reduced by a Brief Intervention, requiring little resources and training. The reduction of khat use in the control group shows that thorough assessment alone might have intervention-like effects. The non-treatment seeking community sample with minimal initial motivation and the non-professional counselors are distinct from Screening and Brief Intervention studies with other substances in other countries but can support the sustainability of this approach in khat use countries.

5.2. Introduction

Chewing Khat (*catha edulis*) is a well described social event with a long standing tradition (Krikorian, 1984). The preferred way of consumption is chewing the fresh leaves and tender stems for effects of excitability, euphoria, talkativeness and flow of ideas. During the last decades, khat production around the Horn of Africa and the Arabian Peninsula has increased significantly and today, the khat sector is a considerable part of national economies in countries like Yemen, Ethiopia and Kenya (Gatter, 2012; Klein et al., 2009).

In contrast to the traditional moderate way of consumption, modern excessive patterns of use are related to various physiological and psychological health consequences (Al-Habori, 2005; Al-Hebshi, Al-Sharabi, Shuga-Aldin, Al-Haroni, & Ghandour, 2010; A. Al-Motarreb et al., 2010; Beckerleg, 2010; Odenwald, Hinkel, et al., 2007; Omolo & Dhadphale, 1987; Warfa et al., 2007; Zein, 1988). Researchers early on recognized the potential of khat to induce psychological dependence which is confirmed by a number of recent studies with adapted versions of the Severity of Dependence Scale (SDS) and the World Health Organization´s Composite International Diagnostic Interview (CIDI) with dependence rates between 5-100% (Awas, Kebede, & Alem, 1999; S. Kassim et al., 2013; S. Kassim et al., 2010; Odenwald et al., 2012; Widmann et al., 2014).

Despite the great need for culturally adapted medical and psychological interventions for khat dependence, currently there's very limited published research available on this specific topic (Odenwald & al'Absi, 2016). In one single study, psycho-education had a small effect on khat use behavior among psychotic patients in Somalia (Odenwald et al., 2012). Because most countries where khat use is common have an understaffed and over-burdened public health system, with little or no institutional care for addiction (Duresso, Matthews, Ferguson, & Bruno, 2016) most suitable interventions would be those which involve little resources and can be implemented by community health workers or in primary care settings, like Brief Interventions (BI). There is strong evidence for the effectiveness of Screening and Brief Intervention in primary health care settings to reduce hazardous alcohol use (O'Donnell et al., 2014); however, the evidence for other substances is weaker (Saitz, 2014; Young et al., 2014). There's no specific study targeting khat use interventions and no such study conducted in community settings.

Somalia is among the world´s 'Fragile States' (Foreign Policy, 2014) and has continuously suffered from organized violence, famine and natural disasters over the last decades. By the end of 2014 more than 1.1 million Somalis were internally displaced and 970.000 were living as refugees in neighboring countries, of which more than 420.000 were hosted by Kenya (UNHCR, 2015). Because of the culture of khat use, it is very likely for Somalis to chew khat to cope with adversities; it is supposed to strengthen a sense of identity and social wellbeing (Klein, 2007; S.L. Patel, 2008) and after traumatic experiences the amount of use was shown to be increased in order to reduce painful memories and cope with other symptoms (M. Odenwald et al., 2009). In our previous studies we found extreme use patterns among the Somali refugee population (Widmann et al., 2014).

Here we report on a pilot RCT that had two aims: We wanted to gain first experiences on the acceptance and applicability of screening and brief intervention for khat in Somalis where khat use is integral part of the culture. Secondly, we tested the effectiveness of the ASSIST-linked BI that had been adapted to Somali language and culture among a non-treatment seeking and a non-selected community sample of khat chewers. We expected that khat users reduce their khat use after receiving ASSIST-BI compared to a control group who only participated in the repeated assessments of their substance use. We expected small reductions for amount and frequency of khat consumption in favor of the treatment group.

5.3. Methods

Study location

This study was implemented in Eastleigh, a part of Nairobi, Kenya, with approximately 300,000-500,000 inhabitants the majority of them being ethnic Somalis of many who are urban refugees (Lindley, 2007; Micheni, 2010).

Design

In this randomized controlled intervention trial male Somali khat users from the community were randomly assigned to Screening and ASSIST-linked Brief Intervention (SBI) or Assessment Control (AC). In the course of a two-months study period, three individual appointments were scheduled: t1 at study entry, t2 four weeks after t1, and t3 four weeks after t2. Participants of the intervention group received SBI in the first appointment and a brief refresher BI at t2 appointment, asking for changes in khat use in the previous four weeks. The AC group received the BI after two months in the third appointment. See Figure 2.

		t1 (study entry)	t2 (4 weeks after t1)	t3 (4 weeks after t2)
SBI	Measurement	TLFB (1 month) Khat use history Living conditions	TLFB (1 month)	TLFB (1 month)
	Intervention	ASSIST-linked BI	Refresher BI	none
AC	Measurement	TLFB (1 month) Khat use history Living conditions	TLFB (1 month)	TLFB (1 month)
	Intervention	none	none	ASSIST-linked BI

Figure 2. Design of the study

Sample

Male khat chewers with initial motivation to stop or reduce their khat use were recruited from the community. We only included male participants because khat chewing is a predominantly a male habit and female users are often stigmatized in the community, which leads to significant underreporting.

Using the G*Power software (Faul, Erdfelder, Buchner, & Lang, 2009), we calculated a total sample size of n = 260 as being sufficient to be able to detect a small effect with sufficient power (ß = .95; α = .05).

Recruitment took place via radio announcements, printed flyers and oral information provided by community elders and the local research team. Also snowball effects happened as khat users included into the study motivated other fellow users to participate. In the case of cliques of khat chewers, the whole group was assigned to SBI or AC in order to minimize treatment contamination; group allocation was determined following an alternating order by the project coordinators. Inclusion criteria were being a male Somali, chewing khat (past month), being motivated to learn about or change his khat use while exclusion criteria were severe mental disorders, disabilities and impaired communication skills.

330 participants were randomly assigned to SBI (161) and AC (169) and we had an initial participation rate of 90.2% as illustrated in Figure 3. In order to identify individuals who took someone else´s place in a follow-up assessment, we checked socio-demographics at each assessment. The numbers of excluded participants are shown in Figure 3. Sample characteristics are described in Table 1.

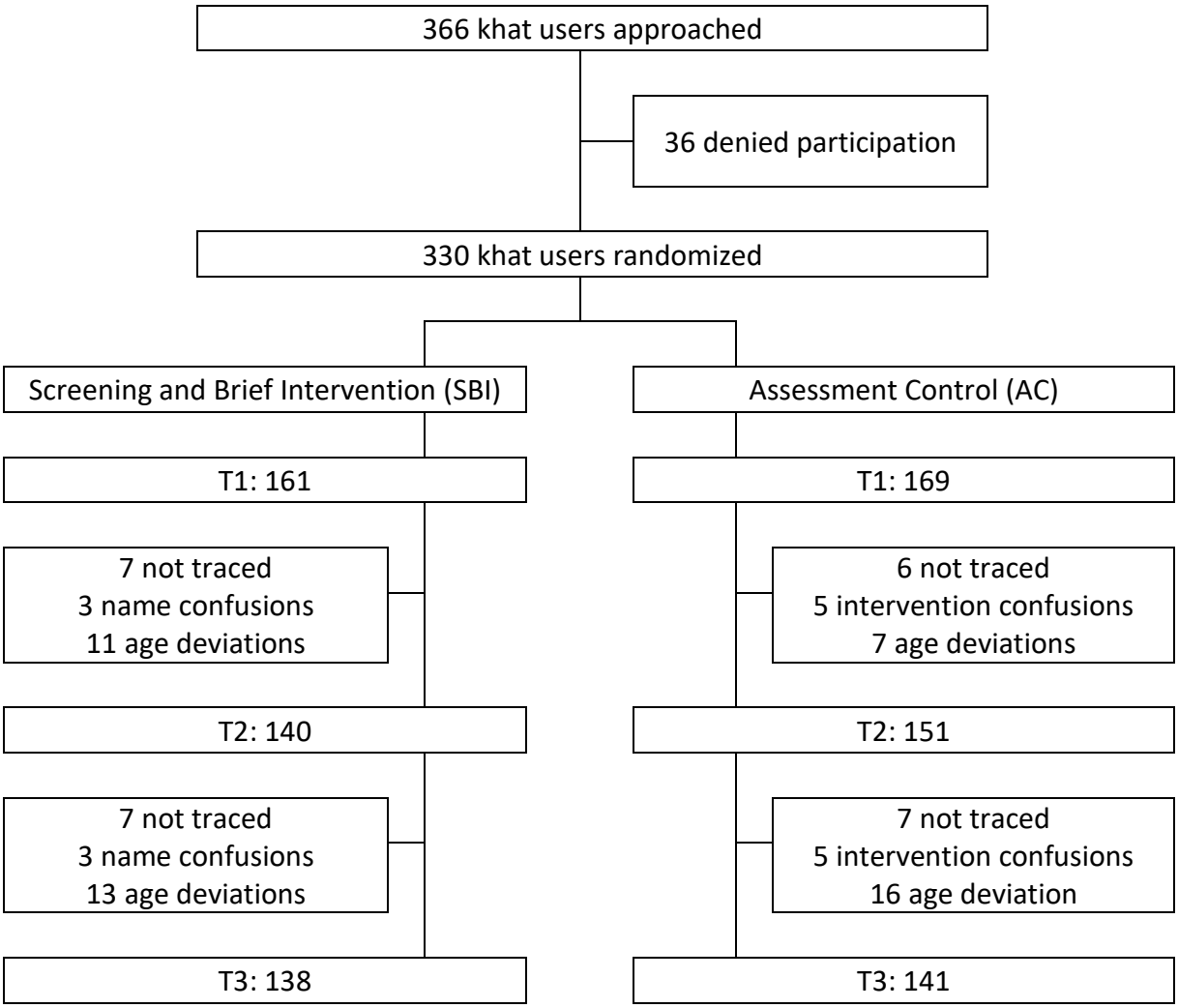


Figure 3. Flow diagram

		Total (M, SD) / %(N)	Brief Intervention group (M, SD) / %(N)	Assessment control group (M, SD) / %(N)	p
N		100% (330)	48.8% (161)	50.2% (169)	-
Socio demographics					
Age (Mean, SD)		27.8 (6.6)	27.7 (6.2)	28.0 (7.0)	.698
Marital Status (% married)		23.9% (79)	20.5% (33)	27.2% (46)	.153
Occupation (% not working)		40.0% (132)	38.5% (62)	41.4% (70)	.590
Immigration status (% refugees)		49.4% (162)	51.2% (82)	47.6% (80)	.511
Persons per household		4.1 (2.5)	4.1 (2.7)	4.1 (2.3)	.950
Education, years formal school (Mean, SD)		9.0 (4.1)	8.8 (4.4)	9.3 (3.7)	.267
Home type	*House*	0.6% (2)	0	1.2% (2)	.289
	Lodge	11.2%(37)	13.8%(22)	8.9%(15)	
	Apartment	70.8%(233)	69.4%(111)	72.2%(122)	
	Part of apartment	17.3%(57)	16.9%(27)	17.8%(30)	
Household type	*Family based*	67.4%(221)	65.8%(106)	68.9%(115)	.658
	Rent sharing	17.5%(56)	17.1%(27)	17.9%(29)	
	other	15.3%(49)	17.1%(27)	13.6%(22)	
Substance use					
Start age regular khat use		21.0 (3.9)	20.6 (4.0)	21.4 (3.8)	.066
Other substance use last year, excluding khat and tobacco [1]		23.2% (74)	26.1% (42)	20.3% (32)	.217

[1] missing values: SBI n = 161, AC n = 158

Table 1. Characteristics of the study sample.

Instruments

Translation of instruments

All materials were used in Somali language after a translation and independent back-translation process.

Substance use measures

Khat use was measured by two indicators: consumed traded units (bundles) and days with khat use in the 4 weeks prior to each assessment. We used an adapted version of the Timeline Follow Back (Sobell & Sobell, 1995), a calendar method with high reliability and validity (Fals-Stewart, O'Farrell, Freitas, McFarlin, & Rutigliano, 2000). In order to be able to compare the amount of use of different local khat qualities we developed, together with experienced Somali khat users and Somali physicians, a scheme of equivalent traded standard units with brief explanations, photos and local terms before the study.

Household economic situation and living conditions

In order to assess living conditions, we asked for the participant's home type, household type, the number of people living in the household, marital status, schooling years and occupation.

Intervention

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

The ASSIST is a brief and easy to apply interviewer-administered instrument developed by WHO for the identification of problematic substance use and starting point for a Brief Intervention to reduce substance use in primary care (R. Humeniuk et al., 2012b). It is widely used and has a good to excellent reliability (WHO, 2002). With eight questions on nine groups of substances, a substance involvement score and risk level for each substance (range 0-44) is assessed. In the original version, khat is not included into the categories of substances. A multi-disciplinary group of experts adapted the ASSIST interview and defined a khat risk level

analogous to alcohol (0-10, 11-26, 27+) as khat use has a long-standing tradition and is an omnipresent phenomenon with social functions so that non-use leads to social exclusion.

In the present project, the ASSIST interview was only used as part of the khat-related ASSIST-linked BI; therefore, we assessed all questions for khat, and for all other substances, we only employed questions 1 and 2. We opted against the ASSIST interview as standard evaluation instrument because we wanted to create a clear difference between the two groups.

Adaptation of the ASSIST-linked Brief Intervention (ASSIST-BI)

The ASSIST-BI is a standardized brief intervention of approximately 15 min duration that builds upon substance involvement scores derived from the ASSIST interview (WHO, 2010). The intervention follows the FRAMES model, i.e. containing the six elements (Feedback, Responsibility, Advice, Menu of options, Empathy, and Self-efficacy) that are considered effective to reduce substance use (Bien, Miller, & Tonigan, 1993) and incorporated techniques derived from Motivational Interviewing (Miller & Rollnick, 2004). Additionally, a self-help booklet that transports simple information and advice by brief texts and illustrative drawings is given to the client as part of the ASSIST-linked BI. The effectiveness of the ASSIST-BI to reduce substance use has been shown in a large international study(R. Humeniuk et al., 2012b). The above mentioned expert group, slightly adapted the original ASSIST-linked BI in order to fit to khat-specific and cultural requirements similarly to the way practiced in the WHO's multi-country validation study (R. Humeniuk et al., 2012b). Especially the self-help booklet was modified and translated to Somali language, using the method described above.

Training and procedures

The assessment and ASSIST-BI was implemented by a group of 15 Somali youth leaders with college degree and 3 supervisors, all being from Eastleigh's Somali community and fluent in Somali, Swahili and English. Prior to the study, they participated in a four-week intensive workshop and trainings on theoretical background and practical aspects of BI, interviewer skills and the assessment tools with continuous supervision during the project implementation.

Assessment and interventions were conducted in Somali language. Initial appointments (t1) took place in a collaborating local health center where a medical doctor supervised the screening for exclusion criteria. Follow-up appointments were arranged flexible to the needs of participants. At any location, privacy and data protection was assured in order to be able to talk about sensitive topics. The interviewers were blinded on the previous substance use reports of the interviewed participant but not for group (SBI or AC). Participants were not paid nor compensated for their participation.

Ethics

The Institutional Review Boards of the Kenyatta National Hospital/ University of Nairobi and of the University of Konstanz (Germany) approved this study. Due to the high level of illiteracy among the participants, information on study purpose, procedures and participants' rights were read to the participants before asking for participation. Participants were only included into the study after signing an informed consent.

Statistical Procedures

We analyzed data with SPSS 20. For continuous variables we report means and standard deviations (M±SD) and percentages for bivariate variables with Alpha ≤ 0.05.

Proportions between groups were compared with Chi^2 tests or Fisher's exact tests. For continuous variables, we used t-tests or Mann-Whitney-U tests to analyze simple group differences.

For the outcome variable "number of consumed bundles", square root transformed data were used due to skewed distributions.

Cohen´s d was used to describe effect sizes within and between treatment groups. Following the recommendation of Morris (2008) for between-treatment effect sizes, pre-post differences were weighted for their pooled standard deviation of the baseline measurement (d_{ppc2}).

Mixed-effect models

In order to deal with the large number of missing values we chose mixed-effect models for the analyses of changes over time and post-hoc tests. They have the advantage of being relatively robust to missing data (Siddiqui, Hung, & O'Neill, 2009). The model predicts treatment response (consumed khat bundles and days with khat use) including 'treatment', 'time' and 'treatment x time' as fixed effects and 'time' as within-participants repeated factor. Predictors were included stepwise into the model; to correct for multiple testing in the two post-hoc tests, Alpha was set to .025 according to Bonferroni correction. The type of covariance was set unstructured due to best model fit according to -2Log Likelihood information criteria. Random intercepts and slopes were included stepwise as subject specific random effects when proven to enhance model fit as recommended by Raudenbush and Bryk (2002). The model selection was based on maximum likelihood estimation.

We matched the extreme 5% (N = 16) of the participants in order to correct for the a priori existing differences but not to reduce the sample size too much. Using the variable "consumed khat bundles", participants were paired (± 3 bundles). This resulted in the exclusion of the 8 participants with lowest (8 AC) and the 8 with highest (1 AC, 7 SBI). In cases with more than one matching equivalent, the most similar age was deciding. The exclusion of extremes seems legitimate because various studies showed the effectiveness of brief interventions might be moderated by the amount of use (Saitz, 2014). After this procedure, khat use in the month before study entry, age and other socio-demographic variables did not differ between the groups.

Reliable Change Index:

For individual treatment effects we used the Reliable Change Index (RCI) to compare treatment outcomes (Jacobsen & Truax, 1991) using the test-retest reliability of the Time Line Follow Back for alcohol as it is the most comparable substance regarding popularity, legal status and availability (taken from Fals-Stewart et al., 2000). Percentages of participants with and without significant improvement (which includes change for the worse) were compared with a cut-off for significant change at RCI = 1.96 and Alpha ≤ 0.05 (Jacobsen & Truax, 1991).

5.4. Results

One-hundred-sixty-one participants were assigned to the SBI and 169 to the AC group. Table 1 reports the socio-demographic and socio-economic data of both groups. They were comparable in relation to all items.

The duration of the ASSIST Screening and Brief Intervention for the intervention group was 28.8 (±12.5) minutes at t1 and 13.1 (±8.0) minutes at t2 (refresher); in the AC group the intervention at t3 took 38.5 (±14.9) minutes.

Intervention effects

The quantitative indicators of khat use in the observation period (12 weeks) are reported in Table 2.

At study entry, participants in the AC consumed almost 50 bundles, in the SBI group almost 60 with a statistically meaningful difference. With the partially matched data, this difference was not statistically significant anymore. Participants in the AC and SBI group had around 20 days with khat use, in the 28 days prior to the study, also after partially matching. Mixed-effect model results for amount and frequency of khat use are reported in Table 2.

Quantity (bundles in last 28 days; M, SD)				
time	matching	AC	BI	p
t1	no	48.11 (43.91)n = 169	58.56 (48.11)n = 161	.006
	yes	49.40 (44.20)n = 160	54.37 (44.72)n = 154	.101
t2	no	47.75 (38.80)n = 155	50.75 (48.61)n = 143	.556
	yes	48.39 (39.03)n = 144	46.44 (44.36)n = 136	.159
t3	no	42.64 (31.75)n = 141	43.52 (35.94)n = 142	.727
	yes	42.77 (31.31)n = 133	42.07 (33.66)n = 134	.510
Frequency (use days in last 28 days; M, SD)				
t1	no	20.74 (6.28)n = 169	21.57 (6.40)n = 161	.147
	yes	21.04 (6.18)n = 160	21.44 (6.39)n = 154	.436
t2	no	18.91 (6.10)n = 155	17.19 (6.58)n = 143	.023
	yes	19.03 (5.93)n = 144	16.96 (6.57)n = 134	.008
t3	no	18.59 (7.40)n = 141	17.27 (8.22)n = 142	.100
	yes	18.81 (7.26)n = 133	17.34 (8.15)n = 132	.078

Table 2. Amount and frequency of khat use in the 28 days prior to t1, t2 and t3 for the intervention group (SBI) and the assessment control group (AC).

Changes in the quantity of khat use

With the original data, over all 12 weeks (t1 – t2 – t3) we found that the amount of consumed khat was reduced with significant main effects for time and group and with a significant interaction time x group. The same was found for changes over t1 and t2 but from t2 to t3 no significant effects were found. Results with the partially matched data (t1 – t2 – t3 and t1 – t2) still showed significant main effects for time and the interaction time x group but not for group.

Using the unmatched data, significant change on an individual level was assessed with the Reliable Change Index. In the SBI group, more participants reduced the amount of consumed khat bundles significantly (t1 to t3) compared to AC; χ^2 (1, *N* = 281) = 4.371, *p* = .026 (See Figure 5).

The pre-post effect size (t1 – t3) for the SBI group was d = .36, for the AC group d = .14 and the between-group effect size was d_{ppc2}=.21. After the partial matching it was d = .19 for the AC, d = .34 for the SBI and d_{ppc2}=.13 between the groups.

Changes in the frequency of khat use

Using the unmatched data to test the changes in the frequency of khat use, the main effect for time and the interaction time x group were significant but not the main effect for group (t1 – t2 – t3 and t1 – t2). From t2 to t3 none of the effects was significant (see Table 3 and Figure 4).

Using the partially matched data the same effects remained significant (see Table 3).

Using the unmatched data, with the Reliable Change Index no significant change could be found for the number of days with khat use in the last month, χ^2 (1, *N* = 279) = .831, *p* = .215 (Figure 5).

With the unmatched data the effect size (t1 – t3) for the SBI group was d = .62, for the AC group d = .32 and the between-group effect size was d_{ppc2} = .34. After the partial matching it was d = .34 for the AC, d = .58 for the SBI and d_{ppc2}=.29 between the groups.

		original					matched		
Quantity (bundles)									
t		df	F	p	t		df	F	p
	g	1, 332.63	8.66	.003		g	1, 317.21	3.31	.070
1-2-3	t	1, 325.40	26.26	.000	1-2-3	t	1, 308.48	24.89	.000
	g x t	1, 325.40	8.23	.004		g x t	1, 308.48	4.77	.030
	g	1, 331.06	9.70	.002		g	1, 317.66	4.89	.028
1-2	t	1, 302.73	10.26	.002	1-2	t	1, 290.29	12.01	.001
	g x t	1, 302.73	6.73	.010		g x t	1, 290.29	5.40	.021
	g	1, 297.13	.01	.975		g	1, 283.67	.28	.599
2-3	t	1, 295.79	3.85	.051	2-3	t	1, 281.99	2.16	.142
	g x t	1, 295.79	.01	.935		g x t	1, 281.99	.10	.753
Frequency (days)									
t		df	F	p	t		df	F	p
	g	1, 329.19	3.49	.063		g	1, 313.69	1.81	.180
1-2-3	t	1, 320.51	58.93	.000	1-2-3	t	1, 305.93	54.16	.000
	g x t	1, 320.51	7.16	.008		g x t	1, 305.93	5.66	.018
	g	1, 323.68	7.86	.005		g	1, 306.74	5.81	.017
1-2	t	1, 304.83	70.94	.000	1-2	t	1, 290.10	73.35	.000
	g x t	1, 304.83	12.62	.000		g x t	1, 290.10	11.76	.001
	g	1, 281.30	1.49	.223		g	1, 269.38	2.32	.129
2-3	t	1, 277.32	.03	.860	2-3	t	1, 264.35	.07	.788
	g x t	1, 277.32	.34	.560		g x t	1, 264.35	.60	.440

Table 3. Results of linear mixed effect model analyses over t1- t2- t3; t1-t2 and t2-t3. Main effects for group (g), time (t) and the interaction group x time (g x t) are reported for original data and partially (5%) matched data.

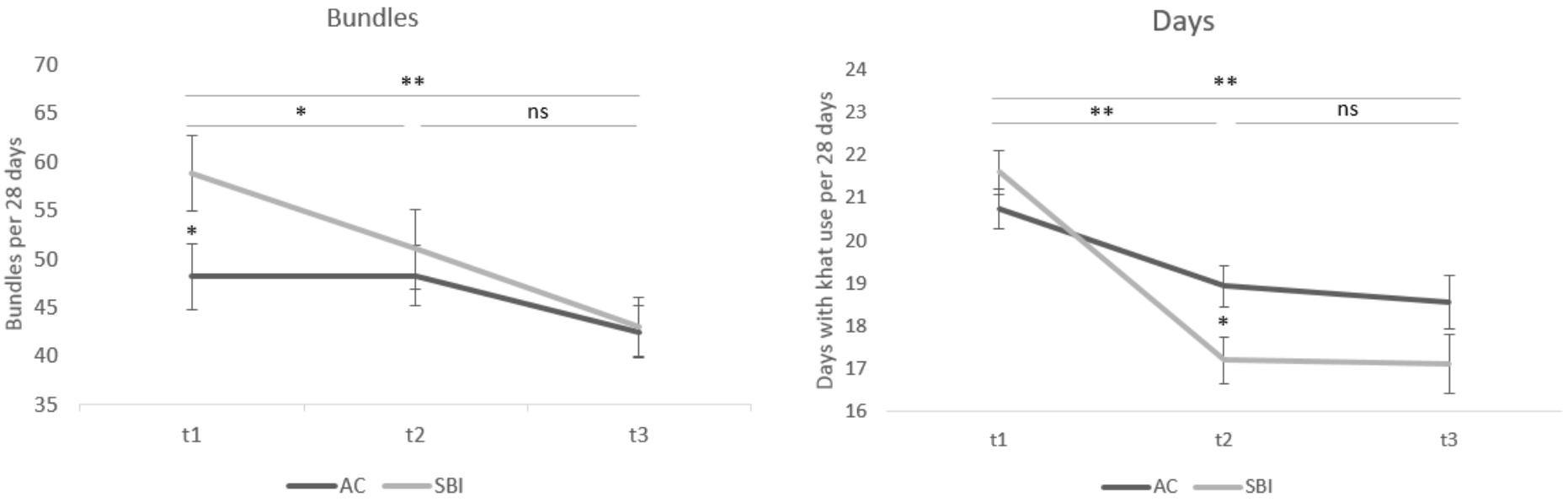


Figure 4. Amount and frequency of khat use with unmatched data. Means, standard errors, significant group differences and time x group interactions are displayed.

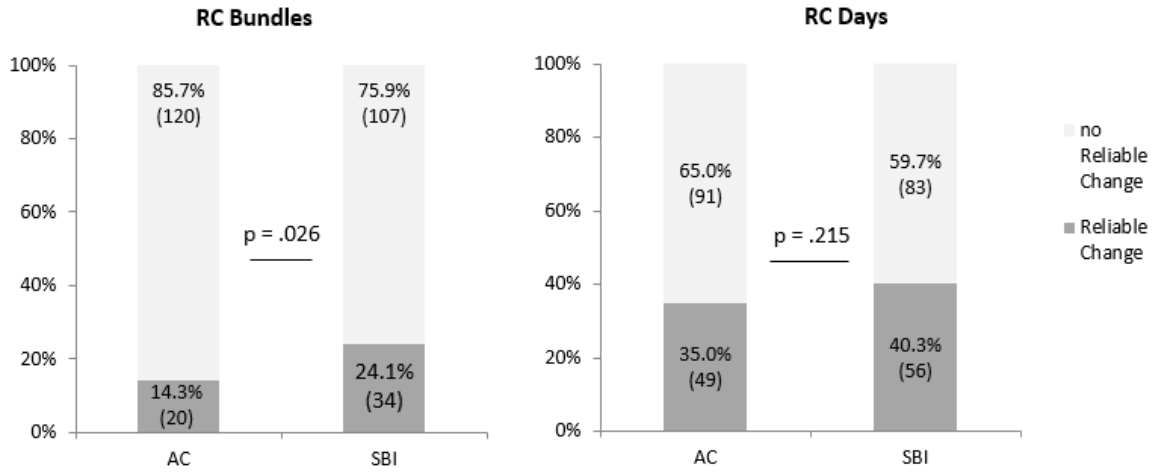


Figure 5. Reliable Change Index for bundles and days using uncorrected data. Percentages and n of participants with and without significant reduction at t3 compared to t1.

5.5. Discussion

Male Somali khat chewers from the community in Eastleigh/Nairobi participated in a khat-specific Screening and Brief Intervention RCT (one session of modified ASSIST-linked Brief Intervention plus refresher vs. assessment only) with a 2-month follow-up. Due to pre-existing group differences, we partially matched the groups for statistical testing. Screening and Brief Intervention for khat use was well accepted and could be easily applied in Somali culture, as shown by this study's ability to recruit and retain participants as well as through the application of the FRAMES model during training and study without any difficulties. It seemed that the wish to reduce one´s own khat use is common in the Somali community in Nairobi. The main empirical findings of this study were that the intervention clearly reduced khat use amount and frequency in the first month but no further reduction in the second month. This result shows the positive potential of very brief psychotherapeutic interventions, even if conducted by trained lay persons and with non-treatment-seeking participants from the community in the Somali khat culture where khat is integral part of daily life.

In this study we dealt with a form of substance use that is strongly related to a defined geographical region, specific ethnic groups and cultures and which has a well-described , khat tradition and use culture as well as numerous social functions (Olden, 1999). It is likely that Somali immigrants use khat to strengthen group identity and to cope with various stressors and psychopathology (K. Bhui & Warfa, 2010; Fangen, 2006; Klein, 2007; Odenwald, Hinkel, et al., 2007; M. Odenwald et al., 2009; S.L. Patel, 2008). For this reason it is almost impossible for male Somalis in Eastleigh to participate in social life and to cope with past and current adversities without chewing khat – their physical and social environments are full of khat-related triggers and role models. Furthermore the lack of alternative, non-destructive activities and the illegal immigration status of many Somalis, which complicates employment, make it difficult to reduce khat chewing. This background is important when discussing intervention effects.

In the reported study, the effects of SBI on khat use were small, i.e. at the end of the observation period the intervention group had reduced the amount by 5 khat bundles more (baseline range 8 to 336 bundles in 28 days) and the frequency by 2 days more (baseline range 4 to 28 days) than the control group. These differences are, indeed, small, and did only reach significance for the frequency of use. When compared to previous studies, especially in non-western settings, larger effect sizes were reported (R. Humeniuk et al., 2012b). These small effects can be explained by some typical features of khat use and by some characteristics of our study:

Compared to other intervention studies, we set the inclusion criteria very low and aimed for a representative community sample instead of a treatment-seeking sample. As a consequence, we included users with a wide range of consumption patterns, from addictive and excessive use to moderate and occasional use. Most other SBI studies pre-selected participants and included only those with moderate use, recruited from primary care facilities and with probably higher levels of motivation to change. Here, we did not and we did not follow the ASSIST treatment recommendations, because our interest was khat use change in the community as a whole. Because of these factors we had to deal with large variances in our two central outcome measures (amount and frequency), which made it difficult to identify small changes by methods of statistical testing. The variance of our measures of amount of

khat use is large especially because of the local definition of a standard unit - a relatively small quantity that easily varies at the individual level between one and ten per day. Furthermore we employed measures to retain participants in our study, even those with minimal motivation to change, e.g. methods to minimize the effort for participants to keep the follow-up appointments, e.g. setting very flexible times and locations, and we had two staff members from the community to motivate participants. This led to very low dropout rates and even participants with low interest and motivation completed the study, which of course weakened the effects.

Additionally, we have to take into account a variety of factors that might have diminished the difference of intervention and control condition: First, the assessment only control group also had intervention-like effects as revealed by the course of change (Figure 4) - especially in the first month a window of earlier reduction occurred in the SBI group and the control group partially caught up in the second month. The overall reduction of khat use might have various reasons: The assessment of khat use and related problems (not all reported here, i.e. comorbid psychopathology) could have worked as intervention-like elements, i.e. like in the balancing exercise of MI - all these assessment components can create *discrepancy* and *change talk*. Also in other studies, control groups have shown a reduction in their substance use (e.g. R. Humeniuk et al., 2012a). A further element that could have reduced the difference between both groups is contamination: Eastleigh is a densely populated and crowded part of Nairobi and the Somali community as a minority in Kenya is very communicative and social, sharing big parts of their everyday life. This physical closeness and cultural sociality might have also contributed to exchange of information and experience about the intervention. Another reason for the small difference between intervention and control conditions might have been the trained young college graduates who weren´t trained health workers, for whom the ASSIST-linked BI originally has been developed for. Probably they had not performed the intervention as efficient and they might have not managed to deliver the *difference* between the two arms as effective as experienced health staff; in sum, our counselors might have produced lower effects.

But in sum, effect size measures showed the expected small treatment effects (d=.29 and .13) favoring SBI and we believe that the above mentioned factors all increased the external

validity of the study and show the potential of SBI for the reduction of khat use in the community.

This study also needs to be discussed in the context of the growing evidence that Screening and Brief Intervention works well for alcohol but that its effectiveness for illegal substances is seriously questioned (Saitz, 2014). Saitz (2014)discussed potential explaining factors, such as non-legal status or comorbid use of other substances among drug users. In the Somali community in Nairobi, khat use has some features that are typical for alcohol use in western countries: It is a fully legal substance in Kenya, it is officially not even considered a drug; khat is the most used substance, it is normal to use it and chewing khat is even considered part of the mainstream Somali culture; and in contrast to other substances, moderate Islamic currents sanction khat use. Though we found relatively low comorbid substance use, in contrast to representative samples (e.g. Martin, 2008) khat use in Eastleigh has also some similarities to illegal drug use in western countries, e.g. the amphetamine-like effects and the typical use culture. Thus, khat chewing cannot be easily classified along the distinction between alcohol and illegal substances in western countries and SBI in khat use needs to be studied as a separate topic.

Limitations

The randomization strategy used in our study partially failed, as the SBI group showed greater baseline khat use as the control group. But after matching the extreme ends the effectiveness of ASSIST-linked Brief Intervention could be shown. These baseline differences probably were the consequences of our sampling method that included snowball sampling and randomization of whole cliques. As an unwanted consequence, participants who were assigned to the intervention group probably had a higher motivation to recruit friends or family members (in order to help them). We believe that it was especially more likely for heavy chewers who received the intervention to recruit fellow users compared to participants from the control group. But it was only a small proportion of participants who were recruited by that way (total snowballed proportion approximately 15-20% including approximately 10 heavy chewers) so that we believe this could be effectively dealt with. After matching and

even very strict correction methods similar outcomes with comparable baselines were produced (e.g. post-stratification, winsorizing or complete matching). Nevertheless, future studies are needed to replicate our findings.

We had no objective outcome measures such as urine screenings or hair measurements partly because of missing screening tools for khat alkaloids that are applicable under precarious field conditions and were not able to control for current comorbid substance use. However, in our sample comorbid substance use was not as large as in typical studies among substance users.

The study setting was extremely challenging: Gang criminality and the current political situation lead to high tension in Eastleigh by the time of assessment. Therefore, a continuous supervision and treatment fidelity could not be fully controlled. Nevertheless, we believe that it´s extremely important to conduct such studies despite the difficult circumstances in order to develop intervention tools for extremely neglected populations in need.

Furthermore the missing blindness of interviewers for group allocations could have caused assessment effects in the sense that interviewer behavior could have induced more socially desired answers. However, in order to minimize this potential effect we strictly organized the study in a way that no interviewer saw a participant more than once.

Conclusions

Based on our experiences from this and other projects with Somalis, we conclude that psychotherapeutic measures are culturally accepted and applicable among this extremely disadvantaged population and in the difficult setting of the countries around the Horn of Africa. With these results, we could show that a very economical intervention that requires little investment in time and training is effective and has a large potential to change khat use on a broader scale. After this first, basic evidence, it is justifiable to devote further attention and resources to the development and implementation of khat use treatment and prevention programs. There is a huge demand for such programs in the traditional khat use countries where treatment opportunities and community based counseling services for khat users who suffer from their khat use are completely lacking.

6. Comorbid psychopathology and everyday functioning in a Brief Intervention study to reduce khat use among Somalis living in Kenya: description of baseline multimorbidity, its effects of intervention and its moderation effects on substance use[2]

[2] Eingereicht zur Publikation bei *Social Psychiatry and Psychiatric Epidemiology*

6.1. Abstract

Background and aims: Migration and khat use were found to correlate with high rates of psychopathology. In this paper we aimed for assessing baseline multimorbidity and its interactions with a Brief Intervention.

Methods: In the RCT, 330 male Somali khat users were assigned to treatment conditions. The ASSIST-linked BI for Khat users was administered. Using the TLFB Calendar, the PHQ-9, a Somali short version of the PDS and parts from the CIDI, khat use and comorbidity was assessed. With a regression analysis we tested for the influence of comorbidity and with mixed effect models group differences over time in sleep, use time and everyday functioning were tested.

Results: We found high rates of multimorbidity: 51% (N = 168) for depression, 22% (N = 74) for PTSD and 23% (N = 73) for khat-psychotic symptoms. Depression and khat-psychotic but not PTSD symptoms were reduced without group differences. Use-time decreased and functional time increased with significant time x group interactions ($p \leq .046$). Depression and PTSD did not influence therapy success but in participants without comorbid psychopathology, more reduction after the intervention was found ($p = .024$).

Conclusion: Somali khat users in Kenya are highly burdened by multimorbidity of depression, PTSD and khat-psychotic symptoms. The main effects for time and differences in healthy versus mentally ill khat users indicate potential by unspecific support and the specific need for mental health care in combination with substance abuse treatment. The increase of everyday functioning promises more options for alternative activities, preventing excessive use and addiction.

6.2. Introduction

Khat leaves (Catha edulis) with their mild stimulant effects are traditionally chewed in social contexts in many African and Arab countries including Somalia (Krikorian, 1984). The young and tender twigs are harvested and mostly wrapped in banana leaves to keep them fresh for sales and consumption within one day. The leaves are chewed slowly over hours to release active stimulant components like cathinone and its metabolites cathine (norpseudoephedrine) and norephedrine (Kalix, 1990; Toennes et al., 2003); cathinone and its derivatives are highly addictive and constitute a large group among the so called legal highs (…). Used in a moderate way, khat is not reported to cause health problems (Pennings et al., 2008) whereas excessive use is related to various health consequences such as cardiovascular, gastric and liver disorders, periodontal problems and impotence as well as mental problems like depression, hallucinations induced psychotic disorders and dependency (Al-Habori, 2005; Al-Hebshi et al., 2010; A. Al-Motarreb et al., 2010; Beckerleg, 2010; M. Odenwald et al., 2009; Warfa et al., 2007).

Somalia is one of the world´s most Fragile States (Foreign Policy, 2014) and organized violence, famine and natural disasters have burdened its human population for decades and led to emigration and flight. Currently more than 1.1 million Somalis are internally displaced and almost 980.000 are living as refugees in neighboring countries, of which almost 415.000 are hosted by Kenya in refugee camps and urban resettlements (UNHCR, 2016a). In such a context, it is very likely for Somalis to chew khat. Tradition, availability in host countries and the burden of adversities they have to cope with are supporting factors for khat consumption and misuse (Klein, 2007; M. Odenwald et al., 2009). Current observations describe modern forms of consumption as extremer, in bigger amounts and often combined with other substances compared to traditional use patterns (Omolo & Dhadphale, 1987; Widmann et al., 2014; Zein, 1988). Khat chewing is supposed to strengthen a sense of identity and social wellbeing (Klein, 2007; Patel, 2008) and after traumatic experiences or migration some studies found an increase of use, which is likely to be a functional try to reduce painful memories and other symptoms (Bhui et al., 2003; Griffiths et al., 1997; Odenwald et al., 2009).

The prevalence rates for mental disorders among refugee populations vary due to a large number of factors like age, ethnic group, context of migration, education, gender etc. (Fazel,

Wheeler, & Danesh, 2005; Lindert, Ehrenstein, Priebe, Mielck, & Brähler, 2009). A meta-analysis on labor migrants and refugees shows prevalence rates of 47% for PTSD and 35% for depression (Lindert et al., 2009), another one by Fazel et al. (2005) focusing on refugees in western countries found lower rates of 12% for PTSD and 7% for depression and about 2% for psychotic illnesses. Among Somali refugees, khat users were found to have a higher risk of mental disorders (adjusted OR = 10.5) (Kamaldeep Bhui et al., 2006), whereas another study with Somali refugees in a none-conflict zone country by Bhui and Warfa (2010) found no correlations between the frequency of khat use and the presence of psychotic symptoms, anxiety or depression, nor traumatic events.

We recently reported a randomized controlled intervention trial with a community sample of Somali khat chewers (N = 330) in Nairobi, Kenya, on Screening and Brief Intervention (SBI) for khat use (Widmann et al., submitted). A single session of SBI reduced khat use frequency and amount in the following month, with small effect sizes.

In this article we report further data from this SBI study, especially related to comorbid mental health problems. The aims of the study were (1) to describe baseline comorbid psychopathology, use time, every-day functioning and sleep in this community sample of khat chewers in Nairobi, (2) to report how these variables change over time as a function of Screening and Brief Intervention, and (3) to test whether there is evidence for an influence of comorbid psychopathology on the intervention effect, i.e. the reduction of khat use.

6.3. Methods

Study location

This study was conducted in Eastleigh, a suburb and business center of Nairobi, Kenya. Its total population is estimated to be 300,000-500,000 (Lindley, 2007; Micheni, 2010) and ethic Somalis are the predominant inhabitants.

Design

In this randomized controlled intervention trial, male Somali khat users from the community were randomly assigned to Screening and Brief Intervention (SBI) or Assessment Control (AC). Participants were enrolled for two months with a total of three appointments. Participants of the intervention group received the BI at the first appointment. The Assessment Control group received the BI after two months during the third appointment. Psychopathology was assessed at t1 and t3.

Sample

Male khat chewers with initial motivation to stop or reduce their khat use were recruited from the community. With an initial participation rate of 90.2%, 330 participants were randomly assigned to BI (161) and AC (169). N of dropouts and methods of dealing with missing values are reported below. Recruitment details and sample characteristics are reported elsewhere (Widmann et al., submitted). There were no group differences concerning age, marital status, occupation (percent not working), refugee status, persons per household, living standard, education and lifetime khat use (Widmann et al., submitted).

Instruments

All materials were used in Somali language after a translation and independent back-translation process. Problematic items were discussed and adapted in the expert team as well as independently back-translated as often as necessary to achieve correct meaning.

Depression

Depression was assessed using the Patient Health Questionnaire – 9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001). The PHQ-9 had been developed in order to have a reliable and valid instrument measuring the nine DSM-IV criteria for a depressive episode (Saß, Wittchen, Zaudig, & Houben, 2003) and has been used in developing countries before (Adewuya, Ola, & Afolabi, 2006; Wulsin, Somoza, & Heck, 2002). Each of the nine questions was answered by indicating how frequently the specified symptom appeared during the last two weeks: "not at all", "several days", "more than half the days" or "nearly every day", the respective scores ranging from zero to three. Thus, a maximum score of 27 could be reached by a person experiencing each symptom nearly every day. In a Nigerian sample the PHQ-9 was found to have a good concurrent validity with Beck's Depression Inventory (BDI; $r=0.67$, $p<0.001$; Adewuya et al., 2006). The internal consistency of the PHQ-9 has been described as *"excellent"* (p.608), given a Cronbach's α of 0.89 (Kroenke et al., 2001). As recommended by Manea, Gilbody, and McMillan (2012) a cut-off score of 11 with the best trade-off between sensitivity and specificity was used for a positive depression screening.

Psychotic symptoms

For assessing psychotic symptoms the following selected items from the Composite International Diagnostic Interview (WHO, 1997) were used: G2 (do you believe that people are following you?), G10 (Are you convinced that you are under control of some power or force, so that your actions or thoughts are not your own or determined by someone else?), G18 (Does it sometimes happen that you can hear things other people cannot hear?), G21 (Do you sometimes have unusual feelings on your skin or inside your body – like being touched when nothing is there or feeling something moving inside your body or feeling that a part of your body is missing or changed?). Items were selected based on our experiences in previous studies (Odenwald et al., 2005; Widmann et al., 2014) and in the preparatory phase of the study; for economic reasons we limited our assessment to the most common psychotic symptoms. According to the CIDI manual, standard descriptions of psychotic symptoms were read to the interviewee and the interviewer further probed to get the information needed to decide whether the answer referred to a clinical symptom, to an expression of a culture-typical belief or to a real experience (Ndetei, 1988). All psychotic symptoms were rated for the

previous four weeks and separately for situations with and without acute khat-influence (during or 6 hours after use) so that we were able to analyze the prevalence of true psychotic symptoms and khat-induced psychotic symptoms. Because of the very low prevalence of true psychotic symptoms we only report on khat-related psychotic symptoms.

Traumatic experiences and PTSD

In order to assess whether a participant had experienced traumatic events and typical post-traumatic symptoms as defined by DSM-IV, we used the Somali version of Posttraumatic Diagnostic Scale (Foa et al., 1997; Odenwald, Lingenfelder, et al., 2007). The Somali version of this instrument was adapted to the cultural and religious background of Somalia (see Odenwald, Lingenfelder, et al., 2007 for a detailed description). An event was counted as traumatic if there was a danger to life for the person himself or someone else and if the person felt helpless and/or terrified. The PDS has good validity and reliability, i.e. a Cronbach´s Alpha of 0.92, test-retest reliability of 0.83 and a kappa of 0.74 compared to the SCID-PTSD module (Foa et al., 1997). The Somali version achieved good reliability and validity (Odenwald, Lingenfelder, et al., 2007). In this study we used a short version of the Somali PDS (Odenwald et al., 2009) a culturally adapted and validated 6-item version. Internal consistency of the Somali PDS was at $\alpha = 0.86$ in the present study. Participants received a positive PTSD screening if all six items were affirmed.

Everyday Functioning

In order to assess everyday functioning among khat users we chose an approach that takes two typical features into account: First, the harsh living reality in the study location where most people sustain themselves with informal employment, i.e. each day an individual has to spent time and effort to make the money needed for food and rent. Secondly, the tendency of khat users to extend the consumption time: Whilst it is generally believed that khat use can induce some tolerance (World Health Organization, 2006), one of the main process believed to be involved into tolerance development is the extension of the time spent for consumption (Odenwald et al., 2015). This is supported by empirical findings of increased use time among more burdened and more addicted users (K. Bhui et al., 2003; Dhadphale & Omolo, 1988;

Odenwald, Hinkel, et al., 2007) and by the finding that amongst Somali refugees employment (accordingly less consumption time) was related to a lower risk of mental disorders (OR = 0.03, 0.01 – 0.61) (Bhui et al., 2006).

Thus, we asked each respondent for the average time per day that has been spent for chewing khat and for sleep during last week. The remaining hours of the day were considered as "functional time" that is left for income generation, training and school, i.e. a measure of "everyday functioning".

Screening and Brief Intervention

The adapted version of the ASSIST-linked Brief Intervention is the result of in-depth discussions among a multi-disciplinary group of experts on the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST, Humeniuk et al. (2010), WHO, 2002) and the related Brief Intervention. The intervention consists of providing information and expert feedback on the individual risk score, asking for and talking about good and less good things about current consume patterns and discussing the client´s concerns. Finally and centrally, change-thoughts are strengthened and advice on how to reduce risks are given, supported by handing out a self-help booklet and emphasizing patient´s responsibility and confidence. The BI ends as it starts in an atmosphere of partnership, acceptance, compassion and evocation. A more detailed description of the intervention and the adaptions is reported elsewhere (Widmann et al., submitted). Eighteen Somali college graduates from the local community were trained by an international group of therapists and researchers on assessment and intervention. Further details on exclusion criteria, trainings and procedures are described in (Widmann et al., submitted).

Ethics

The Institutional Review Boards of the Kenyatta National Hospital (Kenya) and of the University of Konstanz (Germany) approved this study. Due to the high level of illiteracy in Kenya, information on study purpose, procedures and participants' rights were read to the

participants before asking for participation. Participants were only included into the study after signing an informed consent.

Statistical Procedure

We analyzed data with SPSS 20. For continuous variables we report means and standard deviations (M±SD) and percentages for bivariate variables. For statistical testing Alpha ≤0.05 was used. Using Mann-Whitney-U tests, differences of means in symptom sum scores between the groups were compared. To test if there are differences in proportions of fulfilled screening diagnoses between the groups, Chi-square tests were used. To compare the proportions in the course of treatment, four groups (1= screening diagnosis pre and post, 2= screening diagnosis neither pre nor post, 3= screening diagnosis pre but not post, 4= screening diagnosis not pre but post) were built for depression, PTSD and khat-psychotic symptoms, compared between SBI and AC and labelled as overall Chi-square. To compare variances pre and post treatment, a Levene-test was conducted.

For individual treatment effects we used the Reliable Change Index (RCI) according to Jacobsen and Truax (1991). Its calculation relies on pre- and post-treatment-scores, standard deviations and test-retest-reliability of the test.

In order to test changes of comorbid symptoms related to SBI over time we chose general linear mixed-effect models (GLMM). They have the advantage of being relatively robust to missing data and its estimations are preferable to replacements or imputation methods (Siddiqui et al., 2009). The model predicts treatment response of comorbid psychopathology (number of depression and PTSD symptoms) including treatment, time and treatment x time as fixed effects and time as within-participants repeated factor. Predictors were included stepwise into the model. The type of covariance was set unstructured due to best model fit according to -2Log Likelihood information criteria. Random intercepts and slopes were included stepwise as subject specific random effects when proven to enhance model fit as recommended by Raudenbush and Bryk (2002). The model selection was based on maximum likelihood estimation.

For the tests if comorbidity is influencing therapy effects, i.e. reduction of khat use, binary logistic regression analyses were conducted. For these tests, we excluded from the “no-PTSD”

group those participants with positive depression screening and from the “no-depression” group those with positive PTSD screening to make sure that those no-comorbidity groups were solely khat users. Khat-psychotic symptoms were not involved here because they are directly depending on khat use and automatically reduced with a reduction of khat use. Therefore are not considered in the same way as comorbidity like depression or PTSD.

6.4. Results

Description of baseline psychopathology and functioning

Before the intervention out of all participants (N=330), 51% (N = 168) fulfilled the criteria for a positive depression screening, 22% (N = 73) showed at least one khat-related psychotic symptom and 22% (N = 74) had a positive PTSD screening. Frequency and concurrent presence of psychopathological symptoms in the studied sample are illustrated in Figure 6. On average participants slept around eight hours and chewed khat for around eight hours per day, leaving a functional time of eight hours on average, however there was a large variation (see Table 4). The baseline psychopathology and functioning was all similar in both groups as described in Table 4.

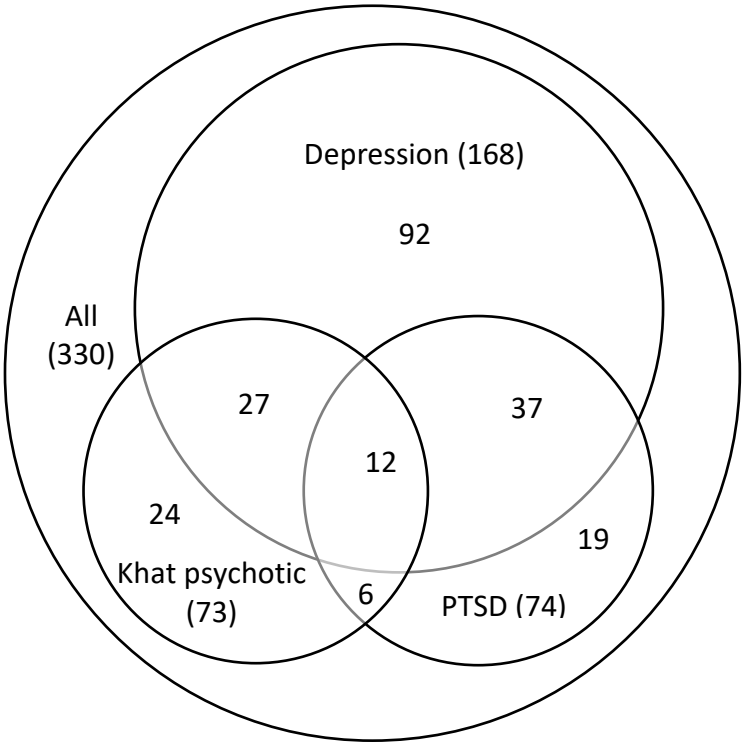


Figure 6. Prevalence and concurrent presence of positive depression screening, positive PTSD screening and khat psychotic symptoms prior to treatment among 330 khat users from the community.

		SBI	AC	total	p		χ^2	p
Positive Depression Screening	baseline	52.2% (84)	49.7% (84)	50.9% (168)	.654	χ^2 (1) = .201		
	post	43.9% (61)	38.6% (54)	41.2% (115)	.367	χ^2 (1) = .813	overall χ^2 (3) = 5.359	.147
Positive PTSD Screening	baseline	21.1% (34)	23.7% (40)	22.4% (74)	.579	χ^2 (1) = .308		
	post	27.3% (38)	31.4% (44)	29.4% (82)	.453	χ^2 (1) = .562	overall χ^2 (3) = .611	.894
Presence of khat-psychotic symptoms	baseline	25.6% (40)	19.9% (33)	22.7% (73)	.217	χ^2 (1) = 1.523		
	post	7.2% (10)	9.6% (13)	8.4% (23)	.490	χ^2 (1) = .476	overall χ^2 (3) = 2.772	.428
							GLMM	
depr sympt (0-27)	baseline	11.03 (5.41)	10.80 (5.96)	10.89 (5.70)	.737	t	F (1, 313,92) = 11.66	.001
	post	9.43 (6.66)	9.01 (5.89)	9.22 (6.28)	.739	g	F (1, 327,80) = .001	.974
						t x g	F (1, 313,92) = .034	.853
PTSD sympt (0-6)	baseline	2.23 (2.16)	2.50 (2.15)	2.37 (2.15)	.236	t	F (1, 293.78) = 3.03	.083
	post	1.94 (2.47)	2.19 (2.57)	2.07 (2.52)	.439	g	F (1, 319.95) = .185	.667
						t x g	F (1, 293.78) = .051	.822
khat-psy sympt (0-4)	baseline	.42 (.82)	.32 (.74)	.37 (.78)	.203	t	F (1, 256.42) = 4.26	.040
	post	.09 (.38)	.13 (.43)	.11 (.41)	.488	g	F (1, 290.09) = .560	.455
						t x g	F (1, 256.42) = 1.08	.300
hrs of sleep	baseline	8.19 (3.31)	7.88 (2.81)	8.03 (3.06)	.603	t	F (1, 321.67) = 2.25	.135
	post	7.81 (1.53)	7.72 (1.65)	7.76 (1.59)	.420	g	F (1, 328.46) = 0.68	.058
						t x g	F (1, 321.67) = 0.44	.507
hrs of khat use	baseline	8.07 (3.36)	7.61 (2.91)	7.84 (3.14)	.354	t	F (1, 326.82) = 276.62	.000
	post	4.22 (2.11)	4.64 (2.07)	4.43 (2.10)	.088	g	F (1, 331.54) = 3.63	.058
						t x g	F (1, 326.82) = 4.74	.030
hrs of functioning	baseline	7.76 (3.74)	8.55 (3.70)	8.16 (3.73)	.045	t	F (1, 318.27) = 191.96	.000
	post	11.94 (2.91)	11.68 (2.95)	11.80 (2.93)	.309	g	F (1, 329.93) = 4.42	.036
						t x g	F (1, 318.27) = 4.003	.046

Table 4. χ^2 and GLMM results for comorbid symptoms, fulfilled screening diagnoses, hours of sleep, khat use and functional time pre and post treatment in the assessment control and screening brief intervention group.

		95% CI for Odds Ratio			
	B (SE)	Lower	Odds Ratio	Upper	p
Included					
Constant	-3.06 (.77)				.047
Group	.043 (1.10)	.12	1.04	8.967	.968
PTSD pre	1.63 (.77)	1.13	5.09	23.01	.035
Depression pre	1.00 (.43)	1.18	2.71	6.25	.019
Group x PTSD	-.79 (1.10)	.05	.45	3.92	.471
Group x Depression	-.11 (.68)	.24	.90	3.40	.876

Table 5. Results of the binary logistic regression analysis to test influences of depression and PTSD on therapy success (RCI).
Note: R^2 = .09 (Hosmer & Lemeshow), .08 (Cox & Snell), .13 (Nagelkerke). Model χ^2 = 24.11, $p < .01$.

Change of symptom severity and functioning by treatment

All results for the change in psychopathological symptoms in the course of the treatment study including GLMM results are reported in Table 4.

Depression

We found a reduction of depression symptoms and of the proportion of positive depression screenings in the total sample. GLMM results for the reduction of symptoms indicate a significant main effect for time, but not for group nor for the interaction time x group.

PTSD

The proportion of respondents with a positive PTSD screening increased slightly in the course of the intervention, whereas the number of symptoms decreased slightly on average (though not reaching significance). The GLMM didn´t indicate any significant main or interaction effects.

Khat psychotic symptoms

We found a significant decrease in khat psychotic symptoms in both groups. According to GLMM results, the main effect for time was significant but not the group effect nor the time x group interaction.

Functioning

We observed a significant decrease in hours spent for chewing khat in both groups. Hours spent for sleeping did not change on average but the variance decreased (F (1,598) = 48.24, p ≤.001). We found a significant increase in functional time in the total sample with significant main effects for time and group and a significant interaction effect time x group, i.e. the

participants in the SBI group showed a greater increase of functional time. This change is illustrated in Figure 7 and described in Table 4.

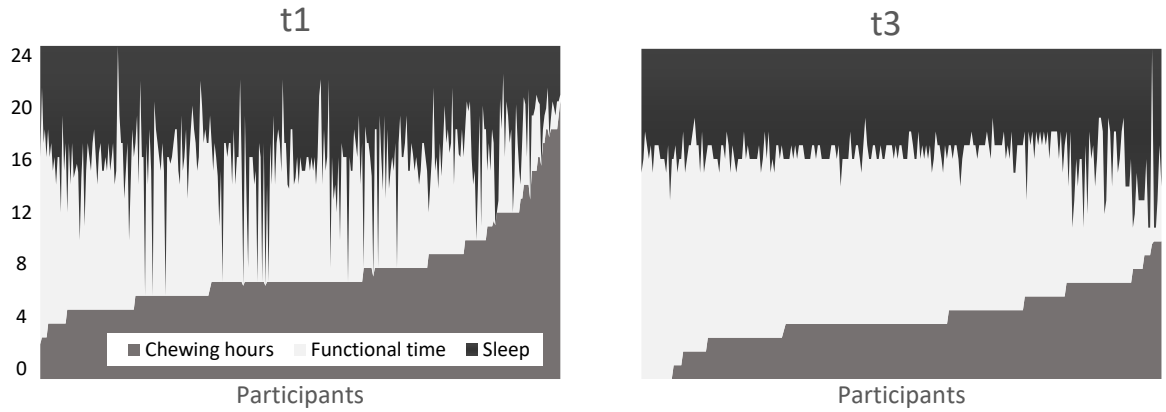


Figure 7. Number of hours of sleep, khat chewing and functional time in the total sample at baseline and after the intervention.

Comorbidity as influencing factor for therapy effects

We explored, whether positive screening for depression and TSD as well as the presence of any khat psychotic symptoms influenced the substance-use outcome measure of Screening and Brief Intervention, measured in significant reduction of consumed khat bundles as indicated by the Reliable Chance Index (See Figure 8 and Table 5).

Depression

Amongst participants with a positive depression screening, no significant association between treatment condition and therapy outcome was observed ($\chi 2$ (1) = 1.37, p = .242; OR = 1.86). But among khat chewers with negative depression screening the intervention group included more participants with significant use reduction at follow up ($\chi 2$ (1) = 5.10, p = .024; OR = 2.52; Figure 8). The regression analysis showed a significant main effect for depression at baseline but no group effect nor a time x group interaction, see Table 5.

PTSD

For participants with positive PTSD screening we found a similar result as for depression: Among participants with a positive PTSD screening, the treatment conditions don´t differ in relation to substance use outcome ($\chi 2$ (1) = .01, p = .973; OR = 0.97) but participants with negative PTSD screening show more use reduction in the intervention group ($\chi 2$ (1) = 5.10, p = .024; OR = 2.52). The regression analysis also showed a significant main effect for PTSD but no group effect or time x group interaction, see Table 5.

Khat psychotic symptoms

No association was found between therapy condition and substance use outcome in participants with ($\chi 2$ (1) = 1.52, p = .217; OR = 1.91) and without ($\chi 2$ (1) = .3.35, p = .067; OR = 1.68) khat psychotic symptoms.

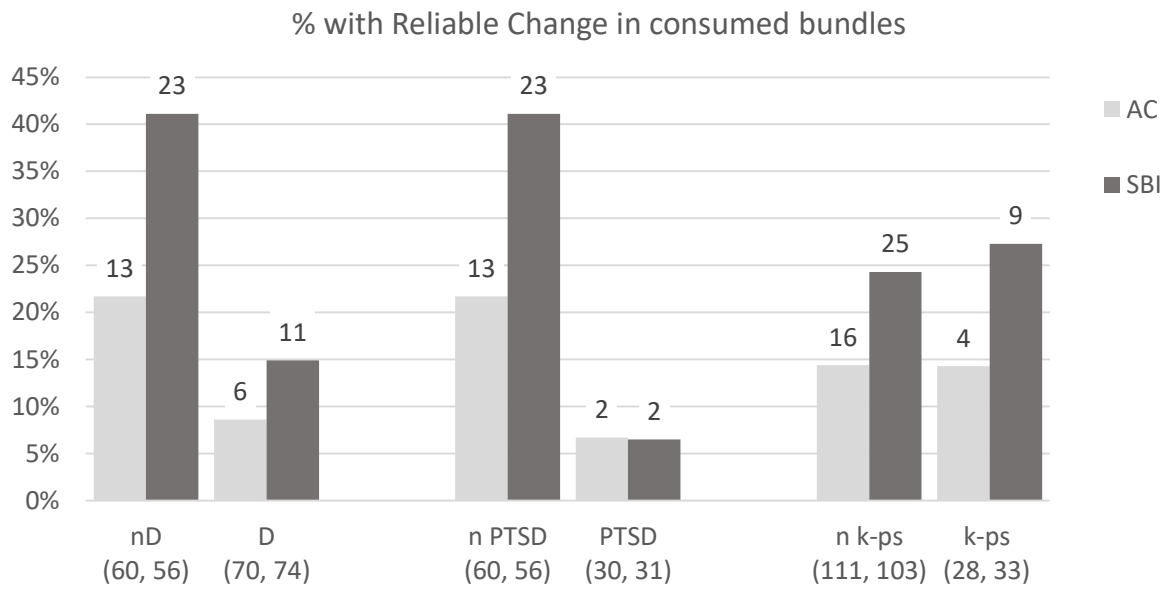


Figure 8. Percentages with reliable reduction in amount of khat consumption in non-depressive (nD) vs. depressive (D), non-PTSD (n-PTSD) vs. PTSD, and non-khat psychotic (n k-ps) vs. khat psychotic (k-ps) participants. N of participants with/without respective symptoms in the Assessment Control and Screening & Brief Intervention groups in brackets. Significant differences are marked with asterisks.

6.5. Discussion

The main findings of this study with 330 male Somali khat chewers were firstly, that the prevalence of comorbidity is very high: Around half of the participants were screened positive for depression and almost a quarter each for PTSD and the presence of khat psychotic symptoms. Secondly, during the three months of assessment, depressive symptoms and khat psychotic symptoms decreased in both groups but not PTSD symptoms and no intervention-specific changes of these comorbid psychiatric symptoms were found. But a general decrease in time spent for consumption and an increase in everyday-functioning was observed with intervention-specific changes, i.e. the brief intervention group showed a higher increase in daily functional time and a larger reduction in khat-use time. Thirdly, we found evidence that SBI is less effective in terms of use reduction among khat chewers with comorbid depression and PTSD compared to participants without comorbid mental problems.

The results for consumption time, everyday functioning and sleep routine are very clear, i.e. the consumption time was reduced to halve - from around 8 hours per day before the intervention to 4 hours after it, and the functioning time increased from around 8 to almost 12 hours per day. This demonstrates the potential of a very efficient intervention to prevent tolerance development through reduction of consumption time. Accordingly, the increase in everyday functioning enables khat users to concentrate more on employment and other every-day duties which serve as prevention for further dependence development. The lowered variance in sleeping routines, i.e. less extreme sleeping periods - can be seen as a more healthy pattern and we conclude a more constant and regular lifestyle could be supported by Screening and Brief Intervention.

The reported findings on comorbidity support the current discourse that there is probably only a specific group which benefits from brief interventions. Consistently with recent reviews (Saitz, 2014) saying that it is likely that various factors have an influence on the success of brief interventions such as comorbid substance use, the legal status of the consumed drug and the intensity of consumption, our data highlight the factor comorbid psychopathology. We find

almost the double amount of use reduction in participants with negative screenings for depression or PTSD compared to those with positive screenings.

We found a reduction of consumption time and symptoms in both treatment and control group. Due to the effects of the assessment control group, this isn´t very surprising: Our repeated assessments in both groups contained the TLFB calendar, which focuses on the individual daily khat use and can work as intervention itself, plus PTSD and depression screening, asking for traumatic life events and psychotic symptoms –especially connected to khat use; all these assessment elements are by themselves potentially motivating for participants' behavior change, i.e. spending less time for chewing, taking care for regular sleep. One could argue that the AC group was too active to work as control group, on the other hand it was necessary to allow detailed comparisons on comorbidity. Also in other studies, control groups have shown a reduction in their substance use (e.g. R. Humeniuk et al. (2012a)).

Suffering from a significant level of PTSD or depression symptoms seems to make a difference when it comes to therapy success, i.e. reduction of khat use. Among participants with PTSD or depression the psychological burden might be heavier and also the function of khat use might be different compared to other participant subgroups – khat helps forgetting painful experiences and enhances mood (Klein, 2007; M. Odenwald et al., 2009). As khat use is a socially well accepted habit, connected to various positive social experiences, it is not very likely to reduce this self-medication without having any substitute and without options for professional support. The surrounding in Eastleigh supports this strategy: There is no work and especially for young persons very few possibilities to spend free time other than chewing khat as well as very little access to mental health care.

Limitations

Our study has some limitations that need to be discussed.

We used only screening instruments to assess depression and PTSD in order to avoid too lengthy interview sessions and due to our focus on detailed assessment of khat consumption.. And our team consisted of community members without professional mental health background. As a consequence, the results of the screening might have limited validity and

reliability. However, the fact that we found significant associations supports the existence of a robust effect.

We used assisted self-reports for assessing khat use amount and frequency instead of gold standard clinical interviews or objective biological measures data such as blood or urine samples. To the best of our knowledge there are currently no such objective tools available, to measure khat alkaloids under field conditions.

The interviews were not validated, i.e. we did not assess an interviewer concordance. However, we did supervise interviews randomly during the whole study period and discussed discrepancies in the whole interviewer group in order to maximize concordance.

General limitations of the assessment concerning study settings in a challenging surrounding, like criminality and political tensions are reported elsewhere in detail (Widmann et al., submitted). We believe that with local Somali interview staff, involving community elders, conducting interviews in participant´s homes, we met the challenges well but still it was not fully possible to supervise every interview due to security reasons. Therefore, treatment fidelity can´t be guaranteed fully. Also social desirability might have influence participant´s answers on symptom improvements.

Conclusion

With these findings and experiences from previous studies we could show the complex psychopathology of khat users and the challenges that are related to the attempt to develop effective treatment tools for this group. Our results point into the direction that positive effects of psychotherapeutic interventions do not expand to comorbid psychiatric symptoms inc contrast to sleep behavior and everyday functioning which can be increased. Additionally, the significance of mental health comorbidity for the effect of brief interventions for khat use was illustrated: Our data highlight the need for assessment of comorbid psychopathology and for integrated treatments for substance use and comorbid mental health problems. Further studies are required to replicate our findings and increase the knowledge on the complex

mental health burden of Somali khat uses and on efficient treatment strategies for low resource settings.

7. Khat use amongst Somalis in Kenya: Aspects of lifestyle and environmental factors in consumption reduction [3]

[3] In Vorbereitung zur Publikation

7.1. Abstract

Background and aims: Khat use has changed profoundly in the past decades. Consumption patterns and motivation of use vary across cultures, geographical situations and social classes. The aim of this study was to assess environmental factors that influence the reduction of khat use in a Brief Intervention setting and to evaluate participant´s opinion on the intervention.

Methods: Data from a randomized controlled trial with 330 male Somali khat users from the community who were either assigned to Screening and Brief Intervention (161) or Assessment-only Control group (169) were used. The assessment was conducted in Eastleigh, a suburb of Nairobi, where mainly Somali migrants live and high rates of crime, poverty and violence can be observed. Participants were asked for the most important environmental factors when (not) reducing their khat use and which parts of the intervention they rated as most helpful. We describe and compare answers of both groups and participants who did vs. who did not reduce their consumption. Correlations with therapy success (consume reduction) were the main outcome measures.

Results: Both, reducers and non-reducers rated alternative activities (90%) (mainly sports and work) and environmental khat-cues (65%) as the most relevant factors for (non-)reduction. Supportive families and friends were important for most reducers (80%), less for non-reducers (15-35%) and lack of coping strategies was central for 50% of the non-reducers. Information about khat-related risks were rated as most important part of the intervention and a positive correlation of therapy success and therapy evaluation was found, $r = .27$ ($p = .002$).

Conclusion: The satisfying feedback about the intervention and the involvement indicate good acceptance of this brief psychotherapeutic intervention. Our results refer to intervention strategies involving broadly based information spreading, especially for vulnerable groups, community based, low-threshold opportunities for counselling in order to enhance competence for problem solving other than khat use and creating opportunities for at least recreational occupation. One option could be the approach of self-help groups and a reduction of the omnipresence of khat, possibly through restricting special areas or times for sales and consumption within the community.

7.2. Introduction

Khat leaves (*catha edulis*) are consumed traditionally in many African countries and the Arab peninsula (Krikorian, 1983). Its mild stimulant effects attract consumption for social wellbeing, concentration and strength. The traditional, moderate way of consumption, which is chewing some twigs over hours are reported to cause little or no harm (Nutt et al., 2010; Pennings et al., 2008). Ethiopian farmers say "if cat (khat) chewing is not followed by hard labor it then serves as irritant rather than a stimulant" (Hill, 1965). The traditional, rural way of consumption was more purposive on either getting strength for work and worship and or related to religious ceremonies and special social occasions, mostly transition rituals like birth, marriages or funerals (Kennedy, 1987). The aspect of social interaction is the most important commonalty of most chewing populations in different countries, rural and urban populations and between different social classes (Gebissa, 2004). Friends, neighbors or relatives come together to sit, share and chew khat over hours, traditionally starting with exchanging news, gossip and jokes, often followed by focused, concentrated discussions on politics, economy, business or religious topics before the atmosphere becomes more calm and introverted towards the end of the session (Kennedy, 1987). Gatter (2012) describes current reasons for chewing like *„it gives strength", „makes more alert", „relieves depression", „I like it", „because my friends chew"* und *„for social interaction"* which is in line with an older description for the urban khat chewing population in Ethiopia made by Gebissa (2004). But in contrast to contemporary populations where khat use is common, there is often no (hard) labor or any other occupation anymore. In more educated social classes, khat is used to enhance concentration in order to study continuously or especially during night before exams (Alem et al., 1999). In university students, correlations of khat use and sexual initiative was found (Kebede et al., 2005; Tura et al., 2012) and other studies with students found „relaxation & entertainment" and social reasons as most common reasons for consumption (Kassaye et al., 1999). In the past decades, consume patterns in general are described more excessive, only for recreational or occupational reasons, sometimes in combination with alcohol and other substances in order to either enhance the stimulating effect or to calm down after the chewing session (Gebissa, 2004).

In Kenya, the general migration from rural to urban areas for education and work, as in most developing countries, convenes with a huge number of refugees from Somalia. Many of them

were forced to leave their home country due to civil war and natural disasters (Foreign Policy, 2016; UNHCR, 2016a). In Eastleigh, a suburb and business center in Kenya´s capital Nairobi, mainly ethnic Somalis in first and second refugee generations are living. The combination of high burdens from past and current circumstances and environments with high levels of crime, violence, stigma and terrorism, high rates of unemployment and omnipresent availability of khat create an atmosphere predestined for khat (ab)use. Khat stores and small market stalls offering the green bundles are very frequent along the main business roads as well as in all the small side streets. One can observe small groups of men sitting in comfortable, calm corners along the busy streets, chatting and chewing together. The atmosphere when the daily khat truck from Meru arrives is rather busy and crowded until all merchants are supplied with their daily ration of khat. In front of the shops and the stalls of sale, an important part of Eastleigh´s social life can be observed: Friends, relatives and neighbors meet, talk and chew in the afternoon hours and especially on Fridays after going to the mosque. Khat chewing can definitely be seen as part of Eastleigh´s lifestyle with ascending trend due to persistent overcrowding of the area, ongoing migration and continuing structural problems like criminality, discrimination and missing opportunities for occupation and recreational activities, especially for young people.

Khat use in bigger amounts or combined with other substances can cause severe health consequences such as cardiovascular, gastric and liver disorders, periodontal problems and sexual dysfunction as well as mental health problems and dependency (Al-Habori, 2005; Al-Hebshi et al., 2010; A. Al-Motarreb et al., 2010; Beckerleg, 2010; Odenwald, Hinkel, et al., 2007; Omolo & Dhadphale, 1987; Warfa et al., 2007; Zein, 1988). The combination of changed use patterns, the rapidly grown khat-economy and increased numbers of reported harms in correlation with khat use has led to increased attention to its handling in the legal and health sector in many countries (Gatter, 2012; Weir, 1985). Worldwide, the prevalence of khat use is high: In 2005 it has been estimated that over ten million people are using khat on a daily base (Stefan & Mathew, 2005). However, Manghi et al. (2009) concluded in a recent review that almost all studies on prevalence of khat use focus only on frequency and not on amount –this is also true for most of the studies on consequences of khat use. Thus, clear data on prevalence of unproblematic versus problematic use, or dependence, are lacking.

Though there is a lot of criticism on intercultural treatments, especially in correlation with war and trauma (Bracken, Giller, & Summerfield, 1995; Summerfield, 1999) the great need for culturally adapted interventions for khat dependence is clear and a lot of research had shown the advantage of culturally adapted implementations of evidence based interventions. The meta-analysis of Griner and Smith (2006) showed the importance of community based approaches, native language of therapists and familiar therapy settings as well as involving ideas and opinions of therapy-recipients.

Understaffed health care systems are a problem in most countries around the Horn of Africa and institutional care, especially for addiction and mental health is lacking (Duresso et al., 2016). Therefore, Brief Interventions (BI), implemented by community health care workers, involving little resources are believed to be able to support the over-burdened public health system. Though the evidence for BIs for different substances isn´t unambiguous (Saitz, 2014) and there is no research available for khat specific interventions (Odenwald & Al'Absi, 2016, in press), they have been shown to be effective in primary health care settings for alcohol use (O'Donnell et al., 2014). We believe that with the individual and culturally well adaptable approach of the WHO´s ASSIST-linked Brief Intervention for khat use the needs for this population can be met well.

In general, consumer satisfaction defined as “the extent to which services gratify the client’s wants, wishes, or desires for treatment” and therapy outcome has been correlating in many studies (Lebow, 1983). Although in addiction research the positive relation between treatment satisfaction and a positive therapy outcome has not been found consistently, there are various factors such as working alliance (Tetzlaff et al., 2005), participation in self-help support groups, parental participation (Hsieh, Hoffmann, & Hollister, 1998), peer abstinence (Latimer, Newcomb, Winters, & Stinchfield, 2000) and various others that influence therapy success.

In the present paper we used data from an ASSIST-linked Brief Intervention RCT (Widmann et al., in press). Here we focus on the participant´s perception of the intervention, their acceptance, feedback and their individual evaluation of environmental factors, influencing their khat use behavior. We aim to better understand aspects of lifestyle and modern khat use patterns. We expect a positive correlation between participants rating and involvement in the

BI and the therapy outcome and a distinct description of relevant environmental factors for khat use under adverse living conditions and it´s reduction.

7.3. Methods

We conducted a randomized controlled intervention trial with Somalis in Eastleigh, a suburb of Nairobi, predominantly inhabited by Somalis. At three times of measurement, taking place every 4 weeks, we assessed participant´s khat use with the Time Line Follow Back (Sobell & Sobell, 1995): Four weeks prior to t1, to t2 and t3. At t1 we also measured sociodemographic variables and screened for psychotic symptoms, depression and PTSD, results are reported elsewhere (Widmann et al., submitted). 330 participants were randomly assigned to the Screening Brief Intervention (SBI) and Assessment Control group (AC). The SBI received treatment at t1 (including ASSIST screening, BI session and handing out a self-help booklet), the AC at t3. Details on instruments and the intervention are reported elsewhere (Widmann et al., in pres).

At t2, participants in the SBI group were asked for their personal perception on their consumer behavior and the personal reasons for (not) having reduced their khat use. The first question was *"Do you think, you reduced your khat use in the past 4 weeks?",* followed by further questions on the reasons, i.e. *"if no, why": "Lack of alternative activities", "lack of family support", "peer pressure"* etc. and the same for *"if yes, which strategy helped you?": "Alternative activities (please specify)"* etc. The options *"Not concerned about use", "Need awakening effect for work", "fear withdrawal symptoms/don´t want to miss stimulating effect" and "no other coping strategies for problems"* were asked only for the participants who did not reduce their use because the positive equivalent was only aiming for helpful strategies, not for reasons.

Additionally, we asked for their opinion on the intervention, starting with *"how helpful was the counselling session for reducing/stopping your khat use?",* (answer format: not at all – a bit – very), going into detail with *"which part motivated you most? Information about risk? Talking about individual good and less good things? The self-help booklet?"*. Then we asked, if the participant read the booklet, had worked with the tables and how helpful he found the

self-help-booklet for reducing his khat use (answer format: *not at all – a bit – very*). We did not ask the AC group at t2 for their feedback in order to avoid more therapy-like elements.

At t3, the same questions were asked again in the SBI and also in the AC group.

When asking to specify alternative activities, we clustered the answers in subgroups of sports, work, religious, friends, family, study and others. The assignments were clear for all specifications. Answers like *"playing ball, basketball, going to mosque, reading quran, spending time with parents, working half-time"* etc. were given.

Exclusion of cases

In total, 330 participants were randomly assigned to SBI (161) and AC (169) at t1. Due to different reasons like name confusions during data entry, therapy confusion and probably exchanged participants (friends or relative took original participant´s place), we ended up with 291 participants (140 SBI, 151 AC) at t2 and 279 (138 SBI, 141 AC) at t3 included in the analyses.

Reliable Change Index

For individual treatment effects we used the Reliable Change Index (RCI) to compare treatment outcomes between the intervention and assessment control groups. Therefore, the differences between pre- and post- treatment scores were divided by the standard error of difference (Jacobsen & Truax, 1991).

Ethics

The Institutional Review Boards of the Kenyatta National Hospital (Kenya) and of the University of Konstanz (Germany) approved this study. Due to the high level of illiteracy in Kenya, information on study purpose, procedures and participants' rights were read to the participants before asking for participation. Participants were only included into the study after signing an informed consent.

Statistical Procedure

We analyzed data with SPSS 20. For continuous variables we report means and standard deviations (M±SD) and percentages for bivariate variables. For statistical testing Alpha ≤0.05 was used, respectively ≤0.01 according to Bonferroni correction when the reasons for (not)

reducing were compared. Using Mann-Whitney-U tests, differences of means between the groups were compared. To test for significant correlations, we used Spearman's-Rho.

7.4. Results

Personal perception of reduction of Khat use

59.3 % (N = 83) of the participants in the intervention group said at t2, they had reduced their khat use in the previous 4 weeks and for 81.9% (N = 68) of them, our data confirmed that, i.e. the amount of consumed khat bundles was higher at t1 compared to t2. At t3, 50% (N = 69) said, they had reduced, which was true for 85.5% (N = 59); 45.1% (N = 124) of the whole sample said, they had reduced their use, which was true for 83.1% (N = 103) of them.

The reasons for not reducing or reducing are illustrated in figure 9. The most important factors were reported to be (lack of) alternative activities, (avoiding) environmental cues, (lack of) disclosure or support of family and (lack of) disclosure or support of friends. Alternative activities and environmental cues were given as important factors by persons who did and did not reduce their use. Percentages differ in these two groups for the role of family and friends: Disclosure and support of family/friends were given as most important factors by persons who did reduce, whereas for persons who did not reduce the lack of these factors were the least important reasons for not being successful in reducing. When SBI and AC were compared in each percentage, none of the Chi-square tests was significant.

As helpful alternative activities sports (mostly football, gym and basketball), work, religious activities (mosque and quran reading), time with friends and family and studies were described as illustrated in figure 10 for the whole sample. The proportions look similar for the SBI at t2 and also if split in SBI and AC at t3 (none of the comparing Chi-square tests was significant).

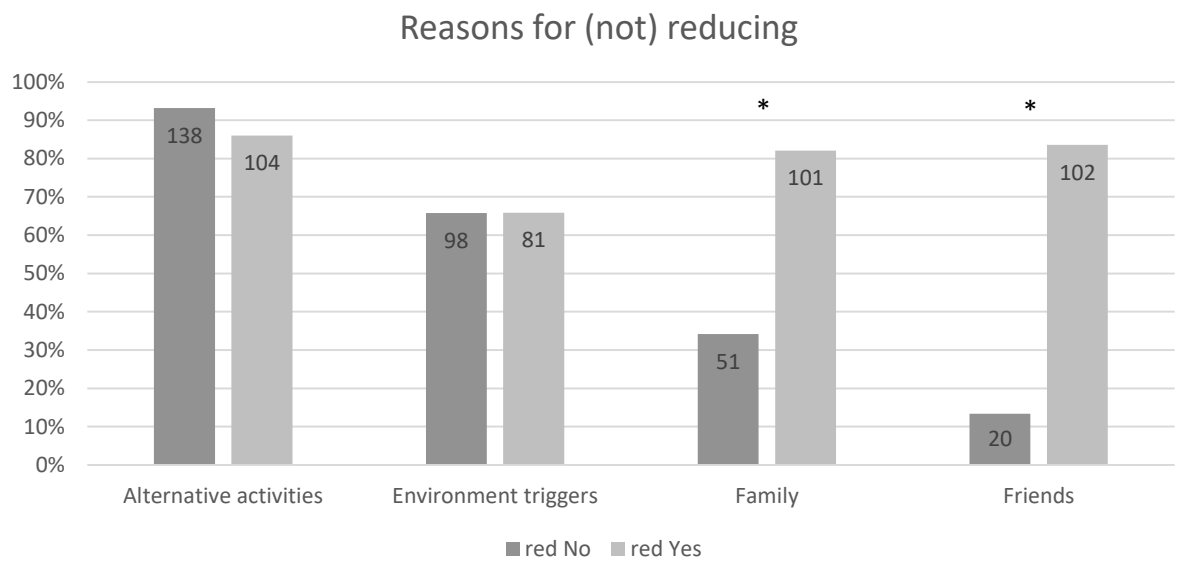


Figure 9. Reasons for (not) reducing khat use in the whole sample for participants who said they did (light)/ did not (dark) reduce their khat use. Percentages and N (inside bars) are described. Significant differences are marked with asterisks.

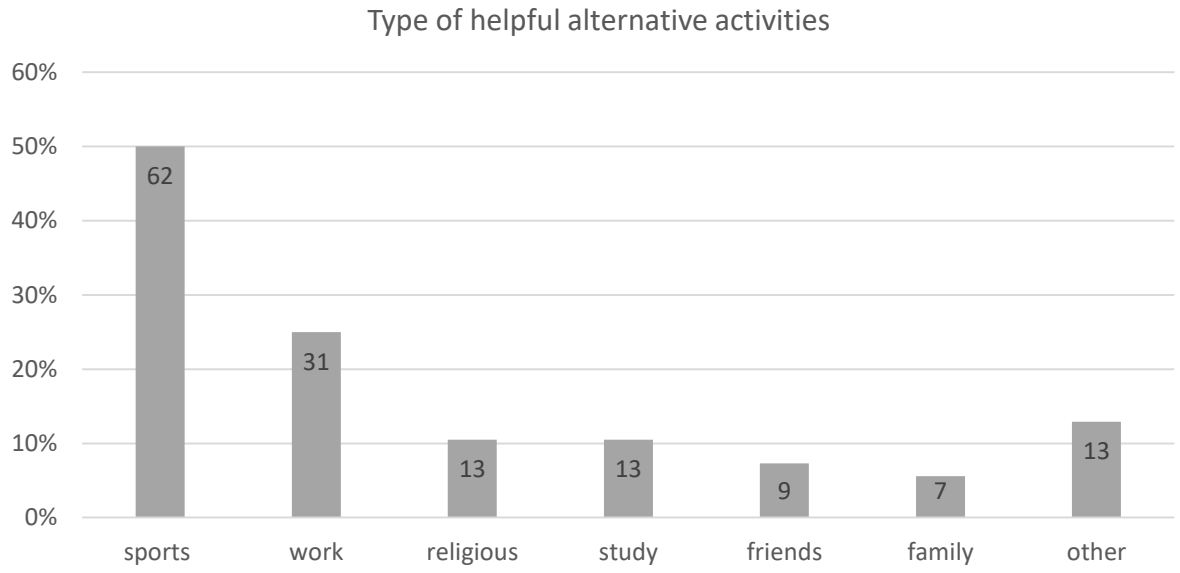


Figure 10. Types of most helpful alternative activities as described by persons who reduced their khat use significantly, percentages and N inside the bars.

Reasons directly related to substance effect

Participants who did not reduce their use amount, additionally named as main substance related reason, they would not have other coping strategies for problems and the rate for this answer was higher in the AC group compared to the SBI group (χ^2 (1) = 4.91, p = .027). For the other reasons, namely not wanting to miss stimulating effect/fear withdrawal symptoms, needing awakening effect for work or not being concerned about own use, no group differences were found. But in sum, in the AC group, more substance related reasons were given as in the SBI group (1.1 (± .96) vs. .69 (±.89), p = .006)). Proportions are illustrated in Figure 11.

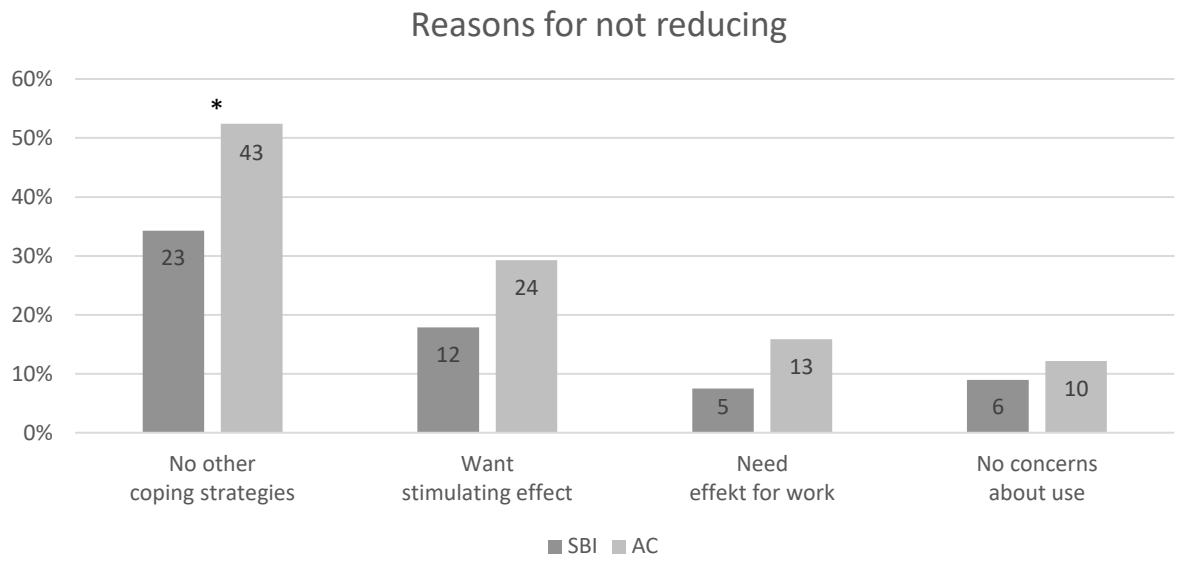


Figure 11. Reasons for not reducing, directly related to the effect of khat for SBI and AC group.

Consumer involvement, satisfaction and therapy success

For the intervention group, we asked how helpful they found the counselling session for reducing their khat use and if they had worked with the self-help materials at home, additionally we asked for the most motivating part. Results are listed in table 6. As the most motivating element, participants rated the information about risks (83.6% (117)), followed by

the self-help booklet (65.0% (91)) and a good half (52.9% (74)) of the participants said, talking about individual good and less good things are most helpful. 80.6% (112) said, they had read the booklet and 31.2 % (43) had worked with the materials (i.e. diaries, tables, etc.).
Therapy success, measured with the RCI correlated significantly with the ratings of the counselling sessions with r = .27 (p = .002) and the ratings of the booklet (r = .201, p=.025).

Participants who did not work with the tables had a higher RCI compared to the ones who did: 1.56 (±3.78) vs .28 (±2.01), p = .004 Reading the booklet did not make a difference in the RCI outcome (1.57 ±2.74 (not read) vs. .87 ± 3.59 (read)) p = .173.

	Not at all (0)	A bit (1)	Very (2)	Mean (SD)
How helpful was the counselling session	9.4% (13)	65.2% (90)	25.4% (35)	1.16 (.57)
How helpful was the self-help booklet	17.9% (25)	51.4% (72)	30.7% (43)	1.13 (.69)

Table 6. Participant´s ratings of the counselling session and self-help booklet.

7.5. Discussion

This assessment of participant´s evaluation was part of a randomized controlled intervention trial conducted with male Somalis in Eastleigh, Nairobi. Main findings are: (1) The most important environmental factor for consumption reduction were alternative activities of which sports and work were the most relevant ones, followed by triggering khat cues in the environment. The role of family and friends was rated ambiguously amongst persons who did and did not reduce their consumption and (2) not having alternative coping strategies for problems was the most relevant challenge for persons who did not reduce. Furthermore we found that (3) evaluation and therapy success were positively correlated and (4) in general, the intervention with all elements were rated as moderately helpful with the information about khat-related risks as highly valuated element.

Khat use patterns generally depend on various factors and have a wide range from traditional, non-problematic, occasional use over moderate consumption as part of everyday life to

excessive use, related to various problematic consequences concerning health, social and legal issues and finances (Manghi et al., 2009). Our findings indicate the important role of occupational opportunities: Users describe (lack of) alternative activities and (lack of) work as the most relevant factors to change one´s use behavior. This is consistent with other studies that found employment to be protective for khat use, respectively khat use as reaction of not being able to work in a host country (Shilpa L Patel, Murray, & Britain, 2005). Griffiths et al. (1997) describes increased consume amounts amongst Somalis after emigration to the UK compared to when they were living in Somalia. Furthermore he describes the function of khat to help maintaining cultural identity which seems very consistent with our observations in Eastleigh, where discrimination towards Somali immigrants, high rates of crime and violence and a highly burdening past increase the need for cohesion, comfort and occupation as it happens during khat sessions.

The result that missing coping strategies for problems is seen as big challenge for reducing consumption supports the approach of functional use after and during burdening experiences, as it was found in other studies as well (K. Bhui et al., 2003; Odenwald, Hinkel, et al., 2007). However, the difference between intervention and control group in this item and the total score of substance-related reasons for not reducing indicate a promising development towards an increased range of perceived options and self-efficacy, as intended by the BI.

Participants who did not manage to reduce their consume amount the role of friends and family for disclosure and support were rated rather unimportant compared to the ones who reduced their consumption. It might be easier for someone who is already linked and embedded into social and familiar networks and structures to reduce, since there is automatically more social support and valuation. There might also be a broader range of potentially distractive and alternative activities through suggestions and offers by friends and relatives with more persons who are potential non-chewers.

For more than 80% we could show their estimations for the own reduction to be true and a generally moderate but positive evaluation of the intervention which indicates generally valid and frank response behavior.

As the most motivating element, over eighty percent of the participants rated the information about risks. The generally lower educational status (also concerning basic biological, social and medical topics) amongst a refugee population in Kenya compared to most western countries

already suggests that the value of providing basic and special information on addiction, especially for khat as an important part of every-day life, is valued higher than in western study settings. There, the general attitude for psychotherapy is very individual-based with face-to-face hierarchy in contrast to other settings where a more distant expert-client and hierarchical treatment approach is common, probably due to the higher discrepancies in education and knowledge. That might be one reason why general information about risks were rated as most helpful part of the intervention. The individual approach of the SBI might be a new concept of treatment for most Somalis. Maybe that´s why they don´t feel as comfortable with the individual weighting of good and less good things about one´s own khat use as with the professional information which is valid for the whole population or community.

Also the self-help booklet was rated as very motivating by over sixty percent of the participants. It might be a helpful tool to consolidate and deepen the concentrated input from the brief intervention, probably with friends and family members at home. This is also supported by the finding that over eighty percent said, they had read the booklet at home, whereas only a third said they had worked with the materials –which is possibly a result of illiteracy, what was common in our sample.

Another aspect of the culturally and geographically diverse use patterns are the different requirements for treatment approaches. One need to keep in mind the differences in every-day function of the consumption in a certain area before estimating universally valid risk scores and trying to motivate persons to change. However, we believe that the individually adaptable frame of the BI is the best and most flexible approach to address different needs.

Limitations

We did not use a validated questionnaire to measure consumer satisfaction or involvement but only two questions, fitting the pilot study setting and field conditions. Also the feedback part was rather adapted to the circumstances than evidence based and validated, which is of course limiting the results. Also social desirability might have caused positive answers concerning the intervention feedback and the base for therapy success itself was an assisted self-report and no objective outcome measures to control for biases.

However we believe these problems to be not too relevant due to the moderate responses and our general focus on getting an impression on lifestyle and environmental factors in a specific area rather than external valid and comparable results for evaluation and feedback.

Conclusion

In a first RCT on a brief psychotherapeutic intervention for khat users we assessed participants´ evaluation of environmental factors, influencing the therapy effects and their general opinion on the treatment and it´s elements. Alternative activities and environmental khat-related triggers were listed as the most important factors to support a consume reduction or respectively the most relevant reason for not being able to reduce. Amongst the alternative activities, sports and work were given as the most helpful activities instead of chewing khat. Functional use seems to be an important factor which could be reduced in the intervention group. As the most helpful intervention part for the clients was the general information about khat-related risks, we assume that the knowledge gap concerning problematic khat use is a central starting point for future intervention approaches. The results demonstrate that environmental factors and considering individual perceptions of problematic or non-problematic use are essential for sustainably and successfully implementing treatment approaches like the ASSIST-linked BI.

III GESAMTDISKUSSION

In dieser Pilotstudie zur Wirksamkeit psychotherapeutischer Interventionen bei männlichen, somalischen Khatkauern in Kenia, fanden wir erste Hinweise auf die Wirksamkeit einer Kurzintervention. Zudem wurden zahlreiche Informationen zur kulturellen Anpassung solcher Verfahren zusammengetragen womit ein wichtiger Beitrag in der Entwicklung und Implementierung angepasster, differenzierter Versorgungsmöglichkeiten psychischer und substanzbezogener Erkrankungen in unterversorgten und gleichzeitig stark belasteten Ländern wie beispielweise Kenia, Somalia oder Äthiopien geleistet werden konnte.

Im ersten Artikel *„The modified ASSIST-linked Brief Intervention for khat users: A randomized controlled effectiveness study"* wurden die Effekte der Kurzintervention auf das Konsumverhalten der Teilnehmer dargestellt. Wir fanden einen Rückgang der Konsummenge und –häufigkeit in beiden Gruppen, mit deutlich stärkeren Effekten in der Interventionsgruppe.

Der zweite Artikel *„Comorbid psychopathology and everyday functioning in a Brief Intervention study to reduce khat use among Somalis living in Kenya: description of baseline multimorbidity, its effects of intervention and its moderation effects on substance use"* zeigt die überdurchschnittlich hohe psychische Belastung khatkauender Somalis in Eastleigh: Etwa die Hälfte der Teilnehmer erfüllte die Screening Diagnose für Depression, ein knappes Viertel für PTSD und ebenso viele zeigten khat-psychotische Symptome. Die Depressionssymptomatik und Anzahl der khat-psychotischen Symptome reduzierte sich in beiden Gruppen über die drei Monate der Erhebung. Die deutlichsten Unterschiede zeigten sich im *„Everyday Functioning"* -der Zeit, die für Aktivitäten wie Arbeit, Familie und andere Unternehmungen zur Verfügung steht. Hier waren deutliche Zeit-, Gruppen-, und Zeit x Gruppen-Effekte zu sehen, d.h. mit der Intervention reduzierten sich die Khat-Kau-Stunden, die Schlafdauer normalisierte sich und die funktionale (khatfreie) Zeit stieg in der Interventionsgruppe um ca. vierzig Prozent an. Teilnehmer, die unter einer Depression oder PTSD litten, zeigten weniger Therapieerfolg als gesunde Teilnehmer, woraus sich schließen lässt, dass mit komorbiden Erkrankungen eine Kurzintervention für Substanzmissbrauch nicht mehr ausreicht, sondern es einer intensiveren Behandlung bedarf.

Das dritte Manuskript konzentriert sich auf umgebungs- und kulturspezifische Aspekte, die bei der Anwendung der Kurzintervention eine Rolle spielten sowie die individuelle Rückmeldungen der Teilnehmer zur Intervention. Dabei fanden wir, dass alternative

Unternehmungen, wie z.B. Sport, Arbeit und religiöse Aktivitäten sowie eine Umgebung mit einer Vielzahl Khat-bezogener Reize die wichtigsten Faktoren für die (Nicht-) Reduktion des Khatkonsums waren. Außerdem wurde der Mangel an alternativen Problemlösestrategien als Hindernis für eine Konsumreduktion berichtet. Insgesamt wurde die Intervention als hilfreich eingeschätzt und es zeigte sich einen Zusammenhang des Therapieerfolges (gemessen an Konsumreduktion) und der Interventions-Evaluierung.

In der Debatte um den richtigen Umgang mit Khatkonsum treffen *„laissez-faire"*-Haltungen und Forderungen nach einem strikten Verbot aufeinander, sowohl was die politisch-rechtliche Einordnung als auch die Empfehlungen für die klinische Praxis und damit auch für weitere Forschung betreffen. Aus der bisherigen Datenlage sind eine Vielzahl möglicher schädlichen Folgen bekannt, doch erfolgt in den wenigsten Untersuchungen eine differenzierte Betrachtung unterschiedlich problematischer Konsumformen wie zum Beispiel exzessive Ausmaß an Menge, Frequenz und Dauer oder die Kombination mit anderen Substanzen (Manghi et al., 2009; Nutt, King, Saulsbury, & Blakemore, 2007; Odenwald et al., 2015).

Aufgrund eines Mangels an Folge- und Ausgleichsmaßnahmen, sind in der Vergangenheit zahlreiche Versuche, den Khatkonsum einzudämmen gescheitert (Gatter, 2012; Warfa et al., 2007). Untersuchungen mit anderen Substanzen lassen vermuten, dass ein Khatverbot möglicherweise zum ersatzweisen Konsum anderer, möglicherweise schädlicherer sowie in Menge und Auswirkung schlechter kontrollierbarer Substanzen und Medikamente resultiert. So würde die Grundlage für einen immensen illegalen Markt geschaffen werden (Copersino et al., 2006; Hammer & Vaglum, 1992; Jelsma, 2005).

Aktuell gibt es keine evidenzbasierten Behandlungsansätze für Khatmissbrauch und –abhängigkeit. Es existieren lediglich vereinzelte Berichte zu Integrationsansätzen von Khatabhängigen in bestehende Drogenberatungsprogramme und Beobachtungen zur Konsumreduktion im Rahmen umfangreicher Studien mit anderen Schwerpunkten (Odenwald, Hinkel, et al., 2007; Odenwald et al., 2015). Zwar existieren Handlungsempfehlungen für einen differenzierteren Umgang mit Khatkonsum, jedoch fehlen konkrete Vorschläge zur Umsetzung, worauf im Folgenden eingegangen wird.

8. Implikationen für die klinische Praxis

Bisherige Arbeiten und Argumente zu khat-induzierten Störungen wie beispielweise Abhängigkeit, Psychosen und andere schwere gesundheitliche Beeinträchtigungen legen nahe, dass ein langfristiger, schwerer Konsum mit frühem Beginn sehr schädliche Auswirkungen haben kann, die sich in einer stressvollen Umgebung mit höherer Wahrscheinlichkeit manifestieren und verschlimmern können (Odenwald et al., 2015; Pennings et al., 2008). Zudem wurde bereits ausführlich auf die große Bandbreite möglicher Konsummotive und Folgen in unterschiedlichen gesellschaftlichen Schichten, geografischen Lagen, Altersgruppen und Geschlechtern eingegangen. Folglich sollten Khatkonsumenten nicht als homogene Gruppe gesehen und behandelt werden und Interventionen daher auf mehreren Ebenen implementiert werden (Manghi et al., 2009). Diese Einteilung und differenzierte Empfehlung zum Umgang mit verschiedenen Risiko-Schweregraden wird auch in Instrumenten zu anderen Substanzen wie bisher Teil des ASSISTs von der WHO und anderen Experten empfohlen (Humeniuk et al., 2010; Odenwald et al., 2015; WHO, 2002). Diese Empfehlungen möchte ich um einige Einzelheiten für den Konsum von Khat ergänzen (dargestellt in Abbildung 12) und näher darauf eingehen:

Risikofaktoren

Auf der Grundlage bisheriger Evidenz aus anderen Untersuchungen sowie der vorliegenden Arbeit lassen sich für Khatkonsum folgende Risikofaktoren zusammenfassen:

- die psychische Belastung infolge von Erfahrungen in der Vergangenheit, z.B. Traumatische Belastung nach Krieg, Gewalterfahrungen, Hungersnöten und Flucht (Artikel 2)
- aktuell belastende Umstände wie Diskriminierung, Gewalt, Bandenkriminalität, Terror, Arbeitslosigkeit, Armut, mangelnder Zugang zu Bildung und Arbeit (Artikel 2)
- ein Mangel an Bewältigungsstrategien wurde als einer der Hauptfaktoren genannt, die eine Konsumreduktion erschweren (Manuskript 3)
- Soziale Gründe wie Gruppenzwang, Geselligkeit aber auch der Mangel an alternativen Beschäftigungsmöglichkeiten werden häufig als Konsummotivation genannt (Manuskript 3)

Je nachdem, in welchem Ausmaß diese Risikofaktoren vorhanden sind, entwickelt sich ein entsprechend (un)problematisches Konsumverhalten mit entsprechenden ***Konsequenzen***, auf die bereits mehrfach und detailliert eingegangen wurde.

Aus dem Schweregrad dieser Konsequenzen ergeben sich unterschiedliche Indikationen für eine Intervention.

Intervention

Professionelle Therapie für multimorbid belastete Konsumenten:

Die intensivste Versorgung für stark konsumierende, unter Umständen auch anderweitig sehr belastete Khatkauer erfordert intensiver geschultes Personal und einen höheren Zeitaufwand. Die Ergebnisse aus dem zweiten Artikel, dass Teilnehmer mit Depression oder PTSD weniger von der Kurzintervention profitierten, begründen diese Schlussfolgerung zusammen mit aktueller Literatur zu integrierten Therapieansätzen, beispielsweise mit einem Fokus auf Sucht und Traumastörungen (Nunes & Levin, 2004; van Dam, Vedel, Ehring, & Emmelkamp, 2012).

Kurzintervention, Monitoring, Beratung für Personen mit moderat problematischem Konsum:

Auf einer nächsten Ebene könnten geschulte Gemeindemitglieder als trainierte *„Brief-Intervention-Counsellor“* ausgebildet werden, wie es auch für die vorliegende Studie umgesetzt wurde und was aus unseren Erfahrungen und auch aus anderen Projekten mit Trauma- oder Aggressionsfokus (Köbach, Schaal, Hecker, & Elbert, 2015; Walters, Matson, Baer, & Ziedonis, 2005) erfolgreich und effizient durchgeführt werden kann. Diese Berater könnten einen großen Teil der therapie-interessierten Konsumenten betreuen und mit sehr geringem Zeitaufwand Verhaltensänderungen im Konsumalltag bewirken.

Die durchgehend deutlichen Zeit-Effekte, auch in unserer Kontrollgruppe, die zu drei Zeitpunkten befragt wurde, weisen darauf hin, dass interessierte Gespräche und ein „Monitoring“ des Konsums bereits effektiv zur Konsum- und Symptomreduktion beitragen können (Artikel 1 und 2).

Alternative Aktivitäten, soziale Unterstützung für alle Konsumgruppen:

Vor allem in Artikel 3 zeigte sich die zentrale Bedeutung alternativer Beschäftigungsmöglichkeiten und sozialer Unterstützung durch Freunde und Familienmitglieder. Durch Selbsthilfegruppen könnte diesen Lücken im Ansatz begegnet werden und über flächendeckende Aufklärungsmaßnahmen könnte die Offenheit zur Diskussion von problematischem Khatkonsum innerhalb von Familien oder öffentlichen Räumen gefördert werden.

Informationen über Khat-Risiken, flächendeckend:

Wir fanden Hinweise, dass die Intervention bei stark konsumierenden Kauern mehr Wirkung zeigt (Artikel 1), was damit zusammenhängen könnte, dass der Leidensdruck bei Gelegenheitskauern oder Personen, die keine großen Mengen konsumieren zu niedrig ist, um ausreichend Veränderungsmotivation aufzubauen. Die Kosten, d.h. auf die sozialen, positiven Begegnungen beim Khat-Kauen zu verzichten und einen Aufwand zu betreiben, alternative Beschäftigungsmöglichkeiten und ggf. einen neuen Freundes- und Bekanntenkreise aufzubauen stehen nicht im Verhältnis zum Nutzen, beispielsweise die gelegentlichen Magenschmerzen zu reduzieren oder etwas mehr Geld zur Verfügung zu haben, falls überhaupt bereits nennenswerte Nachteile durch den Konsum bemerkt wurden. Möglicherweise sind die generell schlechten hygienischen Bedingungen und zwangsweise ungesunde Ernährungsweisen durch die Bedingungen in Eastleigh und geringen Lebensstandard genauso oder gar noch mehr für schlechte Gesundheitszustände verantwortlich als die Khatblätter an sich und die Teilnehmer wissen aus eigener Erfahrung, dass durch die Reduktion des Konsums das Wohlbefinden nicht maßgeblich gesteigert wird. In einem Umfeld von Gewalt, Terror (beispielweise aktuell durch die al-Shabaab) Bandenkriminalität und Armut steht die Problematik, die mit moderatem Khatkonsum assoziiert wird wahrscheinlich und nachvollziehbarerweise, nicht in einem handlungsinduzierenden Verhältnis.

Es wurde durch die hohe Teilnahmerate (Studie 1) und auch durch die Rückmeldung unserer Teilnehmer (Artikel 3) deutlich, dass ein großer Bedarf und gleichzeitig hohe Wertschätzung

an Informationen zu Risiken und möglichen Konsequenzen von Khatkonsum herrschen. Deshalb sollten eine flächendeckende Aufklärung und Information der Gesellschaft der erste und grundlegende Schritt sein -auch für Niedrig-Konsumenten, die nach der Risikoeinschätzung laut ASSIST Manual eine *„no intervention"* – Empfehlung erhalten würden. Ich sehe großes Präventionspotential im Schließen dieser Aufklärungslücke über Khatkonsum und die Zusammenhänge zur psychischen Gesundheit. Die Informationen sollten mit besonderem Fokus auf Kinder, Jugendliche und (schwangere) Frauen vermittelt werden, da sie sich aus der bisherigen Literatur als vulnerabelste Risikogruppen herausstellten (Odenwald, Warfa, Bhui, & Elbert, 2010). Beispielsweise könnten Lehrer geschult werden, die an Infotagen oder Beratungsstunden für Eltern und Schüler o.ä. regelmäßig ein größeres Publikum erreichen könnten. Denkbar wären hierfür auch Jugendliche und junge Erwachsene, die bereits über ein breiteres Wissen verfügen, wie beispielsweise die von uns geschulten Interviewer, die durch Aktionen für Jüngere oder Gleichaltrige eine direktere Kommunikationsebene einnehmen können als wir, als Experten ‚von außen'. Auch die sehr respektierten und geschätzten *„community elders"*, die uns während der gesamten Untersuchung unterstützen, könnten als Ansprechpartner und Berater für Konsumrisiken für die breite Masse der Gemeinde sehr wertvoll sein. In dem mit uns kooperierenden medizinischen Versorgungs- und Gemeindezentrum, der *„Tawakal Medical Clinic"* herrschen bereits sehr gute Grundstrukturen für die Umsetzung solcher Maßnahmen. Für (schwangere) Frauen und bereits vorbelastete Personen in jeglicher Hinsicht sind Gesundheitszentren, Praxen, Kliniken und generelle gemeindenahe Versorgungszentren sicher ein guter Ort, diese Informationen weiterzugeben.

Eine gute und nachhaltige Informationsvermittlung, die nicht in Widerstand resultiert, sollte mit Respekt zu bisher als wertvoll angesehenen Riten und Anwendungsmustern geschehen. Sie sollte auch offen gegenüber individuellen Motiven und ganz im Sinne der wertschätzenden Haltung des Motivational Interviewings umgesetzt werden.

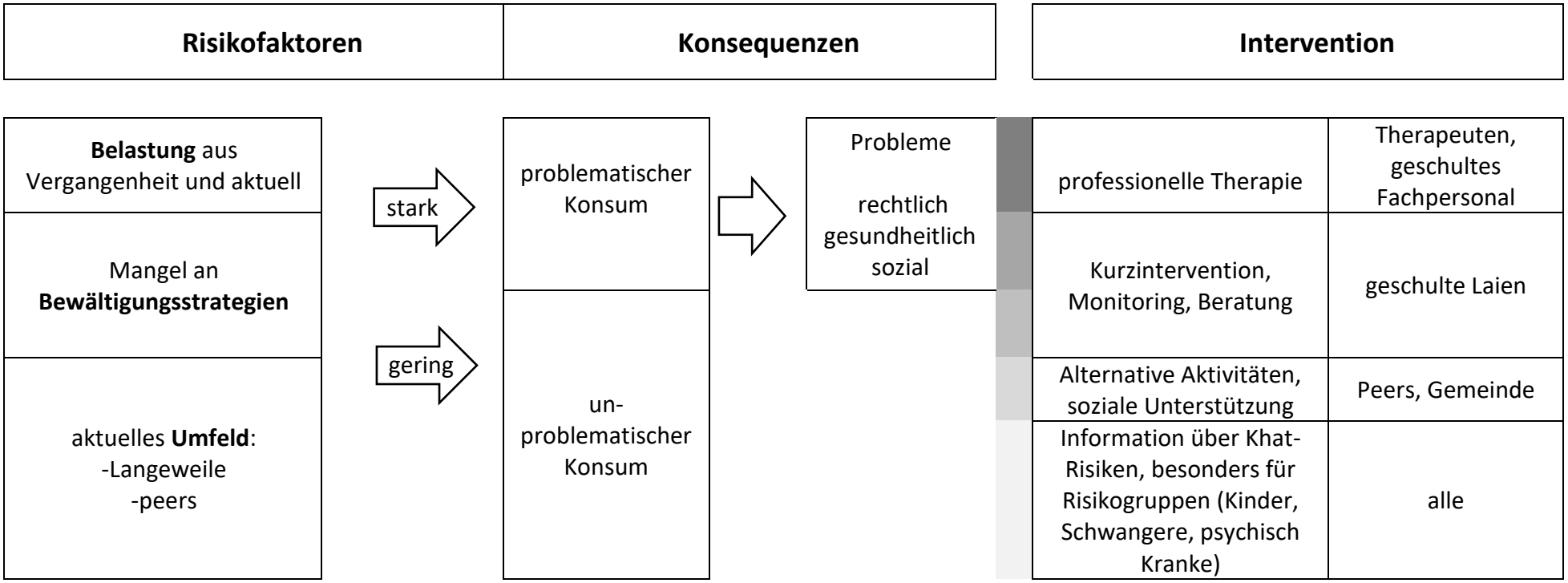


Abbildung 12. Modell zu Risikofaktoren, Konsequenzen und Intervention bei Khatkonsum.

9. Implikationen für weitere Forschung

Flüchtlinge und andere stark benachteiligte Gruppen wie Substanzkonsumenten und schwer psychisch Kranke haben meist kaum Ressourcen, selbst zu einer Veränderung der Umstände beizutragen. Es entwickeln sich Abwärtsspiralen von Krankheit und Diskriminierung, kombiniert mit mangelnder Bildung und Aufklärung hin zu systematischer Ausgrenzung und drastischer Zustandsverschlechterung der betroffenen Personen, für die es dann immer unwahrscheinlicher wird, adäquat versorgt und aufgefangen zu werden.

Ein Ziel auf organisatorischer Ebene sollte eine intensivere Kooperation zwischen den verschiedenen Versorgungsebenen und –Einrichtungsarten sein und eine intensivere, längerfristige Zusammenarbeit international agierender praxis- und forschungsnaher Institutionen und lokaler (traditioneller und modern medizinischer) Einrichtungen sein (Odenwald & Al'Absi, 2016, in press; Odenwald, Warfa, et al., 2010), die auf immer selbstständiger und unabhängiger laufende Strukturen abzielen sollte mit entsprechender begleitender wissenschaftlicher Validierung und fortlaufender Optimierung.

Für zukünftige Forschungsarbeit im **Khatbereich generell,** ist es wünschenswert, genauer zu differenzieren, mit welcher Konsumintensität/ -menge die untersuchten Teilnehmer in die Studien aufgenommen wurden. Da Khatblätter und -zweige keinen Normmaßen unterliegen und somit keine Standardeinheiten quantifizierbar sind, wie es beispielsweise bei Alkohol möglich ist, entwickelten wir basierend auf der Erfahrung aus jahrelangen Untersuchungen in ausführlichen Expertendiskussionen, gemeinsam mit erfahrenen Khat-Kauern und Fachkräften vor Ort ein einfaches Schema zur Mengenerfassung von Khat. Wir berücksichtigten die ungefähre Angabe zur Wirkung einer Verkaufseinheit, meist Bündel, und den aktuellen Marktpreis. Aus Gründen der Übersicht und Anwendbarkeit wählten wir drei Fotos der gängigsten Khat-varietäten in ihrer üblichen Verkaufseinheit und ließen die Teilnehmer, die zum Teil Analphabeten waren, angeben, in welcher Anzahl sie die entsprechende Einheit über einen bestimmten Zeitraum konsumiert hatten (im Anhang sind die entsprechenden Materialien dargestellt).

Ein Hauptergebnis des zweiten Artikels zeigt, dass die khatfreie, potentiell funktionale Zeit deutlich steigt durch die Intervention. Gängige Messinstrumente berücksichtigen selten die Zeitdauer, die die Klienten mit dem Konsum und anderen Aktivitäten verbringen. Da wir aber zudem fanden (Manuskript 3), dass laut Teilnehmer die alternativen Aktivitäten, also konkret *„Was“* über den Tag hinweg getan wird, zentral entscheidend darüber ist, ob und wie stark sich das Konsumverhalten verändert, sollte die zeitliche Dauer des Konsums mehr Berücksichtigung finden.

Bei künftigen Studien zu **Khat-spezifischen Interventionen** sollte in größeren Stichproben und unterschiedlichen Kontexten die Auswirkung von Kurzinterventionen untersucht werden. Hierbei würde die Differenzierung in verschieden intensive Behandlungsstufen in Abhängigkeit der Konsumintensität und Symptomschwere, wie oben vorgeschlagen, genauere Aussagen über die Effekte ermöglichen.

Auch in der Kontrollbedingung fand ein signifikanter Rückgang von Konsummenge, -häufigkeit und Symptomschwere komorbider Erkrankungen statt, was auf die Wirksamkeit unspezifischer Faktoren hinweist. In unserer Kontrollbedingung durchliefen die Teilnehmer ebenfalls ein diagnostisches Interview mit Fragen zu psychotischer Symptomatik, auch im Speziellen nach Khatkonsum, Depression, traumatischer Belastung, der eigenen Geschichte des Khatkonsums und über alle drei Messzeitpunkte hinweg des genauen Konsummusters der vergangenen vier Wochen. Das Interview als solches kann allerdings durch eine Veränderung des Aufmerksamkeitsfokus auf das Konsumverhalten, dem Bewusstmachen der Zusammenhänge zwischen Befindlichkeit, Gesundheitszustand und dem eigenen Konsum sowie generell durch einem aufmerksamen, interessierten, unterstützenden Gesprächskontext eine Veränderung im Khatkonsum bewirken. Für weitere Untersuchungen, die sich mit Kurzinterventionen befassen, halte ich es für empfehlenswert, weniger therapie-ähnliche Elemente in der Kontrollbedingung zu involvieren. Obwohl es für diese Pilotstudie von großem Nutzen war, viele Bereiche abzudecken, um einen umfassenden Überblick wichtiger Einflussfaktoren zu erhalten, wäre eine gesonderte Betrachtung und Untersuchung von Interventionseffekten, ohne Komorbiditäten und anderen Elementen zu Gunsten

größerer Stichproben meiner Einschätzung nach zu bevorzugen und ich würde wesentlich deutlichere Therapieeffekte erwarten.

Trotz vieler Herausforderungen sehen wir durch zahlreiche Forschungsprojekte in verschiedenen Krisengebieten, mit unterschiedlichen Foki wie beispielsweise auf traumatischer Belastung, dass Menschen in benachteiligten Umwelten mit miserablen Zugangsbedingungen zu Versorgung durchaus geholfen werden kann, (Foa, Keane, Friedman, & Cohen, 2008; Schauer, Schauer, Neuner, & Elbert, 2011) etwas mehr Lebensqualität zu erlangen und dass mit relativ geringem personellen und finanziellen Aufwand ein vergleichsweise hoher Gewinn im Sinne von Symptomreduktion und Befindlichkeitsverbesserung erzielt werden kann. Es konnten auch bereits effiziente Trainingssysteme entwickelt werden, die weitgehend auf eine selbstständige Wissensvermittlung abzielen, wie beispielsweise *„train the trainer*“ Programme oder *„peer training*“ Konzepte (Köbach et al., 2015; Walters et al., 2005). Unsere Daten zeigen auch das Potential der Selbsthilfeansätze: Individuelle Selbsthilfe, wie zum Beispiel die Broschüre, die wir den Patienten aushändigten, verdienen auch weitere Aufmerksamkeit in der zukünftigen Forschung, schon allein aufgrund ihrer effizienten Einsatzmöglichkeiten.

10. Fazit

Die vorliegende Thesis beschreibt Ergebnisse aus einer ersten Pilotstudie zu einer khat-spezifischen Kurzintervention mit somalischen Flüchtlingen in Kenia. Die Vermittlung der Behandlungsansätze in den Trainings sowie den Therapien und im Studienverlauf verlief mit großer gegenseitiger Offenheit und ohne besondere Probleme, obwohl das Umfeld der Erhebung mit alltäglicher Gewalt, Kriminalität, Terrorismus und politischer Instabilität das Team vor viele Hürden stellte.

Wir konnten zeigen, dass durch psychotherapeutische Kurzmaßnahmen eine Konsumreduktion bewirkt werden kann und dass die überdurchschnittlich hohe psychopathologische Belastung der untersuchten Stichprobe, vor allem Depression und traumatische Belastung den Therapieerfolg reduzieren. Auch der Anteil an funktionaler Zeit im Alltag der Klienten stieg deutlich mit der Intervention und die Teilnehmer beschrieben in einer abschließenden Evaluation die für sie zentralen Faktoren, die die Konsumreduktion in ihrem Umfeld beeinflussten, was vor allem alternative Aktivitäten wie Sport und Arbeit, sowie ein Umfeld voller Khat-Trigger sowie mangelnde alternative Problemlösekompetenz waren.

Der weltweit immense Bedarf an effizienten Interventionsmethoden für benachteiligte Populationen, insbesondere psychisch Kranke und Substanzabhängige erfordert fokussierte Forschung in diesen Bereichen. Die aktuell steigenden Flüchtlingsbewegungen verdeutlicht die Notwendigkeit vielseitig anwendbarer und leicht adaptierbarer Methoden für psychologische Versorgung. Durch stark belastete, kulturell hoch diverse Menschengruppen mit hoher Prävalenz von Substanzmissbrauch ist die Versorgung durch langjährig geschultes, professionelles Personal nicht zu gewährleisten und alternative Konzepte, die auf die effiziente Ausbildung von Personen aus den entsprechenden Zielgruppen abzielt, sollten weiterentwickelt und implementiert werden. Dafür liefert die vorliegende Arbeit wichtige Erkenntnisse für weitere, dringend notwendige Forschung sowie Vorschläge für eine konkrete Implementierung vorhandener, evidenzbasierter Versorgungsansätze.

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V APPENDIX

1. Fragebögen t1 Interventions- und Kontrollgruppe inkl. ASSIST

    a. Selbsthilfemanual englisch
    b. Selbsthilfemanual somali

2. Fragebögen Interventions- und Kontrollgruppe t2

3. Fragebögen Interventions- und Kontrollgruppe t3

Fragebogen t1 Interventionsgruppe

Inkl. Khat-adaptierter ASSIST

Interview for Brief Intervention study

Magaca Waraystaha: _____

Name of interviewer

Taariikhda: _____ Wakhtiga: _____ Mudada Waraysiga: _____

Date *Time* *Duration of interview*

*Name of participant*_____

Phone number1: _____

Phone number2: _____

Section (place of interview): _____

Description of place where we find participant:_____

_____

_____

_____

Date for 4-week follow up (use the TLFB calendar to calculate)_____

INTERVIEWEE AGREED TO BE CONTACTED AND REMINDED ❑

CODE:(Numberka)_____Age:(dad a)_____ Date:(Tariiqda)_____

Miraa Use (Odenwald, Lingenfelder et al. 2007)		Haa *Yes*	Maya *No*
1	Labo iyo tobankii bilood ee u danbeeyay ma isticmaashay qaad *Did you use miraa within the last 12 months?*	❑	❑
2	Afartii asbuuc ee ugu danbaysay ma isticmaashay qaad *Did you use miraa within last 4 weeks?*	❑	❑

TIMELINE FOLLOWBACK CALENDAR

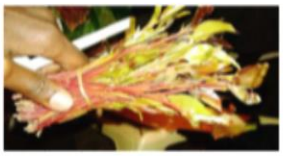
To help us evaluate your khat use, we need to get an idea of what your khat use was like in the past 30 days. To do this, we would like to fill out this calendar with you. It is not hard and I would like to try to be as accurate as possible. We recognize you won't have perfect recall. That's OKAY.The idea is to put a number in for each day on the calendar. On days when you did not chew, we should write a "0". On days when you did chew, you should write in the total number of standard units you had. (Show and explain standard units with extra pictures)

It's important that something is written for every day, even if it is a "0".

1 standard unit of khat is equal to



1 surba of Kangeta or



1 surba of Giza, Alenle, Asili, Lare or



1 bag of Magoka

Complete the Following (4 weeks): Start Date (Day 1): _____**End Date** (yesterday):_____

Day month year day month year

2014	SUN	MON	TUES	WED	THURS	FRI	SAT
AUG	17	18	19	20	21	22	23
	24	25	26	27	28	29	30
S	31	1	2	3	4	5	6
E	7	8	9	10	11	12	13
P	14	15	16	17	18	19	20
	21	22	23	24	25	26	27
	28	29	30	1	2	3	4
O	5	6	7	8	9	10	11
C	12	13	14	15	16	17	18
T	19	20	21	22	23	24	25
	26	27	28	29	30	31	1

Malmahee qaadka cunaysay.*For days when chewing miraa last week:*			
3	Imisa jeer ayaad si iskuxigta u isticmaashay khatka mudo dheer oo 24 saacdood ama in kabadan isbuuci lasoo dhaafay. *How many times did you continuously you chew miraa for extremely long periods of 24 hours and more last week? Times:* _____		
4	Asbuucii tagay malintii intee saacadood baa ku dhumisaa cunida qaadaka.*What is the usual number of hours spent chewing miraa per day in last week:* *Calculation:* _____ *days chewed x* _____ *hours per day ÷ 7 =*	_____hours	
5	Ma isticmaashaa khat indha fur ah markaa soo toosto. *Do you use Miraa when you wake up (Indha fur, to unlock yourselve)?*	Yes☐	No☐
6	Asbuucii ugu danbeeyay meel nooce ah baa qaadka ku dhex cuntay.*In what kind of social setting did you chew in the last week?* ❑Kaligay ugu badanaa *Mostly alone* ❑ Dadka dhexdooda ugu badanaa *Mostly with others*		
Asbuucii tagay jaadkaiyo hurdada:*Miraa and sleep last week*			
7	Asbuucii tagay afar iyo labaatan saacadood intee saac baa ka seexatay: *How many hours of sleep per 24 hours did you have last week*	_____hours	
8	Asbuuci tagay meeqo habayn ayaada seexan hurdo (inta u dhaxaysa 10 p.m. iyo 5 a.m.)? *How many times during the last week did you not sleep during the night (between 10 p.m. and 5 a.m.) because of miraa.*	_____times	
Nolashaada mudaada qaadka isticmaalaysay.*Duration of miraa use in one's lifetime:*			
9	Markii kugu horaysay oo aad isticmaashay qaad da dada.*What was your age when you first used Miraa*		
10	Markii ugu horaysay aad bilowday in aad isticmaasho qaadka si joogta ah da dada *What was your age when you started to use miraa regularly (weekly base*	_____	
11	Ma waxaa sitoos ah u bilawdey istic maalka qaadka markaa Nairobi timid. *Did you start to use miraa regularly after you came to Nairobi*	Yes☐	No☐
12	imisa sano ayaad jaad si joogta ah u cuneysay *How many years have you chewed miraa regularly in life?*	_____	
Functional Miraa use:			
13	Qaadka ma kaa cawiya in uu ku ilowsiiyo dareen xanuun leh sida dagaalka oo kale? *Does Miraa help you to forget painful experiences (e.g. war)?*	Yes☐	No☐
14	Qaadku had iyo jeer ma ku farxad galiya? *Does Miraa usually cheer you up/make you feel better?*	Yes☐	No☐
15	Goorma ayaa Kenya utimi qaxooti ahaan (Bukanka)? *When did you come to Kenya as a refugee? (Year)*		_____

Now I would like to ask some questions concerning your living conditions:

16	Gurigina nocee u dhisan yahay? *What is your home type?*	1 ❑ guri deer leh / house in own compound 2 ❑ lojin deer kamid ah/ lodge, i.e. part of a compound 3 ❑ guri dhan/ whole apartment 4 ❑ qeyb kamid ah guriga/ part of an apartment	
17	What is your household type:	1 ☐ Family-based household 2 ☐ Rent-sharing household of unrelated people 3 ☐ Other	
18	Gabi ahaan immisa qof ayaa ku nool gurigiina?wexay lamid tahay imisa qof aya halkan sexanayey afarti todobaad ee ugu danbesay? / *How many persons are there in total living in your household? That means, how many people were sleeping here most of the times in the last 4weeks?*		***No.*:** **Tirada:**
19	maledihin boyeso/shaqalo/ *does your household have a househelp?*		❑ haa ❑ maya
20	maledihin alada intarnetka iyo kombutar/ *do you have a computer with internet?*		❑ haa ❑ maya
21	hadii aad xanusatid isbital nooce adaa/*in case you get sick, what type of hospital do you attend mostly?*		❑ dowladed/ public ❑ shaqsiyed/ private
22	maledihin makinada cunto karinta/*Does your household own a gas cooker?*		❑ haa ❑ maya
23	maledihin firinjeer /*Does your household own a fridge?*		❑ haa ❑ maya
24	Gurigiinu Gari ma leeyahay? / *Does your household own a car?*		❑ haa ❑ maya
25	Xaalad xaaseedka? / *What is your marital status?*	1 ❑ .Married(guur) 2. ❑ single(kali ahansho) (inclucing engaged or dating) 3. ❑ divorced(furiin)/separated(kala nolasho)/widowed(laga dhintay)	
26	Imisa sannadood ayuu/ayey tegi jirey/jirtay iskuul oo aanay ku jirin malcaamad quraanku? *How many years did you go to school excluding Koranic school?* _____*years*		
27	maxey qabataan /*What is your occupation?*	1. ❑ aan shaqeyneyn/ *not working* 2. ❑ guri jog/ *housekeeping*	3. ❑ *working (any)* 4. ❑ arday/ *student* 5. ❑ howl gab/ *retired*

28	Hadda waxaan jeclaan lahaa in aan ku weydiiyo inay jiraan in dad ka mid ah qoysku oo qaba cudurka dhimirka kuwaasoo aad u ba'an oo ka saameeyey qofka Masruufka ama dakhliga keena ama caawimada reerka qoyska in ka badan afartii toddobaad ee u dambeeyey ama adaya iskul? */ Now I would like to ask you if YOU have mental problems that are so severe that they affect YOU in providing income or helping in the household or going to school for at least four weeks?*

Now I´m coming to some questions on symptoms that we often find.

Screening questions for present delusions and hallucinations(Modified excerpt from CIDI, part G)(World Health Organization. 1997)			
During the last 4 weeks…	**TICK YES ONLY IF IMPLAUSIBLE! ASK FOR MIRAA!**	Yes haa	No maya
29	Ma rumaysan tahay inay dad ku daba socdaan? *Do you believe that people are following you?*	❑	❑
	a. Sidee ayaad ku ogaatay inay dadku ku daba gurayaan ama ku daba socdaan *How do you know that people are following you? implausible?* _____ _____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
30	Ma hubtaa in qof aan adiga ahayni uu awooddaada kuu hayo ama uu ku kaantaroolayo? Sidaa darteed ficilkaaga iyo fikirkaaga aanay ahayn kuwaagii ama uu go'aaminayo qof kale. *Are you convinced that you are under control of some power or force, so that you actions or thoughts are not your own or determined by someone else?*	❑	❑
	a. Kuma ama maxay ayaa ku xukumaya ama kaantaroolaya/xukumid? *Who or what power or force controlles you? implausible?)*_____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
31	Mararka qaar ma dhacdaa inaad maqashid waxyaabo aanay maqlanayn dadka kula joogaa? *Does it sometimes happen that you can hear things other people can not hear?*	❑	❑
	a. Maxaad maqashaa? Sidee baad usharixi kartaa? *What do you hear? How do you explain this? (implausible?)* _____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
32	Mararka qaarkood inay ku dhacaan jidhkaaga oogadiisa ama jirka gudihiisa dareenno aan caadi ahayn- sidii adoo lagu taabanayo iyada oon cidi kuu dhoweyn ama aad dareento sidii adoo jirkaaga wax dhex socsocdaan? *Do you sometimes have unusual feelings on your skin or inside your body – like being touched when nothing is there or feeling something moving inside your body?*	❑	❑
	a. Maxaad dareentaa *What do you feel then?* *(implausible?)*_____ _____ _____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
33	Immisa maalmood, toddobaad, bilood amma sannadood ka hor ayay arrintani kugu bilaabatay? *How many days/weeks/years ago did these phenomena begin? a.*_____ b. Age:_____		

PHQ 9 – Murug *Depression*		Not at all marnaba	Several days Dhowr maalmood	More than half the days Kabadan maalmaha barkood	Nearly every day Kudhawaan maaliin kasta
Labadii isbuuc ee ugu danbaysay ma ku dhibeen mid kamida dhibaatooyinkaan soo socda *Over the last 2 weeks, how often have you been bothered by any of the following problems?*		0	1	2	3
34	Xiiso yar ama kuraaxeysato sameynta waxyaabo *Little interest or pleasure in doing things*				
35	Niyad jab,muruug iyo rajo la'aan *Feeling down, depressed, or hopeless*				
36	Kugu adkaato inad seexatid, iska jiifto ama hurdo badan *Trouble falling asleep, staying asleep, or sleeping too much*				
37	Daal aa dareemaysid ama awooda oo kugu yar *Feeling tired or having little energy*				
38	C unto xumo ama cunitaan badni *Poor appetite or overeating*				

39	Si xun aad dareemaysid, aad dareemaysid inaad fashilantay, ama dareemaysid inaad naftaada ama qoyskaaga hoos udhigtay (qiimo la'aan, dambiile,...) *Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down (feeling worthless, guilty, ...)*				
40	Dhib ay kugu tahay inaad wax xooga saartid sida aqriska wargayska ama daawashada televison *Trouble concentrating on things such as reading the newspaper or watching television*				
41	U dhaqaaqid ama u hadlid si tartiib ah taaso dadka kale ay dareemi karaan. tacbaan ama nasasha la'aan noqotid aad in badan dhaqdhaqaaqday kabadan inti caadiga ahayd *Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual*				
42	ku fakaraysid inaad dhimasho ku fiicnaan lahayd ama aad rabto inaad naftaada si uun u waxyeelayso. *Thinking that you would be better off dead or that you want to hurt yourself in some way.*				
43	Guud *Total*				

Soodhaweynta ogalanshaha gurmadka (caawinada). *Acceptance of self-help approaches(Odenwald, Lingenfelder et al. 2012)*		Haa *Yes*	Maya *No*
44	Mauaragtaa tagerid/gurmad/damashaad inaad lafarisato jiilkada/qeyrkaada lanahadashid. *Do you find it supportive/helpful/enjoyable to sit with peers and talk?*	☐	☐
45	Badanaa malafarisataa dariskaaga ama saxibadaada lanahadashaa. *Do you often sit with your neighbros or friends and talk?*	☐	☐
46	Mauaragtaa iney cawimaad kuutahay inaad kalahadashid dhibatoyinkaada koox jiilkaaga(qeyrkaaga). *Do you find it helpful for you to discuss decisions and problems with a group of peers?*	☐	☐
47	Mauaragtaa gurmaad inaad kamaqashid dadka kale iney qabaan dhibatoyin kuwaaga lamid ah. *Do you find it helpful to hear from others that they have similar problems?*	☐	☐
48	Maudarenta iney tahay wax loo bogo in koox dadka kamid ah eey wadagaandhibatoyin iskumid ah. *Do you feel comfortable in a group of people who share the same problems?*	☐	☐
49	Mauaragtaa iney fududahay inaad kahadasho dhibatoyinkaada hadaad ogtahay iney kulaqabaan dhibkaada oo kale. *Do you see it easier speaking out your problems if you know they have the same problems?*	☐	☐
50	Mauaragtaa iney fududahay inaad kalahadasho dibatoyinkaada qof kulamid ah intaa aad kalahadli leheed qof kutaqasusay. *Do you find it easier to talk about your problems to someone with a similar problem than to a professional.*	☐	☐
51	Magaraneysaa kulamo ladiyaariyey kuwaaso dadku dhibatoyin iskumid ah ufaristaan si wadajir ah una hadlan. *Do you know any organised meetings, were people with similar problems sit together and talk?*	☐	☐
52	Waligaa makaqeeb qadatay sida isku imansho wadajir ah ama fadi wadajir ah. *Have you ever participated in such a "coming together"/"sitting with others"?*	☐	☐
53	Guud ahaan makaqeeb qaadan leheeyd.*Would you generally participate?*	☐	☐

EVENT LIST (tick only if person felt helpless and terrified)

	NO	Lakulantay (experienced)	Goob joog ah (wittnessed)	
54		☐	☐	Shil khatar ah , dab ama qarax (tusaale: warshad, beer, gaadhi, diyaarad, ama shil doonyeed. *(accident, fire, explosion)*
55		☐	☐	Masiibo dabiici ah (tusaale: duufaano, daad, ama dhulgariir.) *(natural disaster, storm, flood, drought, earthquake)*
56		☐	☐	Weerar kaaga yimid dad qoyskaaga ah ama aad garanayso (tusaale: dhicid, garaacid,toogasho, tooriyeyn, qori ku qabasho.) *(Violent assaoult. by family member, for example being mugged, physically attacked, shot, stabbed or held at a gunpoint)*
57		☐	☐	Weerar kaaga yimid dad aadan aqoon (tusaale : dhicid,garaacid, toogasho, tooriyeyn, ama qori ku qabasho.)*(vioent assaoult by stranger for example being mugged, physically attacked, shot, stabbed or held at a gunpoint)*
58		☐	☐	Dagaal ciidan, ama goob dagaal. *(military combat or war zone)*
59		☐	☐	Waxaan ognahay in addunka dagaalada ka dhacaa ay sobabaan kufsi. Ma u malaynaysaa inuu ka dhacay Dalkeena wakhtigii Dagaalada sokeeye? *(We know that in the world violent rape of both, males and females happens in war zones. Have you heard about that this happened here or in Somalia?)* Ma maqashay inay ka dhacday Somalia? Ha: ☐ Maya: ☐ (Haddii ay tahay haa:) ma ku aragtay ishaada? *(witnessed)* Ha: ☐ Maya: ☐

				Ma ku dhacday qof aad taqaanid? *(s.o.you know)*	Ha: ☐ Maya: ☐
60		☐	☐	Adiga ma kugu dhacday? *(experienced)* Adigu ma u noqotay dhibane cid aad garanaysid *(were you victim of s.o. you know?)*	Ha: ☐ Maya: ☐ Ha: ☐ Maya: ☐
61		☐	☐	'Maxbuusid (tusaale: xarig; maxbuus dagaal; qafaalasho; ama afduub.) *(Imprisonment, for example prison inmate, prisoner of war, hostage)*	
62		☐	☐	Jirdil. *(torture)*	
63		☐	☐	Cudur noloshaada khatar galiyey. *(life-threatening illness)*	
64		☐	☐	Dhacda kale oo reebtay saameyn. *(other)*	
65		*(Tilmaan wareyste: hadii 11 uu kaga jawaabay haa, wareystuhu wuxuu odhanayaa.)* Fadlan cadee dhacdada kale ee saameynta kuugu reebtay.*(specify)*			

Worst Event (write number):_____

PDS Somali Short Version (Odenwald, Neuner et al. 2005) *(Rate yes, when already clear, if not probe again)*		Yes haa	No maya
66	Ma dareentay inaadan waxba qaban karayn, Ma dareentay argagax marka aad kusugan tahay xalad qatar ah ama markaad ufirsato si toos ah qof kale noloshiisa oo kusugan qatar? Hadey tahay maya kabood PDS. *Did you ever feel helpless or horrified when you were in a situation in which your life was in danger or when you directly observed that someone's else's life was in danger? If no skip the PDS*		
67	Majiraan Xusuuso kicinaya ama murugo naxdin leh oo la xariira dhacdada saameynta leh ee ku soo noqonaysa maskaxdaada adigoon rabin?. *Do you have upsetting thoughts or images about these bad events that come into your head even when you don't want them to? Did you experience this last month (= last four weeks)?*		
68	Ma isku daydaa in aadan ka fakarin, ka hadlin ama dareemin dhacdadaan ugu xun ee kugu dhacday. Miyaad sidoo kale ka fogaatay arintaan bishii lasoo dhaafay, (4tii asbuuc ee ugu danbaysay) *Do you try not to think about, talk about or have feelings about the most shocking experiences, that you had? Did you also avoid this in the last month (= last four weeks)?*		
69	Ma dareentaa in rajadaadii ama qorshahaagii mustaqbal aanay rumoobeyn, tusaale, inaadan yeelanayn takhasus, waxbarasho, guur, caruur, cimri dheer, ma lakulantaytan bishii ugu danbaysay (4tii asbuuc ee lasoo dhaafay) *Do you feel as if your future plans or hopes will not come true for example, you won't have a career, marriage, children or a long life? Did you experience this in the last month (= last four weeks)?*		
70	Dhibaatooyin maqabta markaad seexaneysid ama markaad jiiftid? Sidaan maisku aragtay bishii lasoo dhaafay? *Do you have trouble falling asleep or staying asleep? Did you experience this in the last month (= last four weeks)?*		
71	Ma fudfuduudahay ama manaxdaa (Tusaale:markaad si kadis ah qwylo umaqashid ama markaad si kadis ah uragtid qof gadaashaada socdo) sidaaan maisku aragtay bishii lasoo dhaafay? *Are you jumpy or easily startled (for example, when there is a sudden noise or when you suddenly find someone walking behind you?) Did you experience this in the last month?*		

WHO ASSIST (modification of v 3.0)

Waa ku mahadsantahay aqbalaadaada ah in aad nagala qeyb qaadato wareysigan ku aadan khatka,tubaakada iyo daroogooyinka kale.Waxaa ku weydiinayaa su'aalo yar oo ku saabsan qibradaada ku aadan isticmaalka walxahan noloshaada oo idil iyo saddexdi bilood ee u danbeesay.Walxahan waa la cabbi karaa ama la liqi karaa ama waa la fiifin karaa ama waa la isku durri karaa ama waxaa loo qaadan karaa sidda kaniini camal { tussi kaarka daroogadda}

Walxaha qaar ee lacayimay waxaa laga yaabaa in uu soo qoray dhaqtar { sida daawooyinka badiyo awooda,xassilin,iyo xanuun yareeyaha}.wareysigan guddihiis ma diiwaan gellineyno daawooyinka uu qoray dhaqtar.haddaba waxa aad u qaadatay daawooyinkan sababo aa aheeyn in laguu qoray oo kaliya ama u qaadatay si xad dhaaf ah ama ka badan inta laguu qoray.fadlan ii ogoloow in aa ogaano.anaga oo waliba daneeneyna in aa ogaano isticmaalkaada daroogada sharciga eheen.fadlan ogoow in warbixintaada ku aadan isticmaalka walxahan ee tahay mid aad kalsooni ku qabtid mar walba.

"Now I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be available in pharmacies or prescribed by a doctor (like sedatives, pain medications or amphetamines). For this interview, we will not record medications that are used as prescribed by your doctor, i.e. to treat a disease. However, if you have taken such

medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. Please be assured that all information we get from you will be treated as strictly confidential."

Inta aadan weydiinin su'aalo,sii ASSIST jawaabta kaarka ee bukaanka. *Note: before asking questions, give ASSIST response card to patient*

Question1

Noloshaada,walxahan soo socda mid kee baa waligaa isticmaashay? (kuwa aa laguu soo qorin kaliya) *In your life, which of the following substances have you ever used (non medical use only)?*	*No* Maya	*yes* haa
a. Miraa/Khat (Chat, Giza, Alene, Magoca,…)	0	3
b. Walxaha tubaakada (sigaarka,tubaakada lacalaanjiyo iyo waxii la mid ah) *Tobacco products (cigarettes, chewing tobacco, cigars, etc.)*	0	3
c. Kaniiniyaasha hurdada sida (valium, serepax, Rohypnol, iyo waxii la mid ah.) *Sedatives or sleeping pills (valium, serepax, Rohypnol, etc.)*	0	3
d. Cannabis (marijuwaana,pot,grass,hash,iyo waxii la mid ah) *Cannabis (marijuana, pot, grass, hash, etc.)*	0	3
e. Alcoholic beverages (beer, wine, spirits etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, iyo waxii la mid ah.) *Inhalants (nitrous, glue, petrol, paint thinner, etc.)*	0	3
g. nooc Amphetamine ah(xawli, diet pills, ecstasy iyo waxii la mid ah) *Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)*	0	3
h. xashiish (coke, crack, iyo waxi la mid ah.) *Cocaine (coke, crack, etc.)*	0	3
i. hallucination (LSD, acid, mushrooms, PCP, Special K, iyo waxi lamid ah.) *Halluzinogenes (LSD, acid, mushrooms, PCP, Special K, etc.)*	0	3
j. Opioids (heroin, morphine, methadone, codeine, iyo waxi la mid ah) *Opioids (heroin, morphine, methadone, codeine, etc.)*	0	3
k. kuwo kale – sheeg Other – specify:……	0	3

Baar haddii ee jawaabaha dhan yihiin diidmo ,xittaa markaa iskuulka dhiganeesay?"
Haddii „maya" tahay waxyaalaha dhan jooji wareyiga. haddii „haa " tahay wax kamid ah walxahan weydii su'aasha labaad ee ku aadan isticmaalka walxahn
Probe if all answers are negative: „not even when you were in school?"
If „no" to all items, stop interview If „yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

Saddexdi bilood ee u danbeesay ilaa intee in la eg ayaad isticmaashay walxahan aad xustay (daroogada koowaad,daroogada labaad,iyo waxi la mid ah) In the past three months, how often have you used the substances you mentioned (ask for all the drugs that the client told you)	marnaba never	Hal mar ama laba mar Once or twice	Bille ah monthly	Isbuucle ah weekly	Maalin kasto ama ku dhaw maalinkasto Daily or almost daily
a. Miraa/Khat (Chat, Giza, Alene, Magoca,…)	0	2	3	4	6
b. Walxaha tubaakada (sigaarka,tubaakada lacalaanjiyo iyo waxii la mid ah) *Tobacco products (cigarettes, chewing tobacco, cigars, etc.)*	0	2	3	4	6
c. Kaniiniyaasha hurdada sida (valium, serepax, Rohypnol, iyo waxii la mid ah.) *Sedatives or sleeping pills (valium, serepax, Rohypnol, etc.)*	0	2	3	4	6
d. Cannabis (marijuwaana,pot,grass,hash,iyo waxii la mid ah) *Cannabis (marijuana, pot, grass, hash, etc.)*	0	2	3	4	6
e. Alcoholic beverages (beer, wine, spirits etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, iyo waxii la mid ah.) *Inhalants (nitrous, glue, petrol, paint thinner, etc.)*	0	2	3	4	6
g. nooc Amphetamine ah(xawli, diet pills, ecstasy iyo waxii la mid ah) *Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)*	0	2	3	4	6
h. xashiish (coke, crack, iyo waxi la mid ah.) *Cocaine (coke, crack, etc.)*	0	2	3	4	6
i. hallucination (LSD, acid, mushrooms, PCP, Special K, iyo waxi lamid ah.) *Halluzinogenes (LSD, acid, mushrooms, PCP, Special K, etc.)*	0	2	3	4	6

j. Opioids (heroin, morphine, methadone, codeine, iyo waxi la mid ah) *Opioids (heroin, morphine, methadone, codeine, etc.)*	0	2	3	4	6
k. kuwo kale – sheeg *Other – specify:*.....	0	2	3	4	6

Haddii 'marnaba' tahay walaxaha dhan ee su'aasha labaad u bood su'aasha 6.
Haddii walxaha qaar ee suaasha labaad la isticmaalay saddexdi billood ee hore sii aad su'aasha saddexaad ,afaraad iyo shanaad ee walax kasto oo la isticmaalay.
If „never" to all items in question 2, skip to question 6.
If any substances in question 2 were used in the previous three months, continue with question 3,4 & 5 for each substance used.

Question 3

Saddexdi billood ee u danbeesay,meeqa mar ayaad laheed damac saa'id ah oo ku aadan isticmaalka walxahan.(daroogada koowaad,daroogada labaad,iyo waxii la mid ah) In the past three months, i.e. since (calculate 3 months back) how often have you had a strong desire or urge "Xaraaro" to use Khat.	marnaba *never*	Hal mar ama laba mar *Once or twice*	Bille ah *monthly*	Isbuucle ah *weekly*	Maalin kasto ama ku dhaw maalinkasto *Daily or almost daily*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,...)	0	3	4	5	6

Question 4

Saddexdi billood ee u danbeesay ilaa meeqa mar ayee isticmaalka walxahan kugu dhalisay caafimaad xummi,dhaqan ama dhaqaalo xummi.(daroogadda koowaad,daroogada labaad) During the past three months, how often has your use of khat led to health, social, legal or financial problems? Fill in EXAMPLES	marnaba *never*	Hal mar ama laba mar *Once or twice*	Bille ah *monthly*	Isbuucle ah *weekly*	Maalin kasto ama ku dhaw maalinkasto *Daily or almost daily*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,...)	0	4	5	6	7

Question 5

Saddexdi billood ee u danbeesay meeqa mar ayaad ku guul dareesatay in aad qabato waxyaalo aad qaban jirtay caadiyan sababo la xariira isticmaalka walxahan?(daroogada kooowaad,daroogada labaad) During the past three months, how often have you failed to do what was normally expected of you because of your use of khat? Fill in EXAMPLES	marnaba *never*	Hal mar ama laba mar *Once or twice*	Bille ah *monthly*	Isbuucle ah *weekly*	Maalin kasto ama ku dhaw maalinkasto *Daily or almost daily*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,...)	0	5	6	7	8

Su'aal su'aasha 6 iyo 7 ee walxaha idil ee la isticmaalo (tusaale ahaan suaasha 1)

Ask question 6 & 7 for all substances ever used (i.e. these endorsed in Question 1)

Question 6

Ma leedahay saaxiib ama qaraabo kale oo ka sheegtay isticmalkaada walxahan (daroogada koowaad,daroogada labaad? Has a friend or a relative or anyone else ever expressed concern about your use of khat ?	**maya, marnaba** *No, never*	**Haa ,saddexdi billood ee u danbeesay** *Yes, in the past 3 months*	**Haa ,laakiin ma ahan saddexdi billood ee u danbesay** *Yes, but not in the past 3 months*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,...)	0	6	3

Question 7

Waligaa ma isku dayday mana ku guuldareesatay in aad yareeso ama aad joojiso. (daroogada koowaad,daroogada labaad,iyo waxi la mid eh?). Have you ever tried and failed to control, cut down or stop using khat?	**maya, marnaba** *No, never*	**Haa ,saddexdi billood ee u danbeesay** *Yes, in the past 3 months*	**Haa ,laakiin ma ahan saddexdi billood ee u danbesay** *Yes, but not in the past 3 months*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,...)	0	6	3

Question 8

	maya, marnaba *No, never*	**Haa ,saddexdi billood ee u danbeesay** *Yes, in the past 3 months*	**Haa ,laakiin ma ahan saddexdi billood ee u danbesay** *Yes, but not in the past 3 months*
Waligaa daroogo ma isku durtay? Have you ever used any drug by injection? (NON-MEDICAL USE ONLY)	0	2	1

Ogeysiis muhiim ah ***Important note:***

Bukaanka isku duray daroogo saddexdi billood ee u danbeesay waa in la weydiiyaa xilliyada uu isku duri jiray daroogada. Ogaanshaha xilliyaddan waxa ee sheegeeysaa heerka halista ee joogto iyo sida ugu wacan ee loo faragalin karo.

Hand out "risks associated with injecting" card, if YES. Brief Intervention will be given only for KHAT

Sida loo xisaabiyo xadka isticmaalka walxaha qaar.

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE

Wadarta walax kasto (lagu calaameeyay a. illaa j.) waa su'aasha 2 ilaa suaasha 7.haku darin natiijada laga helay suaasha 1 iyo suaasha 8 jawaabaha.tusaale ahaan ,natiijada cannabis-ka waxaa loo xisaabinayaa sida tan Q2c +Q3c+Q4c+Q5c+Q6c+Q7c

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do

not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be

calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c**

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT''S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Diiwangelinta natiijada walxaha qaar record specific substance score	Malaha faragelin no intervention	La farageliyay wax yar receive brief intervention	Aad loo daaweeyay more intensive treatment*
a. Miraa/Khat		0-10	11-26	27+

OGOW: qiimeeynta dheeriga ah iyo daawooyinka saaidka ah waxaa bixinaya qabiiro caafimaad ee jooga agagaarkaaga ama qabiiro ku takhasustay daaweeynta daroogada ama khatka ee meesha yaala.

NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s)

within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

KAARKA JAWAABTA EE BUKAANKA ***RESPONSE CARD FOR PATIENTS***

KAARKA JAWAABTA-WALXAHA

Response card – substances

a.	Miraa/Khat (Chat, Giza, Alene, Magoca,...)
b.	Walxaha tubaakada (sigaarka,tubaakada lacalaanjiyo iyo waxii la mid ah) *Tobacco products (cigarettes, chewing tobacco, cigars, etc.)*
c.	Kaniiniyaasha hurdada sida (valium, serepax, Rohypnol, iyo waxii la mid ah.) *Sedatives or sleeping pills (valium, serepax, Rohypnol, etc.)*
d.	Cannabis (marijuwaana,pot,grass,hash,iyo waxii la mid ah) *Cannabis (marijuana, pot, grass, hash, etc.)*
e.	Alcoholic beverages (beer, wine, spirits etc.)
f.	Inhalants (nitrous, glue, petrol, paint thinner, iyo waxii la mid ah.) *Inhalants (nitrous, glue, petrol, paint thinner, etc.)*
g.	nooc Amphetamine ah(xawli, diet pills, ecstasy iyo waxii la mid ah) *Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)*
h.	xashiish (coke, crack, iyo waxi la mid ah.) *Cocaine (coke, crack, etc.)*
i.	hallucination (LSD, acid, mushrooms, PCP, Special K, iyo waxi lamid ah.) *Halluzinogenes (LSD, acid, mushrooms, PCP, Special K, etc.)*
j.	Opioids (heroin, morphine, methadone, codeine, iyo waxi la mid ah) *Opioids (heroin, morphine, methadone, codeine, etc.)*
k.	kuwo kale – sheeg *Other – specify*:.....

Kaarka jawaabta (ASSIST suaasha 2-5)	***Response card (ASSIST Questions 2-5)***
Marnaba:ma isticmaalin 3 billood.	Never: not used in the last 3 months.
Hal mar ama labo :1 ama 2 mar saddexdi billood ee u danbeesay.	Once or twice: 1 to 2 times in the last 3 months.
Bille: 1 ama 3 mar bishi.	Monthly: 1 to 3 times in one month.
Isbuucle: 1 ama 4 mar isbuuci.	Weekly: 1 to 4 times per week.
Maalinle ama ugu badnaan maalin kasto: 5 ama 7 isbuuci.	Daily or almost daily: 5 to 7 days per week.

Kaarka jawaabta (ASSIST suaasha 6-8)	***Response card (ASSIST questions 6-8)***
Maya,marnaba.	No, Never
Haa,laakiin ma aha 3 billood ee u danbeesay.	Yes, but not in the past 3 months
Haa,saddexdi billood ee u danbeesay.	Yes, in the past 3 months

KAARKA JAWAABTA EE BUKAANKA. ***FEEDBACK REPORT CARD FOR PATIENTS***

MAGACA *Name*..... TAARIIKHDA TIJAABADA *Test date*.....

NATIIJADA WALXAHA QAAR *Specific substance involvement scores*

WALXAHA *substance*	NATIIJADA *score*	HEERKA QATARTA *risk level*		
a. Miraa/Khat		0-10 11-26 27+	HOOS DHEXE SARRE	*low* *moderate* *high*

NATIIJADAADA MAXEE KU MACNO TAHAY? ***What do your scores mean?***

HOOS : waxaa ku jirtaa xaalad caafimaad ee hooseesa iyo dhibaatooyin kale ee keentay isticmaalkaaga walxahan.

DHEXE: waxaa ku jirtaa xaalad caafimaad oo Qatar ah iyo dhibaatooyin kale oo ee keentay isticmaalkaaga walxhan

SARRE: waxaa ku jirtaa xaalad cafimaad oo darran oo aad kula kulmi kartid caafimaad xummi darran dhanka (caafimaad,bulsho,dhaqaale, xiriir sharci ah) oo ee kaliftay isticmaalkaaga walxahan

Low: *You are at low risk of health and other problems from your current pattern of use.*

Moderate: *You are at risk of health and other problems from your current pattern of substance use.*

High: *You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent*

Ma ka walwalsantahay isticmaalkaaga walxahan? ***Are you concerned about your substance use?***

b.khat	khatarta kaaga imaan karta waxa ee tahay... **Cunnida khatka si joogta ah waxaa la xariira**	hoose O	dhexxe O (sax hal)	sarre O
	Hurdo la´aan, cuntada oo kaa xiranto, miisaankaaga oo yaraada, caloosha oo ku socoto.			
	Caloosho ku fadhidhiisato, khal xanuun, madax xanuun, murqo xanuun.			
	Isbadal dabeecadeed, xanaaq, walaac, murugo, kacdoon, wali, qalqal, tuhun.			
	Ilkaha oo bolola, gargariir, wadno qaraac, neefta oo yaraato, galmada oo yaraato ama damac yari.			
	Xoogeysi, dabeecad dagaal, wadno xanuun, tusaale wadno qaraac.			
	Waali loo sababeenaayo ku celceliskadaawada.			
	Dhaawac maskaxeed joogta ah.			
	Beer xanuun, dhiig bax maskaxeed, kansarka afka.			

a. miraa/khat	your risk of experiencing these harms is... **regular khat chewing is associated with:**	low O	moderate O (tick one)	High O
	Difficulty sleeping, loss of appetite and weight loss, dehydration			
	Constipation, jaw clenching, headaches, muscle pain			
	Mood swings – irritability, anxiety, depression, agitation, mania, panic, paranoia			
	Teeth delay and loss, Tremors, irregular heartbeat, shortness of breath, impairment of reproductive function and sexual performance			
	Aggressive and violent behaviour, heart problems, e.g. palpitation			
	Psychosis after repeated use of high doses			
	Permanent damage to brain cells			
	Liver damage, brain haemorrhage, mouth cancer			

Fragebogen t1 Kontrollgruppe

Interview for Brief Intervention study

Magaca Waraystaha: _____

Name of interviewer

Taariikhda: _____ Wakhtiga: _____ Mudada Waraysiga: _____

Date *Time* *Duration of interview*

*Name of participant*_____

Phone number1: _____

Phone number2: _____

Section (place of interview): _____

Description of place where we find participant:_____

_____

_____

_____

Date for 4-week follow up (use the TLFB calendar to calculate)_____

INTERVIEWEE AGREED TO BE CONTACTED AND REMINDED ❑

CODE:(Numberka)_____Age:(dad a)_____ Date:(Tariiqda)_____

Miraa Use (Odenwald, Lingenfelder et al. 2007)		Haa *Yes*	Maya *No*
1	Labo iyo tobankii bilood ee u danbeeyay ma isticmaashay qaad *Did you use miraa within the last 12 months?*	❑	❑
2	Afartii asbuuc ee ugu danbaysay ma isticmaashay qaad *Did you use miraa within last 4 weeks?*	❑	❑

TIMELINE FOLLOWBACK CALENDAR

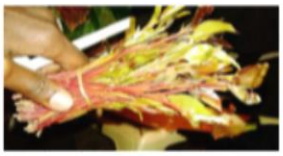
To help us evaluate your khat use, we need to get an idea of what your khat use was like in the past 30 days. To do this, we would like to fill out this calendar with you. It is not hard and I would like to try to be as accurate as possible. We recognize you won't have perfect recall. That's OKAY.The idea is to put a number in for each day on the calendar. On days when you did not chew, we should write a "0". On days when you did chew, you should write in the total number of standard units you had. (Show and explain standard units with extra pictures)

It's important that something is written for every day, even if it is a "0".

1 standard unit of khat is equal to



1 surba of Kangeta or



1 surba of Giza, Alenle, Asili, Lare or



1 bag of Magoka

Complete the Following (4 weeks): Start Date (Day 1): _____**End Date** (yesterday):_____

Day month year day month year

2014	SUN	MON	TUES	WED	THURS	FRI	SAT
AUG	17	18	19	20	21	22	23
	24	25	26	27	28	29	30
S	31	1	2	3	4	5	6
E	7	8	9	10	11	12	13
P	14	15	16	17	18	19	20
	21	22	23	24	25	26	27
	28	29	30	1	2	3	4
O	5	6	7	8	9	10	11
C	12	13	14	15	16	17	18
T	19	20	21	22	23	24	25
	26	27	28	29	30	31	1

Malmahee qaadka cunaysay.*For days when chewing miraa last week:*			
3	Imisa jeer ayaad si iskuxigta u isticmaashay khatka mudo dheer oo 24 saacdood ama in kabadan isbuuci lasoo dhaafay. *How many times did you continuously you chew miraa for extremely long periods of 24 hours and more last week? Times:* _____		
4	Asbuucii tagay malintii intee saacadood baa ku dhumisaa cunida qaadaka.*What is the usual number of hours spent chewing miraa per day in last week:* *Calculation:* _____ *days chewed x* _____ *hours per day ÷ 7 =*	_____hours	
5	Ma isticmaashaa khat indha fur ah markaa soo toosto. *Do you use Miraa when you wake up (Indha fur, to unlock yourselve)?*	Yes☐	No☐
6	Asbuucii ugu danbeeyay meel nooce ah baa qaadka ku dhex cuntay.*In what kind of social setting did you chew in the last week?* ❑Kaligay ugu badanaa *Mostly alone* ❑ Dadka dhexdooda ugu badanaa *Mostly with others*		
Asbuucii tagay jaadkaiyo hurdada:*Miraa and sleep last week*			
7	Asbuucii tagay afar iyo labaatan saacadood intee saac baa ka seexatay: *How many hours of sleep per 24 hours did you have last week*	_____hours	
8	Asbuuci tagay meeqo habayn ayaada seexan hurdo (inta u dhaxaysa 10 p.m. iyo 5 a.m.)? *How many times during the last week did you not sleep during the night (between 10 p.m. and 5 a.m.) because of miraa.*	_____times	
Nolashaada mudaada qaadka isticmaalaysay.*Duration of miraa use in one's lifetime:*			
9	Markii kugu horaysay oo aad isticmaashay qaad da dada.*What was your age when you first used Miraa*		
10	Markii ugu horaysay aad bilowday in aad isticmaasho qaadka si joogta ah da dada *What was your age when you started to use miraa regularly (weekly base*	_____	
11	Ma waxaa sitoos ah u bilawdey istic maalka qaadka markaa Nairobi timid. *Did you start to use miraa regularly after you came to Nairobi*	Yes☐	No☐
12	imisa sano ayaad jaad si joogta ah u cuneysay *How many years have you chewed miraa regularly in life?*	_____	
Functional Miraa use:			
13	Qaadka ma kaa cawiya in uu ku ilowsiiyo dareen xanuun leh sida dagaalka oo kale? *Does Miraa help you to forget painful experiences (e.g. war)?*	Yes☐	No☐
14	Qaadku had iyo jeer ma ku farxad galiya? *Does Miraa usually cheer you up/make you feel better?*	Yes☐	No☐
15	Goorma ayaa Kenya utimi qaxooti ahaan (Bukanka)? *When did you come to Kenya as a refugee? (Year)*		_____

Now I would like to ask some questions concerning your living conditions:

16	Gurigina nocee u dhisan yahay? *What is your home type?*	1 ❑ guri deer leh / house in own compound 2 ❑ lojin deer kamid ah/ lodge, i.e. part of a compound 3 ❑ guri dhan/ whole apartment 4 ❑ qeyb kamid ah guriga/ part of an apartment	
17	What is your household type:	1 ☐ Family-based household 2 ☐ Rent-sharing household of unrelated people 3 ☐ Other	
18	Gabi ahaan immisa qof ayaa ku nool gurigiina?wexay lamid tahay imisa qof aya halkan sexanayey afarti todobaad ee ugu danbesay? / *How many persons are there in total living in your household? That means, how many people were sleeping here most of the times in the last 4weeks?*		*No.*: Tirada:
19	maledihin boyeso/shaqalo/ *does your household have a househelp?*		❑ haa ❑ maya
20	maledihin alada intarnetka iyo kombutar/ *do you have a computer with internet?*		❑ haa ❑ maya
21	hadii aad xanusatid isbital nooce adaa/*in case you get sick, what type of hospital do you attend mostly?*		❑ dowladed/ public ❑ shaqsiyed/ private
22	maledihin makinada cunto karinta/*Does your household own a gas cooker?*		❑ haa ❑ maya
23	maledihin firinjeer /*Does your household own a fridge?*		❑ haa ❑ maya
24	Gurigiinu Gari ma leeyahay? / *Does your household own a car?*		❑ haa ❑ maya
25	Xaalad xaaseedka? / *What is your marital status?*	1 ❑ .Married(guur) 2. ❑ single(kali ahansho) (inclucing engaged or dating) 3. ❑ divorced(furiin)/separated(kala nolasho)/widowed(laga dhintay)	
26	Imisa sannadood ayuu/ayey tegi jirey/jirtay iskuul oo aanay ku jirin malcaamad quraanku? *How many years did you go to school excluding Koranic school?* _____*years*		
27	maxey qabataan /*What is your occupation?*	1. ❑ aan shaqeyneyn/ *not working* 2. ❑ guri jog/ *housekeeping*	3. ❑ *working (any)* 4. ❑ arday/ *student* 5. ❑ howl gab/ *retired*

28	Hadda waxaan jeclaan lahaa in aan ku weydiiyo inay jiraan in dad ka mid ah qoysku oo qaba cudurka dhimirka kuwaasoo aad u ba'an oo ka saameeyey qofka Masruufka ama dakhliga keena ama caawimada reerka qoyska in ka badan afartii toddobaad ee u dambeeyey ama adaya iskul? */ Now I would like to ask you if YOU have mental problems that are so severe that they affect YOU in providing income or helping in the household or going to school for at least four weeks?*

Now I´m coming to some questions on symptoms that we often find.

Screening questions for present delusions and hallucinations(Modified excerpt from CIDI, part G)(World Health Organization. 1997)			
During the last 4 weeks... TICK YES ONLY IF IMPLAUSIBLE! ASK FOR MIRAA!		Yes haa	No maya
29	Ma rumaysan tahay inay dad ku daba socdaan? *Do you believe that people are following you?*	❑	❑
	a. Sidee ayaad ku ogaatay inay dadku ku daba gurayaan ama ku daba socdaan *How do you know that people are following you? implausible?* _____ _____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
30	Ma hubtaa in qof aan adiga ahayni uu awooddaada kuu hayo ama uu ku kaantaroolayo? Sidaa darteed ficilkaaga iyo fikirkaaga aanay ahayn kuwaagii ama uu go'aaminayo qof kale. *Are you convinced that you are under control of some power or force, so that you actions or thoughts are not your own or determined by someone else?*	❑	❑
	a. Kuma ama maxay ayaa ku xukumaya ama kaantaroolaya/xukumid? *Who or what power or force controlles you? implausible?)*_____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
31	Mararka qaar ma dhacdaa inaad maqashid waxyaabo aanay maqlanayn dadka kula joogaa? *Does it sometimes happen that you can hear things other people can not hear?*	❑	❑
	a. Maxaad maqashaa? Sidee baad usharixi kartaa? *What do you hear? How do you explain this? (implausible?)* _____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
32	Mararka qaarkood inay ku dhacaan jidhkaaga oogadiisa ama jirka gudihiisa dareenno aan caadi ahayn- sidii adoo lagu taabanayo iyada oon cidi kuu dhoweyn ama aad dareento sidii adoo jirkaaga wax dhex socsocdaan? *Do you sometimes have unusual feelings on your skin or inside your body – like being touched when nothing is there or feeling something moving inside your body?*	❑	❑
	a. Maxaad dareentaa *What do you feel then? (implausible?)*_____ _____ _____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
33	Immisa maalmood, toddobaad, bilood amma sannadood ka hor ayay arrintani kugu bilaabatay? *How many days/weeks/years ago did these phenomena begin? a.*_____ b. Age:_____		

PHQ 9 – Murug *Depression* Labadii isbuuc ee ugu danbaysay ma ku dhibeen mid kamida dhibaatooyinkaan soo socda *Over the last 2 weeks, how often have you been bothered by any of the following problems?*		Not at all marnaba	Several days Dhowr maalmood	More than half the days Kabadan maalmaha barkood	Nearly every day Kudhawaan maaliin kasta
		0	1	2	3
34	Xiiso yar ama kuraaxeysato sameynta waxyaabo *Little interest or pleasure in doing things*				
35	Niyad jab,muruug iyo rajo la'aan *Feeling down, depressed, or hopeless*				
36	Kugu adkaato inad seexatid, iska jiifto ama hurdo badan *Trouble falling asleep, staying asleep, or sleeping too much*				
37	Daal aa dareemaysid ama awooda oo kugu yar *Feeling tired or having little energy*				
38	C unto xumo ama cunitaan badni *Poor appetite or overeating*				

39	Si xun aad dareemaysid, aad dareemaysid inaad fashilantay, ama dareemaysid inaad naftaada ama qoyskaaga hoos udhigtay (qiimo la'aan, dambiile,...) *Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down (feeling worthless, guilty, ...)*				
40	Dhib ay kugu tahay inaad wax xooga saartid sida aqriska wargayska ama daawashada televison *Trouble concentrating on things such as reading the newspaper or watching television*				
41	U dhaqaaqid ama u hadlid si tartiib ah taaso dadka kale ay dareemi karaan. tacbaan ama nasasha la'aan noqotid aad in badan dhaqdhaqaaqday kabadan inti caadiga ahayd *Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual*				
42	ku fakaraysid inaad dhimasho ku fiicnaan lahayd ama aad rabto inaad naftaada si uun u waxyeelayso. *Thinking that you would be better off dead or that you want to hurt yourself in some way.*				
43	Guud *Total*				

Soodhaweynta ogalanshaha gurmadka (caawinada). *Acceptance of self-help approaches(Odenwald, Lingenfelder et al. 2012)*		Haa *Yes*	Maya *No*
44	Mauaragtaa tagerid/gurmad/damashaad inaad lafarisato jiilkada/qeyrkaada lanahadashid. *Do you find it supportive/helpful/enjoyable to sit with peers and talk?*	☐	☐
45	Badanaa malafarisataa dariskaaga ama saxibadaada lanahadashaa. *Do you often sit with your neighbros or friends and talk?*	☐	☐
46	Mauaragtaa iney cawimaad kuutahay inaad kalahadashid dhibatoyinkaada koox jiilkaaga(qeyrkaaga). *Do you find it helpful for you to discuss decisions and problems with a group of peers?*	☐	☐
47	Mauaragtaa gurmaad inaad kamaqashid dadka kale iney qabaan dhibatoyin kuwaaga lamid ah. *Do you find it helpful to hear from others that they have similar problems?*	☐	☐
48	Maudarenta iney tahay wax loo bogo in koox dadka kamid ah eey wadagaandhibatoyin iskumid ah. *Do you feel comfortable in a group of people who share the same problems?*	☐	☐
49	Mauaragtaa iney fududahay inaad kahadasho dhibatoyinkaada hadaad ogtahay iney kulaqabaan dhibkaada oo kale. *Do you see it easier speaking out your problems if you know they have the same problems?*	☐	☐
50	Mauaragtaa iney fududahay inaad kalahadasho dibatoyinkaada qof kulamid ah intaa aad kalahadli leheed qof kutaqasusay. *Do you find it easier to talk about your problems to someone with a similar problem than to a professional.*	☐	☐
51	Magaraneysaa kulamo ladiyaariyey kuwaaso dadku dhibatoyin iskumid ah ufaristaan si wadajir ah una hadlan. *Do you know any organised meetings, were people with similar problems sit together and talk?*	☐	☐
52	Waligaa makaqeeb qadatay sida isku imansho wadajir ah ama fadi wadajir ah. *Have you ever participated in such a "coming together"/"sitting with others"?*	☐	☐
53	Guud ahaan makaqeeb qaadan leheeyd.*Would you generally participate?*	☐	☐

EVENT LIST (tick only if person felt helpless and terrified)

	NO	Lakulantay (experienced)	Goob joog ah (wittnessed)	
54		☐	☐	Shil khatar ah , dab ama qarax (tusaale: warshad, beer, gaadhi, diyaarad, ama shil doonyeed. *(accident, fire, explosion)*
55		☐	☐	Masiibo dabiici ah (tusaale: duufaano, daad, ama dhulgariir.) *(natural disaster, storm, flood, drought, earthquake)*
56		☐	☐	Weerar kaaga yimid dad qoyskaaga ah ama aad garanayso (tusaale: dhicid, garaacid,toogasho, tooriyeyn, qori ku qabasho.) *(Violent assaoult. by family member, for example being mugged, physically attacked, shot, stabbed or held at a gunpoint)*
57		☐	☐	Weerar kaaga yimid dad aadan aqoon (tusaale : dhicid,garaacid, toogasho, tooriyeyn, ama qori ku qabasho.)*(vioent assaoult by stranger for example being mugged, physically attacked, shot, stabbed or held at a gunpoint)*
58		☐	☐	Dagaal ciidan, ama goob dagaal. *(military combat or war zone)*
59		☐	☐	Waxaan ognahay in addunka dagaalada ka dhacaa ay sobabaan kufsi. Ma u malaynaysaa inuu ka dhacay Dalkeena wakhtigii Dagaalada sokeeye? *(We know that in the world violent rape of both, males and females happens in war zones. Have you heard about that this happened here or in Somalia?)* Ma maqashay inay ka dhacday Somalia? Ha: ☐ Maya: ☐ (Haddii ay tahay haa:) ma ku aragtay ishaada? *(witnessed)* Ha: ☐ Maya: ☐

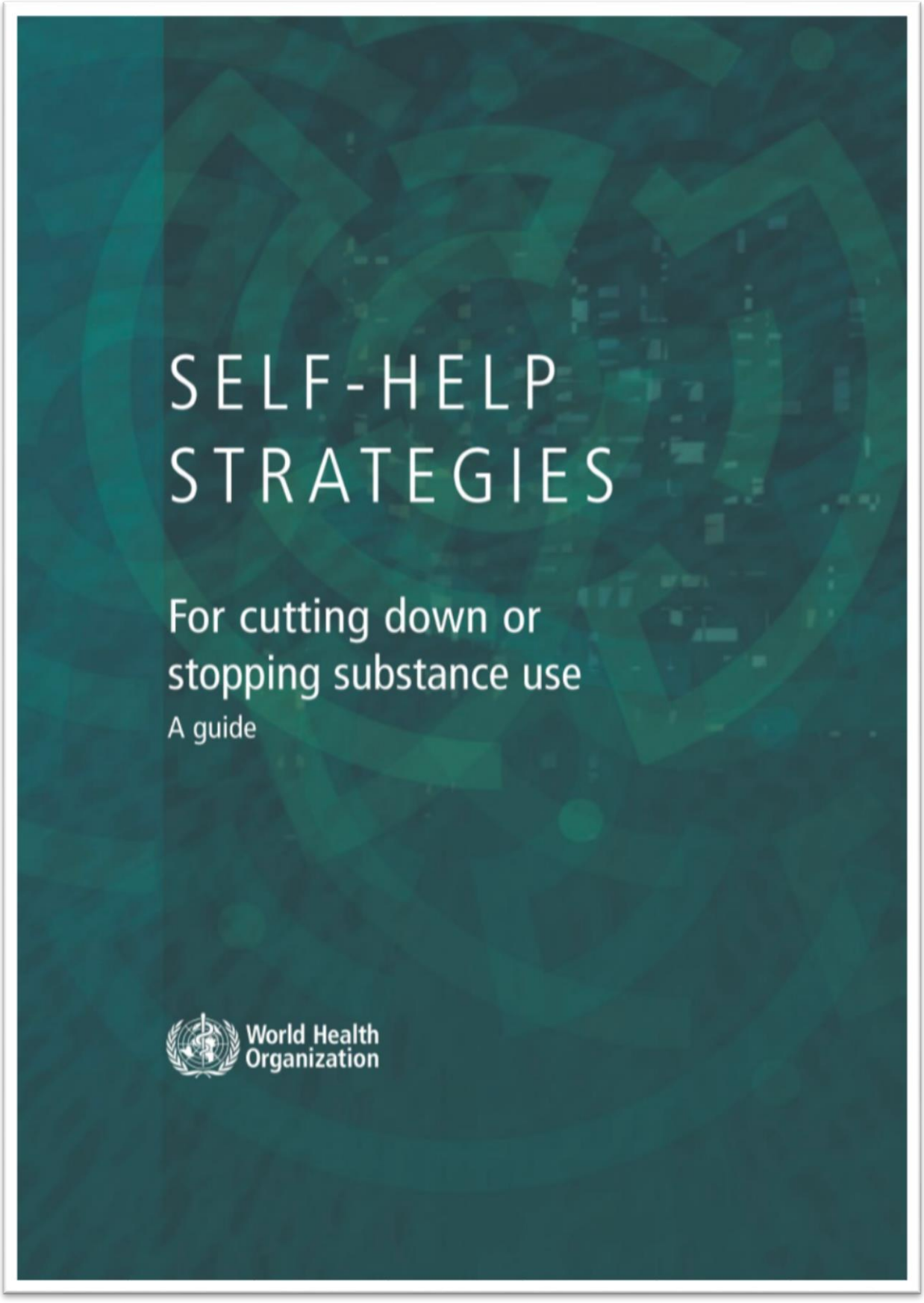
				Ma ku dhacday qof aad taqaanid? *(s.o.you know)*	Ha: ☐	Maya: ☐
60		☐	☐	Adiga ma kugu dhacday? *(experienced)* Adigu ma u noqotay dhibane cid aad garanaysid *(were you victim of s.o. you know?)*	Ha: ☐ Ha: ☐	Maya: ☐ Maya: ☐
61		☐	☐	'Maxbuusid (tusaale: xarig; maxbuus dagaal; qafaalasho; ama afduub.) *(Imprisonment, for example prison inmate, prisoner of war, hostage)*		
62		☐	☐	Jirdil. *(torture)*		
63		☐	☐	Cudur noloshaada khatar galiyey. *(life-threatening illness)*		
64		☐	☐	Dhacda kale oo reebtay saameyn. *(other)*		
65		*(Tilmaan wareyste: hadii 11 uu kaga jawaabay haa, wareystuhu wuxuu odhanayaa.)* Fadlan cadee dhacdada kale ee saameynta kuugu reebtay.*(specify)*				

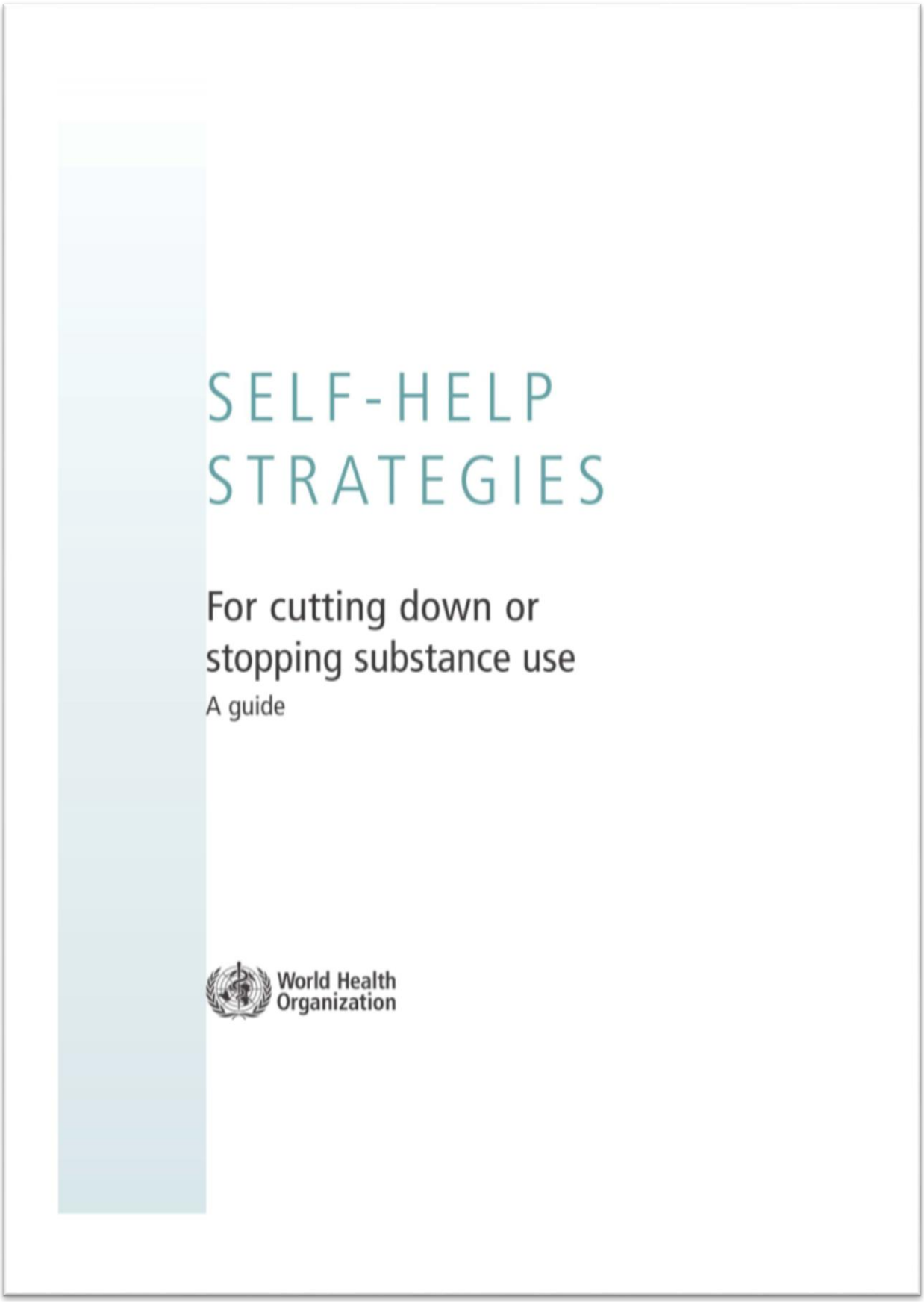
Worst Event (write number):_____

PDS Somali Short Version (Odenwald, Neuner et al. 2005) *(Rate yes, when already clear, if not probe again)*		Yes haa	No maya
66	Ma dareentay inaadan waxba qaban karayn, Ma dareentay argagax marka aad kusugan tahay xalad qatar ah ama markaad ufirsato si toos ah qof kale noloshiisa oo kusugan qatar? Hadey tahay maya kabood PDS. *Did you ever feel helpless or horrified when you were in a situation in which your life was in danger or when you directly observed that someone's else's life was in danger? If no skip the PDS*		
67	Majiraan Xusuuso kicinaya ama murugo naxdin leh oo la xariira dhacdada saameynta leh ee ku soo noqonaysa maskaxdaada adigoon rabin?. *Do you have upsetting thoughts or images about these bad events that come into your head even when you don't want them to? Did you experience this last month (= last four weeks)?*		
68	Ma isku daydaa in aadan ka fakarin, ka hadlin ama dareemin dhacdadaan ugu xun ee kugu dhacday. Miyaad sidoo kale ka fogaatay arintaan bishii lasoo dhaafay, (4tii asbuuc ee ugu danbaysay) *Do you try not to think about, talk about or have feelings about the most shocking experiences, that you had? Did you also avoid this in the last month (= last four weeks)?*		
69	Ma dareentaa in rajadaadii ama qorshahaagii mustaqbal aanay rumoobeyn, tusaale, inaadan yeelanayn takhasus, waxbarasho, guur, caruur, cimri dheer, ma lakulantaytan bishii ugu danbaysay (4tii asbuuc ee lasoo dhaafay) *Do you feel as if your future plans or hopes will not come true for example, you won't have a career, marriage, children or a long life? Did you experience this in the last month (= last four weeks)?*		
70	Dhibaatooyin maqabta markaad seexaneysid ama markaad jiiftid? Sidaan maisku aragtay bishii lasoo dhaafay? *Do you have trouble falling asleep or staying asleep? Did you experience this in the last month (= last four weeks)?*		
71	Ma fudfuduudahay ama manaxdaa (Tusaale:markaad si kadis ah qwylo umaqashid ama markaad si kadis ah uragtid qof gadaashaada socdo) sidaaan maisku aragtay bishii lasoo dhaafay? *Are you jumpy or easily startled (for example, when there is a sudden noise or when you suddenly find someone walking behind you?) Did you experience this in the last month?*		

Khat-adaptiertes

Selbsthilfemanual Englisch


SELF-HELP
STRATEGIES
For cutting down or
stopping substance use
A guide
World Health
Organization


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WHO Library Cataloguing-in-Publication Data

Self-help strategies for cutting down or stopping substance use: a guide.

1.Substance-related disorders - prevention and control. 2.Self care. 3.Attitude to health. 4.Internal-external control. I.World Health Organization.

ISBN 978 92 4 159940 5 (NLM classification: WM 270)

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Printed in France.

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1 Introduction

If you think your substance use is putting you at risk of experiencing health, social, legal, psychological, work or family problems then this guide will help you to weigh up your substance use behavior and give you some ideas about how to change it.



If you experience severe withdrawal symptoms or serious discomfort when you stop using alcohol, tobacco or other drugs, you should seek medical help from your doctor, health care worker or someone from a specialist drug and alcohol service.

THIS GUIDE IS DESIGNED FOR PEOPLE ABOVE 18 YEARS OF AGE WHO ARE AT MODERATE RISK OF SUBSTANCE RELATED PROBLEMS BUT DO NOT HAVE SEVERE SUBSTANCE RELATED PROBLEMS OR DEPENDENCE.



2 How do you know if you are at risk?

Different substances have different harms and risks.

For example you are at risk of experiencing problems:

- If you chew khat
- If you use tobacco products – especially by smoking
- If you have a high consumption of alcoholic beverages or drink to intoxication
- If you use substances such as cannabis, cocaine, amphetamine-type stimulants (including ecstasy and methamphetamine), inhalants, non-prescribed sedatives or sleeping pills, hallucinogens or opioids



If you have a copy of this document it may be because your doctor or health care worker has asked you some questions about your substance use and thinks you might be at risk of harm from one or more substances.

THE RISK OF EXPERIENCING PROBLEMS CAN VARY FROM INDIVIDUAL TO INDIVIDUAL AND DEPEND ON YOUR ENVIRONMENT, HOW MUCH YOU USE, THE WAY YOU USE, YOUR AGE AND GENDER ETC.

Your doctor or health care worker may have given you a feedback card and information leaflets which contain information about specific health problems related to the substance(s) you use.

IT IS POSSIBLE TO CHANGE SUBSTANCE USE BEHAVIOUR, MANY PEOPLE HAVE DONE IT.

3 What is a substance use problem?

Substance use problems can arise as a result of acute intoxication, regular use or dependence - and from the way in which substances are used.

It is possible for a person to have problems from all of these.

Using substances by injection can cause serious health problems no matter which substance is injected. Injecting any drug is a significant risk factor for contracting bloodborne diseases such as HIV and Hepatitis B and C. People who inject drugs have a higher risk of dependence and are likely to have more severe dependence than those who do not inject.

4 Getting started

You might already have decided that your substance use is causing problems for you.

Or, you may want to check whether you really are using too much. Either way the rest of this booklet will help you look at where you are now, and how you could make changes.

Changing our behaviours, including substance use, can seem scary or difficult but It is possible.

5 Getting support

You can use this guide by yourself without involving anyone else in what you are doing. However, it can be an enormous help to have your own supporter - someone who understands what you want to do and is willing to spend time helping.

A supporter needs to be someone you trust and feel comfortable with, such as your partner, a friend, a relative, someone at work, a nurse, a religious person, a counselor or a doctor. It is important that your supporter does not have a problem with substance use at the same time as trying to help you with your substance use.

If you ask someone to support you and, after thinking it over, that person says no, it is worth asking someone else. Many people appreciate being asked to help - it has rewards for them too.

Give your supporter this guide to read before you start, especially the Appendix "Advice for supporters".



As the saying goes, *A thousand mile journey starts with a single step.*

It doesn't really matter if you take breaks along the way: you'll still get there.

What counts is deciding you want to make changes, and then making them,

ONE SMALL STEP AT A TIME.

3

EXAMPLE

John is a 33 year old man who lives with his partner and their young child. He went to the doctor because he continually feels tired and has stomach problems. After a general examination the doctor asked John some questions about his khat use.

John chews 2 or 3 surba of khat most days and 4 surba in the weekend, and he has recently noticed some problems at home and work wich have been made worse because of chewing khat.

The doctor said that John was at risk of experiencing health and other problems from chewing khat and asked him to think about what those problems were.

4

6 Do I need to do something about my substance use?

You'll get an answer to this question by writing down any problems you think your substance use has caused over the last 3 months.

Think about what substance(s) you use and the problems you think it might be causing. You might find that one substance causes several problems, such as arguments with your family or partner, problems with your health – like not sleeping properly, feeling depressed, or feeling anxious or agitated. Some people find that using substances can affect their memory and concentration, which can cause problems with work or study.

EXAMPLE John´s list of problems due to his drug use

Substance	Problem
1. khat	Forgetting things
2. khat	Stomach problems
3. khat	Problems with my family
4. khat	Problems in concentrating at work



Do you think your substance use might have caused any problems for you over the last 3 months?



Write down any problems relating to your substance use here

Substance	Problem
1	
2	
3	
4	
5	
6	

You can experience problems from using substances if you get **intoxicated,** or if you use **regularly**, or if you **inject** drugs. If you inject drugs or use on a regular basis you can become dependent.

If someone else (family member, health professional, etc) has said anything about problems due to your substance use, these might need to be added to your 'Problem' list.

Whether or not you came up with any problems...

THE CHOICE IS YOURS.

YOU CAN CONTINUE ON AS YOU ARE OR YOU CAN CUT DOWN OR STOP YOUR SUBSTANCE USE.

5



OF COURSE, WHATEVER YOU DO WILL HAVE POSITIVE CONSEQUENCES (BENEFITS), AND NEGATIVE CONSEQUENCES (COSTS).

6

7 What is your substance use balance sheet?

Here is a substance use balance sheet to help you weigh up the effects of continuing as you are, cutting down or stopping your substance use. If you regularly use more than one substance you may like to fill in a balance sheet for each substance separately.

Think about both long term and short term positives and negatives.

EXAMPLE | Balance sheet 1. John's balance sheet looked like this.

	Continuing my present substance use pattern	Reducing or stopping my substance use
+	[X] Helps me relax after work [X] I unwind and forget the day Enjoy myself more at parties and with my friends	[X] I wouldn't be so tired [X] I would remember things better [X] My relationship with my partner would be happier and she wouldn't get angry with me [X] I would concentrate better at work [X] I wouldn't miss work so much
−	[X] Affects my memory [X] Affects my concentration [X] I feel hazy and tired after a big night [X] I sometimes miss work after a big night [X] My partner isn't happy about it and we argue about it [X] I spend a lot of time on contracting the supplier for obtaining the drugs	[X] It would be hard to relax after work [X] I wouldn't enjoy myself so much at parties My friends might laugh at me



Balance sheet 1

	Continuing my present substance use pattern	Reducing or stopping my substance use
+		
−		

Once completed, please review it again and mark the positives and negatives that are most important to you **(X)**.

8 Are you concerned about your substance use?

EXAMPLE | When John was asked: "How concerned are you about your substance use? On a scale of 0 to 10, where 0 is not at all concerned and 10 is extremely concerned.

0	1	2	3	4	5	(6)	7	8	9	10
Not at all concerned										Extremely concerned

John rated himself as a 6 because he was worried about his tiredness and forgetfulness and he wanted to improve his relationship with his partner. At the same time, he still felt that he really enjoyed smoking and would be sad to give it up.



Where do you rate yourself on this scale?



7

0	1	2	3	4	5	6	7	8	9	10
Not at all concerned										Extremely concerned

EXAMPLE Substances
John decided he was most concerned about his khat use. He wasn't concerned about any other substance because he wasn't using them regularly or excessively.



Rank the substances that concern you in the order from most concern to least concern
1
2
3
4
5
6

8

9 Measuring your substance use

You can work out how much you are using now by making a "substance use diary" of your substance use over the last week.

Go back over the week a day at a time and write down the information for each day (the time and place, who you were with, what you were using, how much you had, how much you spent) (See also the example below). At the end you will be able to see how much you used in the last week.

EXAMPLE: Substance use diary. This is how John´s diary looked the week before he went to the doctor.			
When? Where? Who with?	What?	How much?	Money spent
Saturday night, Ahmed´s Birthday party	Khat	4 surba	1000 KSh
Sunday, sitting with my family	nothing	N/A	N/A
Monday night, after work, relaxing with friends in their home	Khat	2 surba	500 KSh
Tuesday, I had to work until night	nothing	N/A	N/A
Wednesday afternoon, after work, relaxing with friends in their home	Khat	4 surba	1000 KSh
Thursday afternoon, after work, relaxing with friends in their home	Khat	2 surba	500 KSh
Friday afternoon and night, relaxing and later party with friends	Khat	4 surba	1000 KSh
When John looked over the week he was surprised to see he had chewed 16 surba of khat and spent 4000 KSh.			

START WITH YESTERDAY AND GO BACK OVER THE WEEK. WRITE DOWN:

THE TIME AND PLACE OF YOUR SUBSTANCE USE.



WHO YOU WERE WITH



WHAT YOU WERE USING

HOW MUCH YOU HAD

HOW MUCH YOU SPENT



9



Fill in this "substance use diary" for your substance use over the last week

When? Where? Who with?	What?	How much?	Money spent

10

If you chew khat, you are at risk of a range of health and other problems, especially if:

- You chew more than 2 surba per day
- You don´t have at least 2 days of the week when you do not chew

There is no risk-free level of khat chewing, and for many people consumtion of 2 surba per day can still be associated with significant risks.

There are certain factors which may increase your risk, such as:

- A family history of khat dependence
- You weight less than other people for your gender and height
- You have not eaten anything recently

You should not chew at all if you are:

- Pregnant or brest feeding
- Driving, operating machinery or undertaking other activities that involve risk
- You have health problems which may me made worse by khat
- You are taking medicine which directly interacts with khat
- You cannot control your chewing

A standard unit of khat is:

- 1 surba of Kangeta
- 1 surba of Giza, Alenle, Asili or Lare
- 1 bag of Magoca







THERE IS NO SAFE LEVEL OF CONSUMPTION FOR ALCOHOL, DRUGS AND TOBACCO PRODUCTS.

Smoking is the most harmful method of using tobacco.

Smokeless varieties such as chewing tobacco, snuff (which is inhaled) and snus (which is placed between gum and lip and absorbed) are also risky.

11



ON BALANCE ARE THERE ANY REASONS FOR YOU TO CHANGE?

12

11 Making a decision

Now, look back over your balance sheet, your substance use diary and your problems relating to substance use.

Are there any reasons for you to change?

EXAMPLE | John decided that there were reasons to change so he marked the box.

[X] Yes - Go to Chapter 12

No - You may not want to continue with this booklet now

Not sure - Write down the reasons why in the table below and consider talking it over with your supporter.



Mark your decision below

- ☐ Yes - Go to Chapter 12
- ☐ No - You may not want to continue with this booklet now
- ☐ Not sure - Write down the reasons why in the table below and consider talking it over with your supporter.



Reasons to change my substance use

1	
2	
3	
4	
5	
6	

12 Choosing your goal

Now that you've decided to make a change to your substance use, your next decision is whether you'll use less, or stop using altogether.

To help you make up your mind, do the following three tasks:

1 **Think about these questions**

- Do you have any health or psychological problems that might be made worse by your substance use? Your doctor or other health professional can advise you.
- Do you experience withdrawal symptoms when you stop using? If so, stopping use entirely is probably the best goal for you. Your doctor or other health professional can help you manage the withdrawal symptoms. Please also see Chapter 17 on *Setting targets: How to stop*.
- Do you have any legal, financial or work related problems as a result of your substance use?
- Do you have any relationship or family problems because of your substance use?
- Have you solved substance use problems before by stopping completely? Then this might be your best way now.



WILL I CUT DOWN – OR WILL I STOP MY SUBSTANCE USE?

Remember what you decide now might not be the decision you follow for the rest of your life. You can review your substance use goal regularly. Whatever goal you choose it's a good idea to talk it over with the person you are closest to.

13

2 Write down in the following balance sheet where you can write down the positives and the negatives of cutting down or cutting out.

EXAMPLE | Balance sheet 2. John completed the balance sheet and decided to cut down his cannabis use.		
	Cutting down	Stopping Completely
+	[X] I could still use cannabis with my friends sometimes [X] I would still have fun at parties [X] Using less means I wouldn't be so tired and forgetful [X] If I only use at weekends I wouldn't miss work [X] My partner would be pleased and we would argue less	[X] I wouldn't be tired and forgetful [X] I wouldn't miss work [X] My partner would be happy [X] I would save money by not buying the drug
–	I won't be able to relax with a few pipes after work every day	[X] I would really miss the fun times with my friends [X] I would really miss relaxing with a few pipes after work. My friends would laugh at me [X] I wouldn't enjoy myself so much at parties

14

Once completed, mark the positives and negatives that are most important to you **(X)**.



Balance sheet 2		
	Cutting down	Stopping completely
+		
–		

3 Choosing your goal. Looking over what you have written, which do you feel is the best goal for you?



Mark your answer below

☐ To **cut down** your substance use - Go to Chapter 18
☐ To **stop** substance use completely - Go to Chapter 17

} but before read the Chapters 13 through to 16

13 Changing the way you use

If you have decided to cut down, you might want to think about the way you use the substance, and consider less harmful alternatives.

For example, you may want to consider stopping injecting, or changing from injecting to another, less risky way of using substances.

If you inject drugs you increase the risk of harm from the drug, as well as harms that result from injecting.

Injecting amphetamines or cocaine increases the risk of psychosis and dependence.

Injecting heroin and other depressant drugs increases the risk of dependence and overdose.



It is also better not to inject because of the risk of blood-borne viruses (Hepatitis B and C, HIV/AIDS) and other infections. If you still inject, you may want to consider making some changes to reduce the risks from injecting. Like, for example, using clean equipment (e.g. needles and syringes, spoons, filters etc).

It is always risky to use drugs, but there are ways to reduce your risks if you choose to keep using.

REDUCE THE RISKS:

- DON'T DRIVE OR UNDERTAKE DANGEROUS ACTIVITIES WHILE USING DRUGS.
- IF USING DRUGS, USE SMALLER AMOUNTS AND USE LESS OFTEN TO AVOID BECOMING DEPENDENT.
- DON'T USE DAILY.
- DON'T USE DRUGS WHEN NO HELP IS AVAILABLE IF SOMETHING GOES WRONG.
- DON'T USE MULTIPLE SUBSTANCES ON ANY USING DAY.
- DON'T USE DRUGS WHILE YOU ARE PREGNANT OR BREAST FEEDING AS IT CAN AFFECT YOUR BABY.

15

Goal setting techniques will help you achieve your goals.

GOALS SHOULD BE **SMART**:

SPECIFIC
MEASURABLE
ATTAINABLE
REALISTIC
TIME BOUND

16



14 My contract with myself

Now that you have made some decisions about your substance use and what you want to do about it you can write yourself a contract (see also examples below). This will help to remind you exactly what you have decided to do.

EXAMPLE | My contract with myself
EXAMPLE A
I will stop using (substance) on ..../..../....
EXAMPLE B
I will cut down my (substance) use to no more than once per fortnight starting from ..../..../....
I will do this for three months until ..../..../.... when I will review my progress.

My contract with myself
I will…
I will…
I will…
I will…
I will…
I will…

15 Moving ahead

To be able to make the changes you have decided to make, you can keep track of your substance use by keeping a weekly substance use diary (similar to the one you used in chapter 9).

Use the weekly diaries that are included at the end of this guide and follow these instructions:

- Keep your diary every day.
- Write it up when **you did** use or when **you felt** like using (there is an extra column in the diary called 'wanted to use but didn't' for you to record this).
- Keep it for 3 months. This will help you to see changes. Later, you can record "spot checks" for a week or two every few months.
- Add up the money you've spent on substance use.
- If you like, review your diary with your supporter.
- Put a cross against 'high risk times' - when you had more than you meant to, or had a strong urge to use.
- Read what you have written and think about it several times a week.

Your diary shows you just what is happening, and when and where change is occurring.

The diary also makes it easier for you to spot your "high risk" situations – times when you use substances, or use too much, or badly want to use.

The situations that make you feel like using might be when you are with certain people, or in a certain place. It might also be how you are feeling - angry or upset, or may be happy and relaxed.

KEEPING A 'SUBSTANCE USE DIARY'.

Information in your diary is private, ensure keeping it in a safe place.

THIS IS AN IMPORTANT PART OF HELPING YOU MAKE CHANGE.

17

16 High risk situations

WHAT ARE YOUR HIGH RISK SITUATIONS?

What situations, circumstances, places or feelings make you want to use substances?

Are there particular situations when you use drugs or use more than you intend to, or use when you don't mean to?

If you can identify your high risk situations - where you used drugs or used more than you meant to or badly wanted to use - it will help you in setting guidelines for yourself:

- In particular places where it is easily available e.g. home, a friend's place, a club, etc?
- Around certain people e.g. partner, particular friends, etc?
- At particular times e.g. after dinner, weekends, celebrations etc?
- Your high risk situations may also be tied to certain emotions such as when you feel depressed, angry, guilty, stressed or worried.
- Think of the last few times your substance use got you into trouble... and when it didn't. What's the difference between these occasions?

To identify them it can help you to have a look at the '*substance use diary*' on page 10 and then list them in the following table (see also an example below).

EXAMPLE | John identified his high risk situations and found he was most likely to smoke cannabis...	
1	To help me relax when I get home from work
2	When I am watching TV
3	When I am with my friends on the weekends
4	At parties with friends
5	
6	



List your 'high risk situations' here	
1	
2	
3	
4	
5	
6	

17 Setting targets: how to stop

If your goal is to stop substance use completely:

- Don't postpone. Decide a target date to stop using the drug. Stop on that date.
- Declare publicly your intention to stop. This will help to mobilize others and you towards maintaining abstinence.
- Stay away as much as possible from the cues and triggers which remind you of drug use.

You may face withdrawal effects after stopping use. Seek support from your health care provider if the withdrawal effects are serious.

How to avoid relapsing

Relapsing means returning to drug use after you have stopped for a while. It is important to identify the situations that could trigger relapse for you. This will help you to stop it from happening.

Common triggers for relapse include:

- When you are experiencing emotions such as frustration, anger, fear, anxiety, tension, depression, loneliness, sadness, boredom, jealousy, worry, grief or loss.
- When you are coping with the physical symptoms of drug use such as craving or withdrawal.
- If you try to test your will power or ability to control yourself.
- When you are coping with problems arising from arguments and disagreements.
- Pressure from others to use drugs.

Please also see *How to cope with cravings* and *How to say no* in this guide where you can learn more about relapse prevention.

NO SUBSTANCE USE IN ANY SITUATION.



RETURNING TO DRUG USE AFTER YOU HAVE STOPPED FOR A WHILE IS COMMON. IT'S NORMAL TO FEEL DISAPPOINTED, BUT THE TRICK IS NOT TO LET IT CONTINUE.

19

SETTING SUBSTANCE USE TARGETS.

20

18 Setting substance use targets: how to cut down

If your goal is to cut down you will need some targets like these

- How many substance free days per week or month?
- How often will I use?
- How many times will I use on using days?
- What is the maximum amount I will use at any one time?
- How much will I use in a week or month?
- What are my high risk situations where I'll avoid using?
- How will I administer the substance?
- How will I reduce the risk of harm?

EXAMPLE | John decided the following strategy would work best for him...	
1	I will avoid smoking cannabis after work on weekdays (Monday to Friday)
2	I will only smoke cannabis on one night of the weekend
3	I will not smoke any more than two pipes of cannabis in any one day
4	I will avoid buying large amounts of cannabis because it is too tempting
5	
6	



My "substance use guidelines" are...
1
2
3
4
5
6

19 How to cope with cravings

Cravings occur when the chemistry and function of your brain changes because of regular drug use.

Try to identify your triggers for cravings. It can help to use a craving diary.

Summarize your cravings under the headings of 'behaviors', 'physical feelings' and 'thoughts'.

EXAMPLE | John's craving diary

Place and time	Thoughts	Physical feelings	Behaviors
23rd June **Evening** **Friend's place**	"I feel I need it now" "I can't get it out of my head" "It calls me"		
23rd June **Evening** **My House** **Old Street**		"I suffered from cravings, I felt pain in my stomach" "I started smelling it"	
23rd June **Evening** **Old Street**			"I went down a street where I used to use drugs with my friends and I immediately had strong cravings"

Cravings are common and normal: they are not a sign of failure.

Abstinence is the best way to ensure complete removal of cravings.

HOW TO COPE WITH CRAVINGS:

- DELAY
- DISTRACT
- DECIDE
- POSITIVE SELF-TALK
- RELAXATION & IMAGERY

21



Craving diary

Place and time	Thoughts	Physical feelings	Behaviors

You can use the following techniques to deal with your triggers for cravings:

Delay – Delay your use of drugs for 30 minutes. The cravings should lessen, or pass, as may your desire to use.

Distract – Do not sit in one place thinking about drugs while you are having cravings. Get busy! Distract yourself with another activity. This could include chores or a hobby.

Decide – Make a list of positives and negatives about your drug use to remind you of why you have chosen the goal of abstinence.

Positive self talk – Talk to yourself out loud about how cravings are destructive feelings that WILL pass with time. Talk yourself through the consequences and the problems you will have if you start taking drugs again.

Relaxation and imagery – Relaxation exercises using positive and relaxing images can be used to take your mind off an urge to use drugs.

20 Helpful tips

After a break from drug use people often find that changing their daily activities can help them to resist returning to drug use.

These tips will help you no matter what your goal is:

- Make sure you have a healthy diet and get plenty of sleep.
- Establish a regular exercise routine – walking, yoga, the gym.
- Drink plenty of water and other non-alcoholic drinks.
- Keep busy with non substance use activities.
- Take up new hobbies or spend more time on old ones.
- Keep yourself active and busy.
- Make non using friends.
- Put the money you save into a special fund to save up for something you really need or want.
- Find paid employment, or do volunteer work.

These tips will help if your goal is to cut down:

- Never buy more than the amount you plan to use in one session.
- Avoid having a stash that might tempt you to use more.
- Start using later than usual and finish earlier and keep this tendency progressing.
- Declare regular non use days – at least..... days per week.



List any other "helpful tips" you can think of
1
2
3
4
5
6

THESE TIPS WILL HELP YOU STICK TO YOUR SUBSTANCE USE TARGETS, NO MATTER WHAT YOUR GOAL IS.

23

YOU WILL FEEL MORE IN CONTROL IF YOU HAVE PREPARED FOR A DIFFICULT SITUATION.

IF NOTHING SEEMS TO HAVE WORKED, SEEK HELP - FROM YOUR SUPPORTER, FRIEND, PARTNER, THE PERSON WHO GAVE YOU THIS BOOKLET OR A PROFESSIONAL COUNSELLOR.

21 Handling high risk situations

Earlier on we looked at how to identify high risk situations - the times, places, occasions, people, thoughts and emotions which might trigger your substance use or your urge to use.

Identifying your high risk times is step one. Step two is learning how to handle them. Rather than wait until you are under pressure, work out beforehand some ways of coping with these situations.

You could decide not to use or delay using. Alternatively you could distract yourself by getting involved in doing something else. You could also make a list of all the benefits you have gained by not using, as well as all the things you will lose if you do use. This can help you decide what to do.

A method that many people find works well in preparing for high risk situations is the **problem solving approach**. Complete the table on page 25 (see also the example).

This is really good for solving other sorts of problems as well.

1 Identify the problem.

2 Brainstorm ideas for handling it - don't be too fussy. Write down even those that may seem crazy or impractical.

3 Think what is likely to happen if you try each one and then select those you feel will be most effective.

4 Try one out. If your first choice doesn't work, try the next one. Keep on trying until you find one that works. If what you tried doesn't work, repeat 3 and 4 until you find something that does.



EXAMPLE John identified his high risk situations and used the problem solving approach to decide what to do in those situations	
High risk situation A	I use khat in the evening to relax and to socialize with my friends
Brainstormed solutions	I´ll go home and see my partner I´ll play with my child I´ll call my parents or relatives I´ll meet my brother to play basketball I´ll watch a movie with my family
Best solutions	Play basketball with my brother
What happened	We played and afterwards I saw my family and we had dinner together
High risk situation B	I chew khat when I want so stay awake or concentrate
Brainstormed solutions	I think about if I cannot do the work the next day and sleep I drink a tea I nap for 20 min and continue the task I ask someone to support me with it
Best solutions	Napping for 20 m in
What happened	I woke up and managed to continue without khat

25



High risk situations	
High risk situation A	
Brainstormed solutions	
Best solutions	
What happened	
High risk situation B	
Brainstormed solutions	
Best solution	
What happened	

PREPARE YOURSELF TO SAY 'NO'



26 CREATE YOUR OWN REFUSAL STYLE.

22 How to say 'no'

One good way to control your substance use is to say 'no' when someone offers you substances.

If you have always said 'yes' in the past it can be hard to say that first 'no' but once you've said it once it becomes easier to refuse the next time. You'll feel good about yourself too.

A simple 'no thanks, not tonight' can be effective. Or you can say:

- 'No thanks, I'm cutting down.'
- 'No thanks, I'm having a rest for a while.'
- 'Sorry, doctor's orders, but you have some if you want to.'

You might find that people accept you saying 'no' without a problem. If it is a problem for people, and you feel uncomfortable about being asked you might have to leave the situation and recognise that **this is a high risk situation and perhaps you need to avoid it.**

Plan and practice your refusal to deal with high risk situations.

Create your own refusal style by using body language as well as what you say

Tips for using body language	Tips for what to say
• Look directly at the person when you answer - it increases the effectiveness of the message. • Stand or sit up straight - it shows you are confident in your choice. • Don't feel guilty about refusing - it won't hurt anyone if you choose not to use. • Leave the room if the other person keeps insisting or pushing.	• Use a clear, firm, confident voice. • 'No' should be the first word out of your mouth. • Suggest an alternative activity if you want to do something else with that person. • Tell the person offering you drugs not to ask you now or in the future to stop them from asking you again. • Change the subject to something else. • Avoid using excuses and vague answers as these imply you might change your mind later.

23 Sticking to your targets

This tips will help you

- Keep going over your reasons for wanting to stop or cut down on your substance use. Check your balance sheet to remind yourself why you wanted to make changes.
- Regularly check your substance use diary. See how much you are using now compared with before.
- Read and re-read your targets, especially on substance use days.
- Distraction: keep yourself occupied – e.g., exercise, housework, movies, gaming, yoga, tai chi, enrol in a course, gardening, etc.
- Every time you resist an old habit you come a step closer to overcoming it. If you feel you've got to use, get busy with something else, quickly. The feeling will pass.
- Aim to talk to your supporter every week. Tell them how you are going. Talk about the good things as well as the bad.
- Don't give up just because you've had a bad day. Be kind to yourself. Think "I'll do it differently next time". Remember the problem solving approach.
- Give yourself a pat on the back and reward yourself with something you enjoy. This could be shopping, going for a walk in your favourite spot, having a bath, listening to music, going out with friends, having a nice meal. Reward yourself often instead of saving up and bingeing on one big reward.
- Be kind to yourself even when you think you haven't done very well. Tell yourself that change doesn't happen overnight and be patient. The smallest step in the right direction takes you towards your goal.

So far, you've written out your substance use balance sheets, your goal and substance use targets. You've also looked at your high risk situations and ways to handle them.

NOW YOU NEED TO STICK WITH THEM.

27



If your substance use is getting out of control, get help. Speak to your supporter, your primary health care worker, a friend or a specialist alcohol and other drug service.

IT'S YOUR CHOICE.

THERE IS ALWAYS AN ALTERNATIVE TO SUBSTANCE USE.

24 When things go wrong…

It's not the end of the world if you stray from your targets.

The trick is not to let any extra substance use continue. Get back to those targets. Look at what happened. Was this a high risk situation that should be on your list? If so, perhaps you need to think of new ways to cope.

Look again at your balance sheet. Is this the best goal for you? Talk it over with your supporter or a health professional.

Above all, be honest with yourself.

25 Alternatives to substance use

For many people, substance use has become a part of their life. It is a habit they feel lost without. But, just as you made a habit in the first place, you can make a new one, step by step.

Every time you stop yourself from following an old substance use habit, you are laying a path to better and safer habits.

You can choose not to use. If so, make your choice easier by finding enjoyable alternatives and non using company.

Many people who use substances say they most want to use when they are trying to cope with uncomfortable feelings about themselves or their lives.

You need to find new ways of coping with your feelings, without substances.

Open up - share your feelings with your partner, a friend, your supporter or a counsellor. Look for activities you enjoy doing.

Be around people who inspire you.

Take courses, read books, watch movies and listen to music that can help you to a happier, healthier lifestyle.

Appendix A

Advice for supporters

Someone close to you - maybe a friend, spouse, or relative, has asked for your support to help them stick to their targets regarding substance use.

Read through the guide with them. Ask them how they would like you to help them handle risky situations and achieve their goal and targets.

They may want to contact you when they are having difficulties sticking to their plan. Let them know where and when they can talk to you.

They might find it helpful to go over their progress with you and discuss any problems. You will encourage them if you congratulate them on their successes. Avoid criticizing or blaming if they do slip up.

Arrange to reward the person you are supporting when they achieve their targets. This could be cooking them a meal, going to a film - anything that is special to them.

HOW CAN YOU HELP?

Remember that changing habits is not easy and there may be times when the person does not stick to their target.

They may need your support in helping them to get back to their targets regarding substance use.

Help them to see the slip up as a one-off lapse, NOT as a reason to give up on their targets completely.

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EXIT THE MAZE OF
HARMFUL SUBSTANCE USE
FOR BETTER GLOBAL HEALTH
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ISBN 978 92 4 159940 5
9 789241 599405

Khat-adaptiertes

Selbsthilfemanual Somali


Xeeladaha caawinada nafta
Yareenta ama joojinta isticmaalka khaatka
hagiid
World Health Organization

Waxyaabaha

1 Hordhac

2 Sideed u ogaata inaad khatar kujirtid

3 Waa maxay dhibaatada isticmaalka daroogadha

4 Bilaabatay

5 Helida teegeerida

6 Ma u baahantahay inaa wax kaqabto waxyalahan aad isticmaaleso?

7 Waa maxay cabirka isticmaalkaada waxyalahan?

8 Makugu yeelatay saameeyn walwal ah isticmaalka waxyalahan?

9 Cabiraada adeegsiga maandooriyaha

10 Intee in la eg aa xad dhaaf ah

11 Go'aan gaarid

12 Doorashada hadafkaada

13 Badalida sida aa u isticmaashid

14 Heshiiska aan nafteyda lagalay.

15 Horray usocod

16 Xaaladaha aadka qatarta u ah

17 Sameeynta haddaf:sida loo joojiyo

18 Isku habeynta haddafka isticmaalka walxaha:sida loo yareey

19 Sida tabashada laisaga caabin lahaa

20 Talooyin wax tar ah

21 Xalinta xaaladaha halista ah

22 Sida loo dhaho "maya"

23 Ku dhag hadafkaaga

24 Markee wax qaldamaan

25 Kubadalka waxyaalo kale booska isticmaalka walxahan

Lifaq

A Waano kusocota lataliyaaasha

1 Hordhac

Hadaad umaleyneysid waxyaalaha isticmaaleysid iney ey khatar ku galinayaan dhinaca caafimaad, bulsho, sharci, maskixiyan, shaqo ama dhibaatoyiin qoyseed kadib haagahaan ayaa kugu caawinaayan sida aa umiisaami leheed dabeecadada isticmaalkaaga maandooriyaha waxeyna fikrado kaa siinaysaa saa ubadalilaheed.



Hadii aad isku aragtay astaamaha daran ama raaxa la'aan marka aad joojisid isticmaalka khaatka waxaad ka raadsataa caawimaad caafimaad dhakhtarkaaga, ama qof ku taqsuusay adeegyada maandooriyaasha

Hagahaan waxaa loo hagaajiyay dadka da'doodu ey ka weyntahay 18 sano kuwaaso kujira khatar dhexdhexaad oo oga timid waxyaala laxiriira dhibaatoyiinka lakin eysan qabin dhibaatooyin daran oo kusaabsan isticmaalka waxyaalaha

2 Khatar sideed u ogaata inaad kujirtid

Waxyaala kala duwan waxey leeyihiin dhibaatooyin kala duwan iyo khataro. Tusaale ahaan waxaad kujirtaa khatar lakulmid dhibaatooyin maandooriyaha waxeyna fikrado kaa siinaysaa saa ubadalilaheed.

- Hadaad khaat cuntid (tusa`ale giza , kangeta, mogoca.)
- Hadaad isticmasho tubako gaar ahan sigaarka
- Hadaad qabtid isticmalka sare ee qamriga eeh mise cabitanada maskaxda maan dhoriya
- Hadaad isticmasho waxyalaha sida cannabis,cocaine,amphetamine-type stimulants(oo kujira ecstasy iyo methamphetamine) nefsado,xanuunka aan uqorneeyn kaniniyada hurdada,hallucinogens mise opioids



hadii aad hasatiid koobi waraaqahaan waxey noqon karta daqtarkaaga ayaa kuweydiiyay suaalo kusaabsan isticmaalkaaga maandooriyaha wuxuuna umaleeya in aad khatar dhibaatooyin kujirtid oo ka imaaday hal ama waxyaalo kabadan

khatarta lakulmida dhibaatooyinka waxey u gudbi karta shaqsi ila shaqsi waxeyna kuxirantahay deegaankaaga, inta aad isticmaashay, si aad u



Dhaqtarkaaga aa laga yaaba inuu kusiiyo warqada jawaabtaada iyo warqado warbixin kusaabsan dhibaatooyinka caafimaadka oo laxariira isticmaalka jaadka

2

WAA SUURTAGAL IN AAD BADASHO DABEECADAADO ISTICMAALKA JAADKA, DAD BADAN AYAA SAMEEYAY

3 Waa maxay dhibaatada isticmaalka daroogadha

Maandoorinta maskaxda waxay kadhalataa isticmaalka walxaha daroogada si joogta ah ama sikalantaali ah iyo sida kala duwan oo loo isticmaalo

Waxaa macquul ah qofka inuu kala kulmo dhibatooyin badan isticmaalka walxahan

Iskudurida cirbadaha daroogada waxeey sababi kartaa dhibaato daran oo dhanka caafimaadka ayadoo loo eegeenin walxaha aa isticmaashay.Iskudurida daroogada waxeey qeyb libaax ka qaadataa sababida cudurada waa weeyn ee ka mid yihiin HIV AIDS iyo HEPATITIS B iyo C.dadka iskudura daroogada waxeey qatar ugu jiraan ineey waayaan kalsoonida gooni unoolaanshaha

4 Bilaabatay

Laga yaabo isticmaalka walxahan inaad fahantay inee lid ku tahay caafimaadkaada.

Ama waxaa laga yaabaa inaa rabtid inaa hubsatid inaad u isticmaaleesid si saaid ah iyo inkale walxahan

Badalida dabeecadeena ku aadan isticmaalka walxahan waxeey u muuqataa mid cabsi gelin leh laakiin ma ahan mid macquul aan aheyn.

5 Helida Teegeerida

Waa isku hanuunin kartaa arintaan adigoon qofna ubaahneeyn,hadaba waxee noqon kartaa saacideeyn weyn inaad heshid saacideeya-qof oo fahmaaya waxa aad u baahantahay inaad sameeso iyo waxa aad rajeeneesid in lagaa cawiyo

Caawiya waxa laga rabaa inuu noqdo qof aad aamini kartid kuna dareemeesid qanac sida lamaanahaga,saaxiibkaada,qaraabadaada,qofka meesha shaqada,kalkaaliso,qof diin leh,lataliyaha ama dhaqtar.Waa muhiim in caawiyahaaga uusan laheen dhibaatooyin xagga walxahan daroogada ah sida adiga oo kale.

Haddii aa weydiisatid qof inuu ku caawiyo ka fakarid dheer kadib,qofkaasna uu dhaho kuma caawin karo.weeydiiso caawimaad qof kale sababtoo ah waxaa jiraan dad badan oo ku faraxsan inee ku caaawiyaan.waxee u tahay guul caawimaadaada.

Sii caawiyaahaaga arimahan si uu u aqriyo inta uusan bilaabin qaasatan lifaaqa "talo katimid saacideyaasha"



Somali waxeey kumahmahdaa safar kasto hal tilabo ayuu kabilawdaa

Muhimada ma ahan in aad waqtiyo u dhaxdhaxeysid, lamagorabo waad gaareysaa

Tilabo katilabo halkii waqti.

6 Ma u baahantahay inaa wax kaqabto waxyalahan aad isticmaaleso?

Waxa heleesaa jawaabta saxsaan marka aad qortid dhibaatooyinka aa is leedahay wee kugu sababtay isticmaalka waxyalahan 3 bilood ee lasoo dhaafay.

Ka fakar waxad isticmaleso iyo dhibaatooyinka aa isleedahay wee sababi kartaa.waxa laga yaabaa inaa heshid inee hal wax ee sababeeso dhibaatooyin badan sida muran aa lamurantid qoyskaaga,lamaanahaaga,dhibaatooyin caafimaad – sida hurdo quman la'aan,dareen walaac , walwal iyo xanaaq leh.dadka qaar waxee ogaadeen in isticmaalka waxyalahan qaar uu sababi karaa xusuus iyo kafiirsasho la'aan taas oo sababi kartaa dhibaatooyin kasoo wajaha dhanka waxbarashada iyo shaqada.

TUSAALE

John waxa uu cuntaa 1 ama 2 surba oo khaat ah badanaa maqribkasta iyo 4 ama 5 surbo oo khaat ah xilliyada fasaxyada waxuuna isku arkay dhibaatooyin badan marka uu joogo guriga iyo shaqada taasoo ee sababtay cunida khaatka.

Dhaqtarka waxa uu sheegay in uu john kusugnaa xaalad qatar ah oo uu kadhaxlay cunida khaatka waxa uuna kacodsaday john inuu xasuusto dhibaatooyinkaas.

Tusaale|john dhibka ee u kuqabto isticmaalka walxaha daroogada

Walaxda	Dhibaatada
1. khaat	Xusuus xummi
2. khaat	Kafiirsasho la'aan
3. khaat	Lamaanaheyga wuu igu xanaaqaa mar walbo oo aanan ka caawinin shaqada guriga
4. khaat	Xiiso umaqabo sameenta shaqo oo idil marka laga reebo daawashada tv-ga

Ma is leedahay isticmaalka waxyalahan waxeey kugu sababtay dhibaato 3 bilood ee ugu dhambesay?

Ku Qor inta dhibaatoyinka laxariira isticmaalkaada walxahan	
Walaxda	**Dhibaatada**
1.	
2.	
3.	
4.	

Waa dareemi kartaa dhibaatada ee leedahay isticmaalka waxyalahan markaad sarqaan noqotid,ama aad si joogta ah u isticmaashid, ama aa isku durtid daroogada.hadii aad u isticmaashid si joogta ah ama isku durtid daroogo waxaad noqon kartaa qof aan isku tiirsaneen.

Haduu qoof kale(qoyska kamid ah,cafimaad qoof kutaqsusay)haduu kuu sheeqo dhibatooyinka kamid ah isticmaalka khaatka tani waxaa laga yaaba in lagu daro liiskaaga dhibatooyinka

Go´aanka adaa leh

Waad sii wadi karta mise waad iska yareen karta ama waad iska dhaafi kartaa isticmaalka khaatka

5

HAA



Dabcan,wax walbo oo aad sameeso waxee lahaanayaan wanaag iyo xumaan danbe.

6

7 Waa maxay cabirka isticmaalkaada waxyalahan?

Waa kanaa cabirka isticmaalka waxyalahan taas oo kaa caawin kartaa in aad cabirto inta aad wadi kartid ama aad joojin kartid isticmaalka waxyalahan.haddii aad u isticmaashid waxyalahan kamid ah waxyalahan si joogta ah waxaad ubaahantahay inaaad u cabirto waxyalahan si gooni ah.

Uga fakar arintaan sida mustaqbal ka dheer iyo kan dhow ah adoo eegaya dhanka wacan iyo kan xunba.

Tusaale|cabirka1.cabirka John waxuu u ekaa sidan		
	Inta aan waday isticmaalka walxahan	**Yareenta ama joojinta isticmaalka walxahan**
+	• waxee isiisaa nasasho shaqada kadib. • waa isku furmaa wana iloobaa malinka dhan • waa ku raaxeestaa xafladaha iyo lajoogida saaxibadeeyda	• saas umadalayo • si kawacan sidi hore aa wax uxasuustaa • xirirkayga aan la leeyahay lamanaheyga waa mid farxad lahaada mana iga xanaaqo. • si fiican aa wax uga fiirsadaa xilliga shaqada • maka maqnaado shaqada badanaa
-	• waxeey dhaawacdaa maskaxdeyda. • waxey dhaawacdaa kafiirsashadeyda • waxaan dareemaa caajis iyo daal habeenki kadib.	• way iguadaktahay intaa nasto shaqada kadib • kamahelo fladaha badanaa • saaxibayga wayiguqosli karaan

cabirka 1		
	Inta aan waday isticmaalka walxahan	Yareenta ama joojinta isticmaalka walxahan
+	- - -	- - -
-	- - -	- - -

Marka aad dhameesid qoralkeeda fadlan dib ugu laabo mar kale calaamadeena dhanka wacan iyo dhanka xun oo muhiimka kuu ah.

8 Makugu yeelatay saameeyn walwal ah isticmaalka waxyalahan?

Tusaale: marki john laweeydiiyay:sameeyn ilaa intee le'eg ayee kugu yeelatay isticmaalka walxahan?ku cabir ka bilaabanaayo 0 ilaa iyo 10.taasoo 0 ee lamacnatahay wax saameeyn ah kuguma yeelan halka 10 kana ee tahay saameyn saaid ah ayee kugu yeelatay.										
0	1	2	3	4	5	6	7	8	9	10
Sameyn kumayeelan								Sameeyn weyn ayee kuyeelatay		
John waxuu isku cabiray nambar 6 sababtoo ah waxuu ka walwalsanaa daalkiisa iyo hiloowshihiisa wuxuuna rabay inuu kordhiyo xiriirkiisa kala dhaxeeya lamaanihiisa isla markaana waxuu dareemay inuu wali kahelsanyahay cabitaanka sigaarka eena ahaan doonto murug hadii uu iska dhaafo.										

Xaggee iskaga aragtaa naftaada cabirkaan?										
										
0	1	2	3	4	5	6	7	8	9	10
Sameyn kumayeelan								Sameeyn weyn ayee kuyeelatay		

Tusaale: Waxyaalaha
John waxuu goaansaday inuu ka walwalsanado isticmaalkiisa khaatka. Muusan kawalwalsaneynin waxyaala kale sababtoo ah musan isticmaaleynin kuwaas marwalbo ama in badan

darajeey waxyaalaha kuquseeyo kabilaawaneso tan ugu koreso ila tan ugu hooseeso
1
2
3
4
5

8

9 Cabiraada adeegsiga maandooriyaha

Waxaad ka shaqeyn kartaa inta aad hadda maandooriyaha adeegsaneeysid usbuucaagi ugudanbeeye

Dhib ugu laabo usbuuci maalin waqtiga ka mid ah hoos ku qor aqbaarta ee maalinkasta (meesha iyo waqtiga,qof aa lajoogte waxa aad isticmaali jirte,inta aad isticmaashe,inta aad ku bixise) (sidoo kale eeg tusaalaha hoose). Marka ugudambeso waxaad awoodi inaad oogatid inta aaad isticmaashay usbuci hore.

Tusaale: Xusuus qorka iscmaalka daroogada. kani waa xusuus qorka john siduu ueka kohor usbuci uu aadey daqtarka.			
goorme?inte? yaad lajoogte	Waa maxay	Meeqo	Lacagta kubaxde
Xafladi habeynki sabtida ee peter	Khaat	4 surbo	1000 KSh
Axadi miyuu falay beerta kuna ciyaaray kubada jiroodin	Waxbo	N/A	N/A
Habeynki isniinta wuu daalay shaqada kadib wuxu ku nastay t.vga hoortiisa	Khaat	2 surbo	500 KSh
Talaadadhawuxuu tagay cashar kaban ah kadib wuxu kusoo daaahay xaafada	Waxbo	N/A	N/A
Habeynki arbacada guriga ayuu ku daawaday banooniga	Khaat	4 surbo	1000 KSh
Habeynki qamista xaafada ayuu t.v ku daawade	Khaat	2 surbo	500 KSh
David iyo peter habeynki jimcada ii imaadeen waxaa isla daawane video	khaat	3 surbo	750 KSh
Markuu john eege usbuuca wuu layabey aragtida in uu cunay 15 surbo oo khaat tubo good ahaan iyo intu isticmaale.			

Kabiloow shalay kuna laalaabo isbuuci dhan

Qor

Waqtiga iyo meesha aad ku isticmaashid.



Yaa lajoogtay



Waxa aad isticmaaleesay

Inta aad heesatay

Inta aad qarash gareesay





Ku buuxi kuwaan "buugaaga xasuus qorka ah" walxaha aad isticmaashay isbuuci udanbeeyay

Goorma? Intee? Yaa lajoogtay?	Maxaa?	Meeqa?	Lacagta qarashgareesay?

10

10 Intee in la eg aa xad dhaaf ah?

Haddii aad khat cuntid waxaa qatar ugu jirtay caafimaad darri iyo dhibaatooyin kale.qaasatan haddii:

- Aad cuntid 2 xirmo oo khat ah aan joogta aheyn isbuuci
- Aad cuntid 1 marduuf oo khat ah

Majiro saameeyn la'aan cunista khatka haba ahaatee hadaa cuntid hal marduuf oo khat ah.

Waxaa jira waxyaalo qaar oo kordhinaayo qatarta sida:

- Dhaxal ah isticmaalka khatka dhanka qoyska.
- Inaad ahaatid mid ku dhexjira xaalad daawo cafimaaad ah
- In aad ka miisaanyaraatid dadka kale dhanka jinsiyadda iyo dhirirka.

Waa inaadan khatka cunin haddii:

- Aad tahay qof uur leh ama naas nuujinaayo
- Gaari wadaayo ama ka shaqeenaayo mashiin ama kugudo jiro waxyaalo leh qatar
- Aad qabtid dhibaatooyin caafimaad taasoo keeni karta in aad ka dartid haddi iaad isticmaashid khatka.
- Ama aad qaadaneesid daawo taaso lafalgali
- Karta khatka
- Haddii aadan kontorooli karin isticmaalka khatka

Marduuf khaat aah:

- **1 mijin Kangeta**
- **1 mijin Giza, Alenle, Lare, Asili**
- **1 bac Magoca**





Majiro heer aan dhibaato laheen oo ah isticmaaalka khatka iyo daroogooyinka kale.

Cabbida waa nooca ugu xun ee isticmaalka tubaakada.

Noocyada kale ee aan lacabbin sida calaajinta tubaakada ama dhuuqida [taas oo lagaliyo inta u dhaxeesa faruuryaha] waa qatar xittaa ayaga.

11



Majiraan sababo kugu qasbaayo inaa is badasho adoo eegaya cabbirkaaga.

11 Go'aan gaarid

Hadda ,dib u fiiri cabirkaada,buugagag xasuus qorka ee isticmaalka waxyalahan daroogada iyo dhibaatooyinkaada laxiriira isticmaalka waxyalahan.

Majiraan waxyaalo sababi kara inaa isbadashid?

Tusaalo| john waxuu ogaaday inee jiraan sababo keeni kara inuu isbadalo marka waxuu calaamadeeyay godkan hoose.

HAA aad cutubka 12

MAYA marabtid inaa wadid buuggan yar hadda

Mahubtid kuqor sababaha miiska hoose adoo tixgelineesid talada saacideeyahaaga.

Ku calaamadee go'aamadaada hoos.

- ☐ HAA aad cutubka 12
- ☐ MAYA marabtid inaa wadid buuggan yar hadda
- ☐ Mahubtid kuqor sababaha miiska hoose adoo tixgelineesid talada saacideeyahaaga.

Sababaha keenaya inaa badalo isticmalka walxahan
1
2
3
4
5

12 Doorashada hadafkaada

Hadda maadaama aad go'aansatay inaad badal kusameesid isticmaaalka walxahan.go'aanka kuugu xigaa waxuu noqonayaa inaa yareesid ama joojisid abid isticmaalka walxahan.

Si lagaaga caawiyo inaa go'aan gaartid samee saddexdan shaqo:

1 Kafakar suaalahan:

- Ma qabtaa caafimaad darri ama dhibatooyin maskaxiyyan ah taaso kaaga darri karto marka aad isticmaashid walxahan?dhaqtartkaada ama qabiir caafimaad oo kale aa kaa caawin karo.
- Ma dareentaa dhibaatooyin markaa joojisid? Hadee saas tahay, haddaba toos inaa u joojisid waa haddafkaaga kuugu weyn.dhaqtarkaada ama qabiir caafimaad kale ayaa kaa caawin karo joojinta walxahan.
- Ma qabtaa dhibaato dhaqaale,shaqo oo ku soo wajahda marka isticmaashid walxahan.
- Maqabtaa dhibaatooyin laxariira qoyskaaga marka aaad isticmaashid walxahan?
- Maku xalisay joojin dhibaatooyinkaan wali?haddaba taasi waa sida ugu wacan ee aad isticmaali kartid.



Mayareeyaa mise waa waa joojiyaa gabi ahaanba isticmaalka walxahan ?

Xasuuso in laga yaabo go'aanka aa hadda gaartay in uu aheeyn go'aanka aad raaci doonto waligaa .waa inaa mar walbo dib ugu laabato hadafkaaga.hadaf kasto oo aad doorato waa arin wanaagsan in aad kagala tashato qofka kuugu dhaw dadka.

13

2 KuQor cabirkaan soo socda meesha wacan iyo meesha xun adoo eegaya inaa toos u joojisid iyo inaa yareesid.

Tusaale|cabirka, tusaale khat		
	Yareen	**Toos u joojin**
+	• Wali waala isticmaali karaa khaat saaxibadeyda • Wali waa ku raaxeestaa aadida xafladaha • Inaa wax yar ka isticmaalo waxee ii keenta inaa saaid u daalin ama aan u iloobin	• Ma daalaayi mana iloobaayi wax • Maka maqnaadi shaqada. • Lamaanaheyga wuu igu farxaa • Lacagta waa aruursadaa intii aa ku isticmaali lahaa gadashada walxahan.
−	ma awoodi inaa nasto shaqada kadib	• Waa u xiisaa saxibadeyda mararka qaar. • Waa u xiisaa nasashadeyda shaqada kadib • Saxibadeyda wee igu qoslaan.

Marka dhameesid calaamadee meesha wacan iyo meesha xun oo muhiimka kuu ah.

cabirida 2		
	Yareenta	**Toos u joojinta**
+	- - -	- - -
−	- - -	- - -

14

3 Doorashada haddafkaaga.Dib u fiiri waxaad qortay ,tee is leedahay waa haddafka kuugu wanaagsan?

Hoos ku calaamadee jawaabahaaga
☐ Si aa u yareesid isticmaalka walxahan aad cutubka 18-aad ☐ Si aad toos u joojisid isticmaalka walxahan aad cutubka 17-aad **lakin marka horeyso aqri qeeybta 13 ila 16**

13 Badalida sida aa u isticmaashid

Haaddii aad go'aansatay inaa toos u joojisay ,waxaa u baahan kartaa inaa kafakartid sida aa u isticmaaleesid walxahan iyo sida ee kuugu keeni karaan dhib yar.

Tusaale ahaan,waxaa go'aansatay inaa joojisid isku durida cirbadaha,ama aad isku durtid mid kaduwan tii hore,si ka qatar yar sidi hore.

Hadaa isku durtid daroogada waxaa kordhineesaa qatarta ee leedahay daroogada iyo iskuduridda ba'.

Iskuduridda amphetamines ama cocaine waxee badisaa qatarta maskaxiyyan iyo iskutiirsasho



Aad ayee waliba uwanaagsanaan laheed hadaadan isku durinba maxaa yeelay tani waxee badineesaa qatarta virus-ka [hepatitis B and C,HIV/AIDS] iyo jeermisyda kala.hadaa wali isku sii dureesid waa inaad fiirisaa xoogaa isbadal ah si aad u yareesid qatarta iskudurida walxahan,sida tusaale ahaan isticmaalida qalab nadiif ah [sida cirbadaha,saliingaha,qaadada,sifeeyaha iyo waxii lamid ah]

Mar walbaahi waa qatar isticmaalka daroogada, balse waxaa jira qaab lagu yareen karo hadaa go'aansatid inaa wadid.

Yaree qatarta:

1.hawadin gaari hana sameenin shaqooyin qatar ah marka aad isticmaaleesid daroogada.

2.hadaa isticmaaleesid daroogo isticmaal qadar yar iyo waqti yar si aad uga feejignaato isku tiirsasho la'aan.

3.maalin walbo haisticmaalin.

4.ha isticmaalin daroogo hadaadan heesan qof ku caawiyo marka ee wax qaldamaan.

5.ha isticmaalin waxyaalo kala duwan maalinka aad

Inaa go'aan sameesatid waxee kaa caawinee inaa gaartid hadafkaaga.

Go'aankaada waa inuu ahaadaa mid fiican.

Mid gaar ah

Mid cabbiran

Lagaari karo

Macquul ah

Waqti leh

16

14 Heshiiska aan nafteyda lagalay

Maadaama aad go'aansatay go'aanno qaar oo ku aadan isticmaalka walxahan iyo waxa aad rabtid inaa kasameesid waxaa ka qori kartaa heshiis nafsiyan ah [arag tusaalahan hoose] tan waxee kaa caawin kartaa inaa xasuusatid waxa aad go'aansatay.

Tusaaale|heshiiska aa nafteyda lagalay
Tusaale koowaad
Waa joojinaayaa isticmaalka walxahan .....
Tusaale labaad
Waa yareenaa isticmaalka walxahan anigoo kusoo koobaya hal habeen kabilaabato..
Waxaa sameena tan saddex bilood ilaa....markaa dib u eegaayo hormarkeyga.

Heshiiskeyga aa nafteyda lagalay
Waxa sameena...
Waxaa sameena...
Waxaa sameena ...
Waxaa sameena...



15 Horray usocod

Si aad u awoodo inaa sameesid arimihi aa go'aansatay waxaa dib u eegi kartaa xasuus qorkaaga cisbuuceed [mid lamid ah midda aa ku isticmaashay cutubka 9]

U isticmaal xasuus qor oo ee ku jirto arimahaan soo socda:

- Heeso xasuus qorkaan maalinkasto
- Qor markaa isticmaashid ama aa dareentay inaa isticmaashid[waxaa jira meel ee ku taalo xasuus qorka dhexdiisa [damcay inaa isticmaashid lakin aadan sameenin]
- Heeso buugan saddex bilood.tan waxee kaa caawinee inaa is badashid.hadhoow waa diiwangelin kartaa isbuuci mar ama labo mar billo kadib.
- Isku dardar lacagta aa ku qarashgareen laheed iibsashada walxahan.
- Saar istilaab mararka aad istiri saa'id u isticmaal kabadan inta aad rabtay.
- Hadaa damacdid waa lawadaagi kartaa xasuus qorkaaga lataliyahaaga. .
- Aqri waxa aad qortay kana fakar marar badan isbuuci.

Xasuus qorkaaga waxa uu tusinayaa waxa dhacaya,goorta ee dhacayaan,iyo sida ee u dhacayaan.

Xasuus qorka waxa uu kuu fududeenayaa inaa ogaaatid qatarta saaidka ah ee kusoo wajahday mararka qaar,marka aad u isticmaashay si saa'id ah ama si xun

Xaaladaha kugu qasbay inaa isticmaasho laga yaabo inee tahay marka aad lajoogto dad qaas ah ama aad joogto meel qaas ah.waxaana laga yaabaa inee tahay sida aa dareento markaad xanaaqdo ama aad faraxdo

Inaa lahaatid buug xasuus qor ah oo daroogada ah

Warbixinta ku qoran buugaaga xasuus qorka waa inee noqotaa mid qaas ah ,hubi in aad meel fican ku xafidid.

Tanni waa qeyb muhiim ah oo kaa caawin karto inaa isbadashid.

17

16 Xaaladaha aadka qatarta u ah

Waa maxay xaaladaha qatarta kuu ah?

Xaaladahee ama meelahee ama dareenkee kugu keena in aad isticmaasho walxahan?

Majiraan marar qaar ah oo aad u isticmaashid walxahan si xad dhaaf ah ama si aadan uladan laheen inaa u isticmaasho?

18

Haddii aad fahmi karto xaaladaha aadka qatarta u ah sida marka aad isticmaashay kabadan inti aad rabtay ama aad rabtay inaa si xun u isticmaashid- tani waxee kaa caabin kartaa inaad hab isku sameesid.

- Meelaha qaar ee kuu fududahay inaa ka heshid walxahan sida guriga,saxibkaa gurigiis,xafladaha iyo waxi lamid ah?.
- Dad qaas kuu ah sida lamaanahaaga,saxibo qaas ah iyo waxii lamid ah?.
- Mararka qaar sida cashada kadib,xilliyada fasaxa,dabaaldegyada iyo waxii lamid ah?
- Xaaladahaaga qatarta kuu ah waxaa laga yaaba inee saameeyn ku leedahay sida aad dareemeeso marka aad naxsantahay,danbiile tahay,murugeesantahay.
- Kafakar mararki kuugu danbeesay aa dhibaato kala kulantay isticmaalka walxahan.

Si aa u ogaatid waxee ka caawineesaa inaa aragtid 'buugaaga xasuus qorka ee walxahan' [fiiri tusaalahaan hoose xittaa]

Tusaale| John waxa uu ogaaday xaaladaha qatarta ah waxuuna helay inuu badanaa cuno khaatka.
1.si ee iigaga caawiso inaa daggo shaqada kadib
2.marka aa tv daawanaayo.
3.marka aa saaxibadeyda lajoogo saaxibadeyda.
4.xafladaha markaa lajoogo saaaxibadeyda

Si aa u ogaatid waxee ka caawineesaa inaa aragtid 'buugaaga xasuus qorka ee walxahan' [fiiri tusaalahaan hoose xittaa]

Ku tax xaaladahaaga qatarta ah inta
1
2
3
4

17 Sameeynta haddaf:sida loo joojiyo

Hadduu haddafkaaga yahay inaa ujoojisid si joogta ah:

- Haddib dhigin.go'aanso xilli go'an oo aad joojineesid.maalinkaasna ku jooji.
- Dadka dhan u bandhig inaa joojisay.tani waxee kaa caawinee inaa dadka kale u fududeesid kafogaanshaha walxahan.
- Kafagoow inta aa awoodid wax kasto oo ku soo xasuusinaayo sida riishadda bunduqa

Waxaa laga yaabaa inaa lakulantid dhibaatooyin kadib markaa joojisid.caawimaad karaadso waaxda caafimadka bixiso hadaa kadartid.

Sida looga badbaado qumbacasho.

Qumbacashada waxa waaye dib ugu laabashada isticmaalka daroogada kadib markaad dhaaftay xoogaa.waa muhiim inaa ogaatid waxa keeno qumbacashadan.waxee kaa caabinee ogaanshahan inaad joojisid ineesan kugu dhicin qumbacashadan.

Waxyaalaha ugu weyn ee keena qumbacashada:

- Marka aad ku dhexjirtid xaalad shacuur sida shacuurta ku wareerida,xanaaq,cabsi,walwal,walbahaar,cidlo,murug,caajis,maseer,qasaaro.
- Marka aad ladagaalmeesid calaamadaha jirka kamuuqda ee isticmaalka daroogada sida baahidda balwadda iyo qaadirada
- Haddii aad isku dayeesid inaa tijaabisid awoodaada ka adkaanshaha nafsadaada.
- Marka aad ladagaalameesid dhibaatooyinka kadhasha doodda iyo is faham la'aanta.
- Culees kayimaada dadka kale ee daroogada isticmaala.

Fadlan arag sida loogaga hortago hilloowga iyo sida loo dhaho maya barnaamijkan gudihiisa kaaso aad ku baran kartid kahortaga qumbacashada.

Ma jiraan xaalado qasbi karo inaa isticmaashid walxahan.



Inaa dib ugu laabatid isticmaalka daroogada kadib marka aad joojisay waa wax loo badanyahay.

Waa iska caadi inaa dareemtid niyadjab lakinu sirtu waa in aadan waligaa wadin.

19

Sameynta hadaf ku aadan isticmaalka walxahan.

18 Isku habeynta haddafka isticmaalka walxaha:sida loo yareeyo

Haduu haddafkaaga yahay inaa yareeso waxaa ubaahantahay haddafyo noocaan oo kale ah:

- Imisa isbuuc ama bil aa maandooriye la'aan tahay?
- Ilaa meeqa mar aa isticmaalaa?
- Meeqa mar aa isticmaaalaa maalmaha aa isticmaalo?
- Waa maxay xaddiga ugu badan ee aa isticmaalaayo waqti go'an?
- Meeqa aya isticmaalaa isbuuci ama bishi?
- Waa maxay xaaladaha qatarta ah oo la iigaga baahanyahay inaa marin?
- Sidee u maamulidoonaa walxahan?
- Sidee u yareeyaa qatarta ee keeeni karto?

Tusaale| John waxuu go'aansaday xeeladda ugu wacan xaggiisa
1.waan dhaafayaa cunida khaatka kadib maalmaha shaqada
2.waxaan canaaya khaatka hal habeen oo maalmaha fasaxa ah
3.ma cunaayi labo surbo kabadan oo ah khaatka maalinki
4.masoo gadanaayi khaat badan sababtoo ah wuu idamac gelinaa.

Kani waa ihaggaha isticmaalka walxaha
1
2
3
4
5
6

19 Sida tabashada laisaga caabin lahaa

Tabbida waxee imaadaa marka kemistiriga iyo sida maskaxda ee u shaqeeso isbadasho sababo laxariira isticmaalka daroogada si joogta ah

Isku day inaa ogaatid waxa kiciya tabashada .tani waxee kaa caabinee inaa isticmashid buuga xasuus qorka ee tabashda

Kusoo koob tabashadaada ciwaankan kudihiisa "dabeecada,dareenka la arki karo iyo fikradaha.

TUSAALE|: xasuus qorka tabashada ee John

Meesha iyo waqtiga	fikradaha	Dareenka la arki karo	dabeecadaha
23-da june, maqrib, saxibkaa meeshiis	„Waxaa dareemayaa inaa hadda ubaahanahay" „Maskaxdeyda kama saari karo" „wee ii wacdaa"		
23-da june, maqrib, gurigeyg, wadadi hore		"tabashaa larafaaday. calooshaa xanuun kadareemaa." "waxaa bilaabay inuu iisoo uro"	
23-da june, maqrib, wadadi hore			"waxaa tagay wadooyinki aa ku isticmaali jiray daroogada weena iqabatay si dhaqso ah"

Tabashada waa wax iska caadi ah .ma ahan calaamadaha guuldarada.

Kafogaanshaha waa qaabka ugu wacan ee aad isaga saari karto tabashada.

Sida la isagaga caabiyo tabashada.

1.daahin

2.ismashquulin

3.go'aan gaaris

4.si fican isugula hadlid

5.is dajin iyo isku muujin wax wacan.

21

Xasuus qoor u degto			
Mesha iyo waqtiga	Fikrado	Dhareenka jirka	Dhabecado

22

Waxaad isticmaali karta farsamooyinka soo socda si aad uqabatid keebtaada xaraarada

Dib udac- daa isticmalkaaga khaatka mudo 30 daqiiqo ah.xararada waa in eey yaraato mise eey dhafto sida lagayabo in aad rabto in aad isticmaasho

Kajeedin- hafarisanin hal meel adoo kafikaraayo khaatka adoo xararada kuheso.Is mashquuli,is kaaga jeeydi waax qabad taan waxeey kujirikartaa howlaha guriga ama hiwaayad

Go'aanso- sameeyso liiska wanaagsan iyo kan xun kusaabsan isticmaalka khaatka sidey kuu xasuusiso sababta aad udhoratay hadafka oo aad uga fogaatay

Wanaag naftada usheeg- la hadal naftada si cod dheer ah sida xararada uburburiso dareenka in la gudbi doonta waqtiga

Nasashada iyo sawirka- nasashada jimicsiga adoo isticmaaleysid wanaag iyo sawiro nasasho ah. waxaad u isticmaali karta in aad kabixiso maskaxdaada xaraarada khaatka.

20 Sida tabashada laisaga caabin lahaa

Dadka inta badan marka ey ka nastaan isticmaalka mandhooriyaha wexey oganayaan isbadal dinaa howlaha maalmeed wexey na kacaawinkartaa in ey kulaabanin isticmaalka mandhooriyaha

Talooyinkan waxee kaa caawinayaan inaa ku dhagtid hadafkaaga ku aadan joojinta walxahan ayadoo loo eegeenin hadafkaaga intuu la egyahay.

Kuwaan waa talooyin ku caawin dhoona wax kasta ey ahaato hadhaf kaaga

- Waxaad hubisaa in aad cuntid cunto caafimad leh iyo hurdo badan
- In aad bilaawdid jimicsi joogta ah – socod iyo jimicsi
- Cab biyo farabad iyo biyo aan kujirin daroogo (alcohol)
- Waxaad isku mashquulisaha ficilo aan mandhooriya ehen
- Waxaad sameysataa hiwaayada cusub ama kuwaagi hore waqti badan geli
- Is firfircooni iyo is mashquuli
- Sameyso saxiba bila balwad ah
- Ku keedso lacaagtaada mel muuhim dhiga si aad marka ubahaatid u isticmaashid
- Raadi shaqo lacag laguug siinaayo mise iskaa wax u qabso ah

Talooyinkaan waxay kuu caawinaayaan hadi aad dooneysi in aad yareysi

- Waligaa ha iibsn wax kabadan waxaad rabtay inaad isticmaaso hal maalin gudihiis
- Iska ilaali sir qarsoon oo kugu qasbi karto inaa wax badan isticmaasho.
- Isticmaal si waqtigeeda kadanbeesa sidi hore,waqti horana dhamee sidaasna kusoco.
- Qabso maalmo aadan isticmaaleeynin ugu yaraan .....maalmo isbuuci.

Liiska waxyaalaha kale ee aad is leedahay wee ku caawinkaraan.
1
2
3
4

23

21 Sida tabashada laisaga caabin lahaa

Waxaa dareemi doontaa kalsooni badan marka aad isku diyaarisid xaalad culus.

Horay waxaa usoo eegnay sida loo ogaan karo xaalada halista ah – waqtiyada,meelaha,xilliyada,dadka,fakarada iyo dareemada taasoo kugu dirdirgelin karto isticmaalka walxahan daroogada.

Inaa ogaato xaaladahan halista ah waa tallaaabada koowaad.talaabada labaad waa inaad barataa sida aa umaamuli kartid intaad sugi laheed inee culees kusaarto.kasii fakar qaabab aa xaaladahan ula qabsan laheed.

Waxaa go'aansan kartaa inaadan isticmaalin ama aad dib dhigato.xataa waxaa isku mashquulin kartaa waxyaabo kale si aad uga mashquusho walxahan.xataa waxaa sameen kartaa liis tusaayo faaiidooyinka aad heshay marka aadan isticmaalin walxahan iyo qasaarooyinka aad gashay marka aad isticmaashay dhaqaalo ahaan.tanni waxee kaa caawinkartaa inaad go'aan gaartid.

Qaab ee dad badani si fiican isugu diyaariyeen xaaladaha halista ah waa xalinta dhibaatooyinka.dhameestir miiskan ee page-ka 25-aad.

Tanni waa qaab wanaagsan oo xittaa aa ku xalin kartid dhibaatooyinka kale ee kala duwan.

- Ogoow horta dhibaatada.
- Soo burqo fikarado kala duwan oo ku xalin kartid-ha isku dhex qasmin.qor xittaa kuwa aa isleedahay macquul ma aha ama waa waali.
- Ka fakar kuwa aa is leedahay haddaa isku daydid mid kamid ah kadibna dooro kuwa aa is leedahay wee ugu wanaagsantahay.
- Mid kamid ah isku day.haddii midda kuugu horeeso eesan kuu shaqeeyn isku day midda labaad.iska wad ilaa aad ka heleesid midda kuugu wacan.haddii kuwa aad isku dayday eesan shaqeeyn kuceli 3 iyo 4 ilaa aad kaheshid mid ku qancissa.

Haddii ee wax isbadal ah dhicin raadso caawimaad-kasocoto caawiyahaaga,saaxiibkaaga,lamaanahaaga,qofka kusiiyay buugan ama qbiir waaniye ah.



Tusaale|john waxuu ogaaday waxyaalaha qatarta ku ah waxuuna isticmaalay qaabka dhibka xalinta ah si uu u go'aansado waxa uu isticmaali lahaa xaaaladahan gudahooda.	
Xaaalada qatarta koowaad	Waxan istimaala khaatka galabtii in aan nasto markaan shaqada ka imaado, guriga joogo t.vga hortiisa.
Xaalal Burqasho	Waxaa isticmaalaa khaatka maqribki si aan unasto marka aan gurigga aado shaqadda kadib una daawado telefishinka. Waa fadhiisanaa lugaheygana kor aa uqaadayaa markaa gurigga imaado. Kataarkeyga aa baranaa. Waxaa dheelayaa banooni guriggeyga dhexdiisa. Waxaa isticmaalayaa xooggaa khaatka si aan unasto
Xalka ugu wacan	Waxaan barranaa kabankeyga iyo waxaan lahadlaa lamaanaheyga.
Maxaa dhacay	Waxaan cayaaray kabankeyga waxaana lahadlay lamaanaheyga waana lacasheyay waaana roonaaday.
Xaaladda qatarta labaad.	Waxaan lacunay khaatka saaxiibadeyda xilliyada fasaxa iyo xafladaha.
Xaalal burqasho	Ma aadaayi xaflad danbe mana arkaayi saaxibadeyda. Waxaa isku dayi doonaa inaa shaqooyin laqabto david iyo peter guriga intaa joogi lahaa. Waxaa la aadaa xafladaha saaxiibadeyda aan isticmaalin khaatka Waxaa keenaayaa xooggaa khaat ah xafladaha. Waxaa usheegaa david iyo peter inaa joojin rabo isticmaalka khaatka. Waxaa isticmaalaa khaatka la isiiyo.
Xalka ugu wacan	Si fiican ula shaqeeyo david iyo peter waxaana usheegayaa inaa joojinaayo.
Maxaa dhacay	Waxaa usheegayaa david iyo peter inaa rabo inaa joojinaayo si aan taam unoqdo Waxaa ku qarashgareenay waqtigeena xalfadda inaa abuurno koox banooni dheesha.

25

Xaaladda halista ah	
Xaaladda koowaad ee halista	
Xal burqasho	
Xalka ugu wacan	
Maxaa dhacay	
Xaalada labaad ee halista ah	
Xal burqasho	
Xalka ugu wacan	
Maxaa dhacay	

Isku diyaari in aad dhahi kartid "MAYA"



26

Abuur diidmo dhankaaga ah.

22 Sida loo dhaho "maya"

Hal nooc oo aad ku kontorooli kartid isticmaalka walxahan waa inaad dhahdid "maya" marka qof uu kuu soo bandhiggo.

Haddii aad mar walbo dhahi jirtay "haa" wee kugu adkaaneesaa inaa maya dhahdid marka ugu horeeso laakiin haddaa hal mar dhahdid maya waa eey kuu fududaaneesaa waana diidi kartaa markasto. Si fiican ayaadna dareemi doontaa.

Waxaa kugu filan "MAYA WAA MAHADSANTAHAY,MAYA CAAWO" inaa dhahdo ama waxaa dhahi kartaa

- 1.maya waa mahadsantahay. Waa joojinaayaa.
- 2.maya waa mahadsantahay waa nasanooyaa hadda.
- 3.iga raali noqo dhaqtarka ayaa i amray

Waxaa ogaan doontaa in dadka ee kaa aqbali doonaan maya marka aad dhahdid dhib la'aan.haddii ee dhib kugu noqoto dadka ama aad dareentid farxad la'aan in mar walbo lagu weydiiyo waxaa kuu fiican inaad isaga tagto meesha ogaatana inee tanni xaalad qatar ah kuu keeni karto.

Qorshee inaa diidid si aad uga hor tagtid xaaladan qatarta ah.

Abuur xaalad aad ku diidi karto si tilmaam ahaan ah ama si hadal ah.	
Sida loo isticmaalo tilmaamo	**Sida loo hadlo**
- Qofka toos u fiiri marka aad u jawaabesid –waxee kordhinee awooda jawaaabtaada. - U istaag ama u fadhiiso si toos ah ...waxee tuseesaa inaa kalsooni ku qabtid dooqaaga. - Haka xumaanin inaa diidid.qofna madhaawaceeso jawaaabtaada. - Qolka isaga tag hadduu qofka kugu adkeeyo.	- Isticmaal hadal faseex ah oo leh kalsooni. - Maya waa inuu noqdaa ereyga ugu horeeyo ee afkaaga kasoo baxa. - Kafakar arin kale oo aad qofkaas kusameen kartid. - Usheeg qofka kuu sheegaaya inaa isticmaashid daroogadan inuusan kaa joojiyo inuu kuugu waco walxahan isticmaalkooda. - Ubadal sheekada arin kale. - Iska ilaali inaa isticmaashid cudurdaar iyo jawaabo qaldan sababtoo ah tani waxee keeni kartaa inaa badasho go'aankaada.

23 Ku dhag hadafkaaga

Talooyinkaaan wee ku caawin karaan

- Wad go'aan kaada ahaa inaa joojisid ama aad yareesid isticmaalka walxahan.eeg cabirkaada si aad isku xasuusiso waxaad go'aansatay
- Aalaaba eeg buugaaga xasuus qorka ee walxahan.fiiri inta aad horay u isticmaali jirtay kahor inta aadan joojin adoo ubarbar dhigaya inta aad hadda isticmaasho.
- Aqri dibna u aqri hadafkaaga qaasatan maalmaha aad isticmaasho.
- Is mashquulin- mar walbaahi is mashquuli sida jimicsi ,shaqo guri,filimaan,cayaaro,beeraha
- Mar walbaahi aad diido wax aad sameen jirtay waxaad u dhawaaneesaa inaa joojisid.haddii aad dareentid dareen kugu qasbaayo inaa markaas isticmaashid walxahan ismashquuli ilaa uu dareenkaas katagayo .
- Mar walbo lahadal isbuuciba,usheeg xaalka meesha uu kula marayo kalana hadal waxyaalaha wanaagsan iyo waxa xunba ee kusoo wajahay.
- Haka quusanin arintan sababo laxariira maalin xun oo kusoo martay .isku naxariiso,kafakar 'waxaan waan badalayaa marka ku xigata" xasuus qaabki lagu xalinayay dhibaatooyinka
- Isasii mooraal iyo abaalgud sida suuq aadid ama sosocod ama qabeeys ama heeso dhageesi ama saaxiib raacis ama cunto cunid.mar walbo abaalgu noocaas ah isasii.
- Isdaji xitaa haddii aad is leedahay si fican ma aadan u qaban. Usheeg naftaada in isbadalka uusan dhicin hal mar dulqaadna yeelo.talaabada ugu yar ee aad u qaado dhanka wanaagsan waxee kaa saacideenee inaad gaarto hadafkaaga.

Ilaa iyo hadda waxa aad qortay cabiraada walxaha aad isticmaashid iyo hadafkaaga ku aadan joojinteeda.waxa aad dabcan aragtay xaaladaada qatarta ah iyo sida aad ku xalin laheed.

Hadda waxa aad ubaahantahay in aad ku adkeesatid go'aankaada.

27



Haddii kontoroolka walxan isticmaalidooda ee ka bixi rabaan gacmahaaga raadso caawimaad.lahadal cawiyaahaaga,shaqa alahaaga caafimaad,saaxiibka ga ama qabiir daroogo.

Waa dooqaaga

28

Waxaa jira marwalbo wax kuu buuxin karaayo booska isticmaaalka walxahan.

24 Markee wax qaldamaan...

Ma ahan gabagabada adduunka haddii aad kaleexato hadafkaaga.

Sirta ma ahan inaad walxahan hal mar joojisid.hadii aad kaleexato jadwalkaaga dib ugu laabo hadafkaaga.fiiri waxa keenay qaloocan.ma waxaa waaye xaalad halis kugu keeni kartaa marka la eego liiskaaga? Hadee saas tahay,waxaa laga yaabaa inaad ubaaahantahay siyaabo kale oo aad ku joojin karti isticmaalka walxahan.

Mar labaad eeg cabirkaada .....tani ma hadafka kuugu fiicanbaa?kagala hadal arintan kutaakuleeyahaaaga ama qabiir caafimaad.

Waxaa intaaas dhan kadaran,daacad unoqodka nafsadaada.

25 Kubadalka waxyaalo kale booska isticmaalka walxahan

Dad badan isticmaalka wlxahan waxee unoqotay mid kamid ah noloshooda. Waa dabeecad ee dareemaayan inee dhumeen haddii ee joojiyaan, laakiin sida aad adigaba uga dhigatay dabeecad walxahan dabeecado kalana waad sameesan kartaa.talaabo talaabo.

Mar walbo oo aad joojisid dabeecad aad ulaheed isticmaalka walxahan waxaad kusocotaa wadada saxda ah iyo dabeecado kale oo wanaagsan.

Waxaa go'aansan kartaa inaa joojisid ,hadee saas tahay dooro waxyaalo kale oo aad ku badasho

Dad badan oo isticmaalo walxahan waxee yiraahdaan inee isticmaalaan walxahan marka ee dareemaan dareen xun oo ku aadan nafsadooda ama noloshooda.

Waxaad ubaahantahay inaad hesho qaabab cusub oo aad isagaga caabbin kartid dareenkaada adoo isticmaleeynin daroogo

Is furfur- laqeybso dareenkaada lamaanahaaaga,saaxiibkaada,caawiyaahaaga ama lataliyahaaga.

Lajoog mar walba dadka ku dhiiri geliya.

Qaado maadooyin,aqri buugaag,daawo filimaan dhageesana heeso kaa caawinaaya inaa faraxsanaatid.qaab caafimaad kujiro.

Lifaaqa koowaad

Waano kusocota lataliyaaasha

Qof xigto kuu ah- sida saaxibkaa,lamaanahaaga,ama qaraabadaada ayaa waxuu ku weydiistay tageero ku aadan inaad kasaacideeso in ay ku dhagaan go'aan kooda ah iney joojinayaan isticmaalka walxahan.

La aqri tusaalayaasha oo idil,weeydii sida ee jeclaan lahaayeen inaad uga caawisid xaaladaha halista ah , gaarista hadafkooda.

Laga yaabo inee doonaan inee kula soo xiriiraan marka xaalad adag ee soo wajahdo qorshahooda.u ogoloow inee ogaadaan goorta iyo meesha ee kaagala soo xiriiri karaan.

Laga yaabo inee kuqanacsanyihiin inaad ladulmarto arimahooda aadna kala xaaajooto dhib kasto .waad dhiiri gelineesaa haddii aad u hambalyeeso marka ee guul kagaaraan.iska ilaali inaad dhaleeceeso ama aad eedeeso haddii ee simbiririxdaan.

U diyaari abaalgud qofka aad taageereesid marka ee gaaraan hadafkooda.abaalgd sidda- cunto ukarin, filim ladaawasho, wax walbo oo qiimo la leh ayaga.

Sidee ku caawin kartaa?

Xasuso marwalbo in labadalo dabeecad ma ahan wax fudud waxaana dhici karto in qofka uusan ku dhagin go'aankiisa ah inuu joojiyo isticmaalka walxahan

Laga yaabo inee ubaahanyihiin in adiga aad dib ugu soo celiso hadafkooda ku aadanaa joojinta walxahan.

Ka caawi inee u arkaan qaladaadkooda mid hal mar dhaco ee eesan aheyn mid keeni karo inee ka quustaan hadafkooda.

29


EXIT THE MAZE OF
HARMFUL SUBSTANCE USE
FOR BETTER GLOBAL HEALTH
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www.who.int/substance_abuse
ISBN 978 92 4 159940 5
9 789241 599405

Fragebogen t2 Interventionsgruppe

Session 2
Intervention Group (got BI in 1st session)

Magaca Waraystaha: _____
Name of interviewer

Taariikhda: _____ Wakhtiga: _____ Mudada Waraysiga: _____
Date *Time* *Duration of interview*

*Name of participant*_____

Phone number1: _____

Phone number2: _____

Section (place of interview): _____

Description of place where we find participant:_____
_____
_____
_____

Date for 8-week follow up (use the TLFB calendar to calculate)_____

INTERVIEWEE AGREED TO BE CONTACTED AND REMINDED FOR 3rd session ❑

CODE:(Numberka)_____Age:(dad a)_____ Date:(Tariiqda)_____

TIMELINE FOLLOWBACK CALENDAR

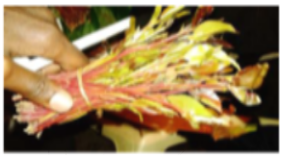
To help us evaluate your khat use, we need to get an idea of what your khat use was like in the past 30 days. To do this, we would like to fill out this calendar with you. It is not hard and I would like to try to be as accurate as possible. We recognize you won't have perfect recall. That's OKAY.The idea is to put a number in for each day on the calendar. On days when you did not chew, we should write a "0". On days when you did chew, you should write in the total number of standard units you had. (Show and explain standard units with extra pictures)

It's important that something is written for every day, even if it is a "0".

1 standard unit of khat is equal to



1 surba of Kangeta or



1 surba of Giza, Alenle, Asili, Lare or



1 bag of Magoka

Complete the Following (4 weeks): Start Date (Day 1): _____**End Date** (yesterday):_____

S	31	1	2	3	4	5	6
E	7	8	9	10	11	12	13
P	14	15	16	17	18	19	20
	21	22	23	24	25	26	27
	28	29	30	1	2	3	4
O	5	6	7	8	9	10	11
C	12	13	14	15	16	17	18
T	19	20	21	22	23	24	25
	26	27	28	29	30	31	1

Malmahee qaadka cunaysay.*For days when chewing miraa last week:*		
1	Imisa jeer ayaad si iskuxigta u isticmaashay khatka mudo dheer oo 24 saacdood ama in kabadan isbuuci lasoo dhaafay. *How many times did you continuously you chew miraa for extremely long periods of 24 hours and more last week? Times:* _____	
2	Asbuucii tagay malintii intee saacadood baa ku dhumisaa cunida qaadaka.*What is the usual number of hours spent chewing miraa per day in last week:* *Calculation:* _____ *days chewed x* _____ *hours per day ÷ 7 =*	_____hours
Asbuucii tagay jaadkaiyo hurdada:*Miraa and sleep last week*		
3	Asbuucii tagay afar iyo labaatan saacadood intee saac baa ka seexatay: *How many hours of sleep per 24 hours did you have last week*	_____hours
4	Asbuuci tagay meeqo habayn ayaada seexan hurdo (inta u dhaxaysa 10 p.m. iyo 5 a.m.)? *How many times during the last week did you not sleep during the night (between 10 p.m. and 5 a.m.) because of miraa.*	_____times

			Haa	Maya
24	Ma umaleeneesaa in aad yareysay isticmaalkaga khatka 4tii isbuuc ee lasoo dhaafay? *Do you think, you reduced your khat use in the past 4 weeks?*		☐	☐
25	**hadii maya tahay,sabab?** *If no, why?*			
	Lack of alternative activities (no job, no hobbies)	Howl lagu bedelo la,aan(shaqo la,aan-hiwaayad al,aan-koox kale)	☐	☐
	Failure to disclose to family	ku guuldareysi inay usheegaan qoyska	☐	☐
	Lack of family support	caawinaad qoyska la,aan	☐	☐
	Failure to disclose to friends	ku guuldareysi inay usheegaan asxabta	☐	☐
	Lack of support of friends	caawinaad la, aan asxaabta	☐	☐
	peer pressure	asaagaaga	☐	☐
	Not concerned about use	aan kawalwaleyn isticmaalka	☐	☐
	Need awakening effect for work	ubaahan saameyn baraarujin ee shaqo	☐	☐
	Fear withdrawal symptoms (headache...)/ don't want to miss stimulating effect	cabsi astaamaha ka dhexbixis (haadache..) aan rabin waxyeelada takoorida	☐	☐
	Many environmental khat-related cues	Intabadan Deegaanka oo khat laxiriira	☐	☐
	No other coping strategies for problems	aan leheen xeelado kale oo tacaalid dhibaatooyinka	☐	☐
	Other, please specify	kuwa kale fadlan qeex _____ _____ _____	☐	☐
26	**haday haa tahay xeelad noocee ayaa kucaawisay?** *If yes, which strategy helped you?*			
			Haa	Maya
	Alternative activities? Please specify:	howlo/waxqabadyo kale?fadlan qeex: a.)_____ b.)_____ c.)_____ d.)_____	☐	☐
	Disclosure to family / Family support	usheegid qoyska/caawinaad qoyska	☐	☐
	Disclosure to friends / friend's support	usheegid asxaabta /caawinaad asxaabta	☐	☐
	Changing social setting (avoiding chewing friends)	bedelid goobaha bulshada(kafogaansho asxaabta qayisha	☐	☐
	Other, please specify	kuwa kale fadlan qeex _____ _____ _____	☐	☐
27	Sidee ayuu kuu caawiyay kullan kii latalinta ee yareynta/jojinta isticmaalkaaga khatka *How helpful was the counselling session for reducing/stopping your khat use?*	☐ marna *Not at all* ☐ xoogaa *a bit* ☐ aad *very*		
28	qeybtee inta badan ku dhiira gelisay?)si aad kuu caawisay *Which part motivated you most?/was most helpful*		Haa *yes*	Maya *no*
	Information about risks	warbixin kusaabsan dhibaatada	☐	☐
	Talking about individual good and less good things	hadal kusaabsan shaqsi wanaga iyo wanaag la,aanta	☐	☐
	Self help booklet	buuga yar ee cawinta nafta	☐	☐
29	Ma aqrisay buuga yar? *Did you read the booklet?*		☐	☐
30	Mabuuxisay bokis yada? Did you work with the tables?		☐	☐
31	isdee cawinad buuxda ooga heshay buuga yar ee cawinta nafta yareynta isticmaalkaaga khatka? *How helpful did you find the self-help-booklet for reducing your khat use?*	☐ marna *Not at all* ☐ xoogaa *a bit* ☐ aad *very*		
32	yaad kala hadashay kullankii latalinta? *With whom did you talk about the counselling session?*		Haa *yes*	Maya *no*
		qoyska *Family*	☐	☐
		Saxibada *Friends*	☐	☐
	asxaab kuwaasoo xitaa kakhayb khaatay wax barashadeena_____ (si loo hubiyo hadii uuyahay isla kooxda *Friends that also participated in our study , Name____ - (to check if same group)*		☐	☐

Fragebogen t2 Kontrollgruppe

Session 2
Control Group (no intervention in 1st session)

Magaca Waraystaha: _____
Name of interviewer

Taariikhda: _____ Wakhtiga: _____ Mudada Waraysiga: _____
Date *Time* *Duration of interview*

*Name of participant*_____

Phone number1: _____

Phone number2: _____

Section (place of interview): _____

Description of place where we find participant:_____
_____
_____
_____

Date for 8-week follow up (use the TLFB calendar to calculate)_____

INTERVIEWEE AGREED TO BE CONTACTED AND REMINDED FOR 3rd session ❑

CODE:(Numberka)_____Age:(dad a)_____ Date:(Tariiqda)_____

TIMELINE FOLLOWBACK CALENDAR

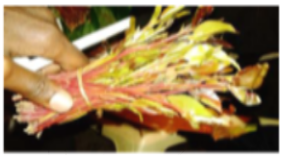
To help us evaluate your khat use, we need to get an idea of what your khat use was like in the past 30 days. To do this, we would like to fill out this calendar with you. It is not hard and I would like to try to be as accurate as possible. We recognize you won't have perfect recall. That's OKAY.The idea is to put a number in for each day on the calendar. On days when you did not chew, we should write a "0". On days when you did chew, you should write in the total number of standard units you had. (Show and explain standard units with extra pictures)

It's important that something is written for every day, even if it is a "0".

1 standard unit of khat is equal to



1 surba of Kangeta or



1 surba of Giza, Alenle, Asili, Lare or



1 bag of Magoka

Complete the Following (4 weeks): Start Date (Day 1): _____**End Date** (yesterday):_____

S	31	1	2	3	4	5	6
E	7	8	9	10	11	12	13
P	14	15	16	17	18	19	20
	21	22	23	24	25	26	27
	28	29	30	1	2	3	4
O	5	6	7	8	9	10	11
C	12	13	14	15	16	17	18
T	19	20	21	22	23	24	25
	26	27	28	29	30	31	1

Malmahee qaadka cunaysay.*For days when chewing miraa last week:*		
1	Imisa jeer ayaad si iskuxigta u isticmaashay khatka mudo dheer oo 24 saacdood ama in kabadan isbuuci lasoo dhaafay. *How many times did you continuously you chew miraa for extremely long periods of 24 hours and more last week? Times:* _____	
2	Asbuucii tagay malintii intee saacadood baa ku dhumisaa cunida qaadaka.*What is the usual number of hours spent chewing miraa per day in last week:* *Calculation:* _____ *days chewed x*_____ *hours per day ÷ 7 =*	_____hours
Asbuucii tagay jaadkaiyo hurdada:*Miraa and sleep last week*		
3	Asbuucii tagay afar iyo labaatan saacadood intee saac baa ka seexatay: *How many hours of sleep per 24 hours did you have last week*	_____hours
4	Asbuuci tagay meeqo habayn ayaada seexan hurdo (inta u dhaxaysa 10 p.m. iyo 5 a.m.)? *How many times during the last week did you not sleep during the night (between 10 p.m. and 5 a.m.) because of miraa.*	_____times

Fragebogen t3 Interventionsgruppe

Session 3
Intervention Group (intervention in 1st session, "refresher" in 2nd session)

Magaca Waraystaha: _____

Name of interviewer

Taariikhda: _____ Wakhtiga: _____ Mudada Waraysiga: _____

Date *Time* *Duration of interview*

*Name of participant*_____

Phone number1: _____

Phone number2: _____

Section (place of interview): _____

Description of place where we find participant:_____

_____

_____

_____

CODE:(Numberka)_____Age:(dad a)_____ Date:(Tariiqda)_____

TIMELINE FOLLOWBACK CALENDAR

To help us evaluate your khat use, we need to get an idea of what your khat use was like in the past 30 days. To do this, we would like to fill out this calendar with you. It is not hard and I would like to try to be as accurate as possible. We recognize you won't have perfect recall. That's OKAY.The idea is to put a number in for each day on the calendar. On days when you did not chew, we should write a "0". On days when you did chew, you should write in the total number of standard units you had. (Show and explain standard units with extra pictures)

It's important that something is written for every day, even if it is a "0".

1 standard unit of khat is equal to



1 surba of Kangeta or



1 surba of Giza, Alenle, Asili, Lare or



1 bag of Magoka

Complete the Following (4 weeks): Start Date (Day 1): _____**End Date** (yesterday):_____

S	31	1	2	3	4	5	6
E	7	8	9	10	11	12	13
P	14	15	16	17	18	19	20
	21	22	23	24	25	26	27
	28	29	30	1	2	3	4
O	5	6	7	8	9	10	11
C	12	13	14	15	16	17	18
T	19	20	21	22	23	24	25
	26	27	28	29	30	31	1

Malmahee qaadka cunaysay.*For days when chewing miraa last week:*		
1	Imisa jeer ayaad si iskuxigta u isticmaashay khatka mudo dheer oo 24 saacdood ama in kabadan isbuuci lasoo dhaafay. *How many times did you continuously you chew miraa for extremely long periods of 24 hours and more last week? Times:* _____	
2	Asbuucii tagay malintii intee saacadood baa ku dhumisaa cunida qaadaka.*What is the usual number of hours spent chewing miraa per day in last week:* *Calculation:* _____ *days chewed x*_____ *hours per day ÷ 7 =*	_____hours
Asbuucii tagay jaadkaiyo hurdada:*Miraa and sleep last week*		
3	Asbuucii tagay afar iyo labaatan saacadood intee saac baa ka seexatay: *How many hours of sleep per 24 hours did you have last week*	_____hours
4	Asbuuci tagay meeqo habayn ayaada seexan hurdo (inta u dhaxaysa 10 p.m. iyo 5 a.m.)? *How many times during the last week did you not sleep during the night (between 10 p.m. and 5 a.m.) because of miraa.*	_____times

Screening questions for present delusions and hallucinations(Modified excerpt from CIDI, part G)(World Health Organization. 1997)			
During the last 4 weeks... TICK YES ONLY IF IMPLAUSIBLE! ASK FOR MIRAA!		Yes haa	No maya
29	Ma rumaysan tahay inay dad ku daba socdaan? *Do you believe that people are following you?* a. Sidee ayaad ku ogaatay inay dadku ku daba gurayaan ama ku daba socdaan *How do you know that people are following you? implausible?* b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑ ❑	❑ ❑
30	Ma hubtaa in qof aan adiga ahayni uu awooddaada kuu hayo ama uu ku kaantaroolayo? Sidaa darteed ficilkaaga iyo fikirkaaga aanay ahayn kuwaagii ama uu go'aaminayo qof kale. *Are you convinced that you are under control of some power or force, so that you actions or thoughts are not your own or determined by someone else?* a. Kuma ama maxay ayaa ku xukumaya ama kaantaroolaya/xukumid? *Who or what power or force controlles you? implausible?)* b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑ ❑	❑ ❑
31	Mararka qaar ma dhacdaa inaad maqashid waxyaabo aanay maqlanayn dadka kula joogaa? *Does it sometimes happen that you can hear things other people can not hear?* a. Maxaad maqashaa? Sidee baad usharixi kartaa? *What do you hear? How do you explain this? (implausible?)* b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑ ❑	❑ ❑
32	Mararka qaarkood inay ku dhacaan jidhkaaga oogadiisa ama jirka gudihiisa dareenno aan caadi ahayn- sidii adoo lagu taabanayo iyada oon cidi kuu dhoweyn ama aad dareento sidii adoo jirkaaga wax dhex socsocdaan? *Do you sometimes have unusual feelings on your skin or inside your body – like being touched when nothing is there or feeling something moving inside your body?* a. Maxaad dareentaa *What do you feel then? (implausible?)* b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑ ❑	❑ ❑
33	Immisa maalmood, toddobaad, bilood amma sannadood ka hor ayay arrintani kugu bilaabatay? *How many days/weeks/years ago did these phenomena begin? a.* b. Age:		

PHQ 9 – Murug *Depression*		Not at all marnaba	Several days Dhowr maalmood	More than half the days Kabadan maalmaha barkood	Nearly every day Kudhawaan maaliin kasta
Labadii isbuuc ee ugu danbaysay ma ku dhibeen mid kamida dhibaatooyinkaan soo socda *Over the last 2 weeks, how often have you been bothered by any of the following problems?*		0	1	2	3
34	Xiiso yar ama kuraaxeysato sameynta waxyaabo *Little interest or pleasure in doing things*				
35	Niyad jab,muruug iyo rajo la'aan *Feeling down, depressed, or hopeless*				
36	Kugu adkaato inad seexatid, iska jiifto ama hurdo badan *Trouble falling asleep, staying asleep, or sleeping too much*				
37	Daal aa dareemaysid ama awooda oo kugu yar *Feeling tired or having little energy*				
38	C unto xumo ama cunitaan badni *Poor appetite or overeating*				
39	Si xun aad dareemaysid, aad dareemaysid inaad fashilantay, ama dareemaysid inaad naftaada ama qoyskaaga hoos udhigtay (qiimo la'aan, dambiile,...) *Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down (feeling worthless, guilty, ...)*				
40	Dhib ay kugu tahay inaad wax xooga saartid sida aqriska wargayska ama daawashada televison *Trouble concentrating on things such as reading the newspaper or watching television*				

41	U dhaqaaqid ama u hadlid si tartiib ah taaso dadka kale ay dareemi karaan. tacbaan ama nasasha la'aan noqotid aad in badan dhaqdhaqaaqday kabadan inti caadiga ahayd *Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual*				
42	ku fakaraysid inaad dhimasho ku fiicnaan lahayd ama aad rabto inaad naftaada si uun u waxyeelayso. *Thinking that you would be better off dead or that you want to hurt yourself in some way.*				
43	Guud *Total*				

Worst Event (write number):_____

PDS Somali Short Version (Odenwald, Neuner et al. 2005) *(Rate yes, when already clear, if not probe again)*		Yes haa	No maya
66	Ma dareentay inaadan waxba qaban karayn, Ma dareentay argagax marka aad kusugan tahay xalad qatar ah ama markaad ufirsato si toos ah qof kale noloshiisa oo kusugan qatar? Hadey tahay maya kabood PDS. *Did you ever feel helpless or horrified when you were in a situation in which your life was in danger or when you directly observed that someone's else's life was in danger? If no skip the PDS*		
67	Majiraan Xusuuso kicinaya ama murugo naxdin leh oo la xariira dhacdada saameynta leh ee ku soo noqonaysa maskaxdaada adigoon rabin?. *Do you have upsetting thoughts or images about these bad events that come into your head even when you don't want them to? Did you experience this last month (= last four weeks)?*		
68	Ma isku daydaa in aadan ka fakarin, ka hadlin ama dareemin dhacdadaan ugu xun ee kugu dhacday. Miyaad sidoo kale ka fogaatay arintaan bishii lasoo dhaafay, (4tii asbuuc ee ugu danbaysay) *Do you try not to think about, talk about or have feelings about the most shocking experiences, that you had? Did you also avoid this in the last month (= last four weeks)?*		
69	Ma dareentaa in rajadaadii ama qorshahaagii mustaqbal aanay rumoobeyn, tusaale, inaadan yeelanayn takhasus, waxbarasho, guur, caruur, cimri dheer, ma lakulantaytan bishii ugu danbaysay (4tii asbuuc ee lasoo dhaafay) *Do you feel as if your future plans or hopes will not come true for example, you won't have a career, marriage, children or a long life? Did you experience this in the last month (= last four weeks)?*		
70	Dhibaatooyin maqabta markaad seexaneysid ama markaad jiiftid? Sidaan maisku aragtay bishii lasoo dhaafay? *Do you have trouble falling asleep or staying asleep? Did you experience this in the last month (= last four weeks)?*		
71	Ma fudfuduudahay ama manaxdaa (Tusaale:markaad si kadis ah qwylo umaqashid ama markaad si kadis ah uragtid qof gadaashaada socdo) sidaaan maisku aragtay bishii lasoo dhaafay? *Are you jumpy or easily startled (for example, when there is a sudden noise or when you suddenly find someone walking behind you?) Did you experience this in the last month?*		

24	Ma umaleeneesaa in aad yareysay isticmaalkaga khatka 4tii isbuuc ee lasoo dhaafay? *Do you think, you reduced your khat use in the past 4 weeks?*		Haa ☐	Maya ☐
25	**hadii maya tahay,sabab?** *If no, why?*			
	Lack of alternative activities (no job, no hobbies)	Howl lagu bedelo la,aan(shaqo la,aan-hiwaayad al,aan-koox kale)	☐	☐
	Failure to disclose to family	ku guuldareysi inay usheegaan qoyska	☐	☐
	Lack of family support	caawinaad qoyska la,aan	☐	☐
	Failure to disclose to friends	ku guuldareysi inay usheegaan asxabta	☐	☐
	Lack of support of friends	caawinaad la, aan asxaabta	☐	☐
	peer pressure	asaagaaga	☐	☐
	Not concerned about use	aan kawalwaleyn isticmaalka	☐	☐
	Need awakening effect for work	ubaahan saameyn baraarujin ee shaqo	☐	☐
	Fear withdrawal symptoms (headache…)/ don´t want to miss stimulating effect	cabsi astaamaha ka dhexbixis (haadache..) aan rabin waxyeelada takoorida	☐	☐
	Many environmental khat-related cues	Intabadan Deegaanka oo khat laxiriira	☐	☐
	No other coping strategies for problems	aan leheen xeelado kale oo tacaalid dhibaatooyinka	☐	☐
	Other, please specify	kuwa kale fadlan qeex _____ _____ _____	☐	☐
26	**haday haa tahay xeelad noocee ayaa kucaawisay?** *If yes, which strategy helped you?*			
			Haa	Maya
	Alternative activities? Please specify:	howlo/waxqabadyo kale?fadlan qeex: a.)_____ b.)_____ c.)_____ d.)_____	☐	☐
	Disclosure to family / Family support	usheegid qoyska/caawinaad qoyska	☐	☐
	Disclosure to friends / friend´s support	usheegid asxaabta /caawinaad asxaabta	☐	☐
	Changing social setting (avoiding chewing friends)	bedelid goobaha bulshada(kafogaansho asxaabta qayisha	☐	☐
	Other, please specify	kuwa kale fadlan qeex _____ _____ _____	☐	☐
27	Sidee ayuu kuu caawiyay kullan kii labaad ee latalinta, yareynta/jojinta isticmaalkaaga khatka *How helpful was the "refresher" session for reducing/stopping your khat use?*	☐ marna *Not at all*	☐ xoogaa *a bit*	☐ aad *very*
28	qeybtee inta badan ku dhiira gelisay?)si aad kuu caawisay *Which part motivated you most?/was most helpful*		Haa *yes*	Maya *no*
	Information about risks	warbixin kusaabsan dhibaatada	☐	☐
	Talking about individual good and less good things	hadal kusaabsan shaqsi wanaga iyo wanaag la,aanta	☐	☐
	Additional tables	Bokis yada lagu soo kor dhiyay	☐	☐
29	Mabuuxisay bokis yada lagu soo kor dhiyay? *Did you work with the additional tables?*		☐	☐
30	yaad kala hadashay kullankii latalinta? *With whom did you talk about the counselling session?*		Haa *yes*	Maya *no*
		qoyska *Family*	☐	☐
		Saxibada *Friends*	☐	☐
	asxaab kuwaasoo xitaa kakhayb khaatay wax barashadeena_____ (si loo hubiyo hadii uuyahay isla kooxda *Friends that also participated in our study , Name____ - (to check if same group)*		☐	☐

Fragebogen t3 Kontrollgruppe

Session 3
Control Group (no intervention in 1st and 2nd session)

Magaca Waraystaha: _____

Name of interviewer

Taariikhda: _____ Wakhtiga: _____ Mudada Waraysiga: _____

Date *Time* *Duration of interview*

*Name of participant*_____

Phone number1: _____

Phone number2: _____

Section (place of interview): _____

Description of place where we find participant:_____

_____

_____

_____

CODE:(Numberka)_____Age:(dad a)_____ Date:(Tariiqda)_____

TIMELINE FOLLOWBACK CALENDAR

To help us evaluate your khat use, we need to get an idea of what your khat use was like in the past 30 days. To do this, we would like to fill out this calendar with you. It is not hard and I would like to try to be as accurate as possible. We recognize you won't have perfect recall. That's OKAY.The idea is to put a number in for each day on the calendar. On days when you did not chew, we should write a "0". On days when you did chew, you should write in the total number of standard units you had. (Show and explain standard units with extra pictures)

It's important that something is written for every day, even if it is a "0".

1 standard unit of khat is equal to



1 surba of Kangeta or



1 surba of Giza, Alenle, Asili, Lare or



1 bag of Magoka

Complete the Following (4 weeks): Start Date (Day 1): _____**End Date** (yesterday):_____

S	31	1	2	3	4	5	6
E	7	8	9	10	11	12	13
P	14	15	16	17	18	19	20
	21	22	23	24	25	26	27
	28	29	30	1	2	3	4
O	5	6	7	8	9	10	11
C	12	13	14	15	16	17	18
T	19	20	21	22	23	24	25
	26	27	28	29	30	31	1

Malmahee qaadka cunaysay.*For days when chewing miraa last week:*		
1	Imisa jeer ayaad si iskuxigta u isticmaashay khatka mudo dheer oo 24 saacdood ama in kabadan isbuuci lasoo dhaafay. *How many times did you continuously you chew miraa for extremely long periods of 24 hours and more last week? Times:* _____	
2	Asbuucii tagay malintii intee saacadood baa ku dhumisaa cunida qaadaka.*What is the usual number of hours spent chewing miraa per day in last week:* *Calculation:* _____ *days chewed x* _____ *hours per day ÷ 7 =*	_____hours
Asbuucii tagay jaadkaiyo hurdada:*Miraa and sleep last week*		
3	Asbuucii tagay afar iyo labaatan saacadood intee saac baa ka seexatay: *How many hours of sleep per 24 hours did you have last week*	_____hours
4	Asbuuci tagay meeqo habayn ayaada seexan hurdo (inta u dhaxaysa 10 p.m. iyo 5 a.m.)? *How many times during the last week did you not sleep during the night (between 10 p.m. and 5 a.m.) because of miraa.*	_____times

Now I´m coming to some questions on symptoms that we often find.

Screening questions for present delusions and hallucinations(Modified excerpt from CIDI, part G)(World Health Organization. 1997)			
During the last 4 weeks... TICK YES ONLY IF IMPLAUSIBLE! ASK FOR MIRAA!		Yes haa	No maya
29	Ma rumaysan tahay inay dad ku daba socdaan? *Do you believe that people are following you?*	❑	❑
	a. Sidee ayaad ku ogaatay inay dadku ku daba gurayaan ama ku daba socdaan *How do you know that people are following you? implausible?* _____ _____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
30	Ma hubtaa in qof aan adiga ahayni uu awooddaada kuu hayo ama uu ku kaantaroolayo? Sidaa darteed ficilkaaga iyo fikirkaaga aanay ahayn kuwaagii ama uu go'aaminayo qof kale. *Are you convinced that you are under control of some power or force, so that you actions or thoughts are not your own or determined by someone else?*	❑	❑
	a. Kuma ama maxay ayaa ku xukumaya ama kaantaroolaya/xukumid? *Who or what power or force controlles you? implausible?)*_____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
31	Mararka qaar ma dhacdaa inaad maqashid waxyaabo aanay maqlanayn dadka kula joogaa? *Does it sometimes happen that you can hear things other people can not hear?*	❑	❑
	a. Maxaad maqashaa? Sidee baad usharixi kartaa? *What do you hear? How do you explain this? (implausible?)* _____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
32	Mararka qaarkood inay ku dhacaan jidhkaaga oogadiisa ama jirka gudihiisa dareenno aan caadi ahayn- sidii adoo lagu taabanayo iyada oon cidi kuu dhoweyn ama aad dareento sidii adoo jirkaaga wax dhex socsocdaan? *Do you sometimes have unusual feelings on your skin or inside your body – like being touched when nothing is there or feeling something moving inside your body?*	❑	❑
	a. Maxaad dareentaa *What do you feel then? (implausible?)*_____ _____ _____		
	b. Kaliya intaa khatka cuneyso ama 6saac kadib *Only during or 6 hours after miraa use*	❑	❑
33	Immisa maalmood, toddobaad, bilood amma sannadood ka hor ayay arrintani kugu bilaabatay? *How many days/weeks/years ago did these phenomena begin? a.*_____b. Age:_____		

PHQ 9 – Murug *Depression*		Not at all marnaba	Several days Dhowr maalmood	More than half the days Kabadan maalmaha barkood	Nearly every day Kudhawaan maaliin kasta
Labadii isbuuc ee ugu danbaysay ma ku dhibeen mid kamida dhibaatooyinkaan soo socda *Over the last 2 weeks, how often have you been bothered by any of the following problems?*		0	1	2	3
34	Xiiso yar ama kuraaxeysato sameynta waxyaabo *Little interest or pleasure in doing things*				
35	Niyad jab,muruug iyo rajo la'aan *Feeling down, depressed, or hopeless*				
36	Kugu adkaato inad seexatid, iska jiifto ama hurdo badan *Trouble falling asleep, staying asleep, or sleeping too much*				
37	Daal aa dareemaysid ama awooda oo kugu yar *Feeling tired or having little energy*				
38	C unto xumo ama cunitaan badni *Poor appetite or overeating*				
39	Si xun aad dareemaysid, aad dareemaysid inaad fashilantay, ama dareemaysid inaad naftaada ama qoyskaaga hoos udhigtay (qiimo la'aan, dambiile,...) *Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down (feeling worthless, guilty, ...)*				

40	Dhib ay kugu tahay inaad wax xooga saartid sida aqriska wargayska ama daawashada televison *Trouble concentrating on things such as reading the newspaper or watching television*				
41	U dhaqaaqid ama u hadlid si tartiib ah taaso dadka kale ay dareemi karaan. tacbaan ama nasasha la'aan noqotid aad in badan dhaqdhaqaaqday kabadan inti caadiga ahayd *Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual*				
42	ku fakaraysid inaad dhimasho ku fiicnaan lahayd ama aad rabto inaad naftaada si uun u waxyeelayso. *Thinking that you would be better off dead or that you want to hurt yourself in some way.*				
43	Guud *Total*				

Worst Event (write number):_____

PDS Somali Short Version (Odenwald, Neuner et al. 2005) *(Rate yes, when already clear, if not probe again)*		Yes haa	No maya
66	Ma dareentay inaadan waxba qaban karayn, Ma dareentay argagax marka aad kusugan tahay xalad qatar ah ama markaad ufirsato si toos ah qof kale noloshiisa oo kusugan qatar? Hadey tahay maya kabood PDS. *Did you ever feel helpless or horrified when you were in a situation in which your life was in danger or when you directly observed that someone's else's life was in danger? If no skip the PDS*		
67	Majiraan Xusuuso kicinaya ama murugo naxdin leh oo la xariira dhacdada saameynta leh ee ku soo noqonaysa maskaxdaada adigoon rabin?. *Do you have upsetting thoughts or images about these bad events that come into your head even when you don't want them to? Did you experience this last month (= last four weeks)?*		
68	Ma isku daydaa in aadan ka fakarin, ka hadlin ama dareemin dhacdadaan ugu xun ee kugu dhacday. Miyaad sidoo kale ka fogaatay arintaan bishii lasoo dhaafay, (4tii asbuuc ee ugu danbaysay) *Do you try not to think about, talk about or have feelings about the most shocking experiences, that you had? Did you also avoid this in the last month (= last four weeks)?*		
69	Ma dareentaa in rajadaadii ama qorshahaagii mustaqbal aanay rumoobeyn, tusaale, inaadan yeelanayn takhasus, waxbarasho, guur, caruur, cimri dheer, ma lakulantaytan bishii ugu danbaysay (4tii asbuuc ee lasoo dhaafay) *Do you feel as if your future plans or hopes will not come true for example, you won't have a career, marriage, children or a long life? Did you experience this in the last month (= last four weeks)?*		
70	Dhibaatooyin maqabta markaad seexaneysid ama markaad jiiftid? Sidaan maisku aragtay bishii lasoo dhaafay? *Do you have trouble falling asleep or staying asleep? Did you experience this in the last month (= last four weeks)?*		
71	Ma fudfuduudahay ama manaxdaa (Tusaale:markaad si kadis ah qwylo umaqashid ama markaad si kadis ah uragtid qof gadaashaada socdo) sidaaan maisku aragtay bishii lasoo dhaafay? *Are you jumpy or easily startled (for example, when there is a sudden noise or when you suddenly find someone walking behind you?) Did you experience this in the last month?*		

WHO ASSIST (modification of v 3.0)

Waa ku mahadsantahay aqbalaadaada ah in aad nagala qeyb qaadato wareysigan ku aadan khatka,tubaakada iyo daroogooyinka kale.Waxaa ku weydiinayaa su'aalo yar oo ku saabsan qibradaada ku aadan isticmaalka walxahan noloshaada oo idil iyo saddexdi bilood ee u danbeesay.Walxahan waa la cabbi karaa ama la liqi karaa ama waa la fiifin karaa ama waa la isku durri karaa ama waxaa loo qaadan karaa sidda kaniini camal (tussi kaarka daroogadda)

Walxaha qaar ee lacayimay waxaa laga yaabaa in uu soo qoray dhaqtar (sida daawooyinka badiyo awooda,xassilin,iyo xanuun yareeyaha).wareysigan guddihiis ma diiwaan gellineyno daawooyinka uu qoray dhaqtar.haddaba waxa aad u qaadatay daawooyinkan sababo aa aheeyn in laguu qoray oo kaliya ama u qaadatay si xad dhaaf ah ama ka badan inta laguu qoray.fadlan ii ogoloow in aa ogaano.anaga oo waliba daneeneyna in aa ogaano isticmaalkaada daroogada sharciga eheen.fadlan ogoow in warbixintaada ku aadan isticmaalka walxahan ee tahay mid aad kalsooni ku qabtid mar walba.

"Now I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be available in pharmacies or prescribed by a doctor (like sedatives, pain medications or amphetamines). For this interview, we will not record medications that are used as prescribed by your doctor, i.e. to treat a disease. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. Please be assured that all information we get from you will be treated as strictly confidential."

Inta aadan weydiinin su'aalo,sii ASSIST jawaabta kaarka ee bukaanka. *Note: before asking questions, give ASSIST response card to patient*

Question1

Noloshaada,walxahan soo socda mid kee baa waligaa isticmaashay? (kuwa aa laguu soo qorin kaliya) *In your life, which of the following substances have you ever used (non medical use only)?*	*No* Maya	*yes* haa
a. Miraa/Khat (Chat, Giza, Alene, Magoca,...)	0	3
b. Walxaha tubaakada (sigaarka,tubaakada lacalaanjiyo iyo waxii la mid ah) *Tobacco products (cigarettes, chewing tobacco, cigars, etc.)*	0	3
c. Kaniiniyaasha hurdada sida (valium, serepax, Rohypnol, iyo waxii la mid ah.) *Sedatives or sleeping pills (valium, serepax, Rohypnol, etc.)*	0	3
d. Cannabis (marijuwaana,pot,grass,hash,iyo waxii la mid ah) *Cannabis (marijuana, pot, grass, hash, etc.)*	0	3
e. Alcoholic beverages (beer, wine, spirits etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, iyo waxii la mid ah.) *Inhalants (nitrous, glue, petrol, paint thinner, etc.)*	0	3
g. nooc Amphetamine ah(xawli, diet pills, ecstasy iyo waxii la mid ah) *Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)*	0	3
h. xashiish (coke, crack, iyo waxi la mid ah.) *Cocaine (coke, crack, etc.)*	0	3
i. hallucination (LSD, acid, mushrooms, PCP, Special K, iyo waxi lamid ah.) *Halluzinogenes (LSD, acid, mushrooms, PCP, Special K, etc.)*	0	3
j. Opioids (heroin, morphine, methadone, codeine, iyo waxi la mid ah) *Opioids (heroin, morphine, methadone, codeine, etc.)*	0	3
k. kuwo kale – sheeg Other – specify:.....	0	3

Baar haddii ee jawaabaha dhan yihiin diidmo ,xittaa markaa iskuulka dhiganeesay?" Haddii „maya" tahay waxyaalaha dhan jooji wareyiga. haddii „haa " tahay wax kamid ah walxahan weydii su'aasha labaad ee ku aadan isticmaalka walxahn

Probe if all answers are negative: „not even when you were in school?" If „no" to all items, stop interview If „yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

Saddexdi bilood ee u danbeesay ilaa intee in la eg ayaad isticmaashay walxahan aad xustay (daroogada koowaad,daroogada labaad,iyo waxi la mid ah) In the past three months, how often have you used the substances you mentioned (ask for all the drugs that the client told you)	marna ba never	Hal mar ama laba mar Once or twice	Bille ah monthly	Isbuucle ah weekly	Maalin kasto ama ku dhaw maalinkasto Daily or almost daily
a. Miraa/Khat (Chat, Giza, Alene, Magoca,...)	0	2	3	4	6
b. Walxaha tubaakada (sigaarka,tubaakada lacalaanjiyo iyo waxii la mid ah) *Tobacco products (cigarettes, chewing tobacco, cigars, etc.)*	0	2	3	4	6
c. Kaniiniyaasha hurdada sida (valium, serepax, Rohypnol, iyo waxii la mid ah.) *Sedatives or sleeping pills (valium, serepax, Rohypnol, etc.)*	0	2	3	4	6
d. Cannabis (marijuwaana,pot,grass,hash,iyo waxii la mid ah) *Cannabis (marijuana, pot, grass, hash, etc.)*	0	2	3	4	6
e. Alcoholic beverages (beer, wine, spirits etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, iyo waxii la mid ah.) *Inhalants (nitrous, glue, petrol, paint thinner, etc.)*	0	2	3	4	6
g. nooc Amphetamine ah(xawli, diet pills, ecstasy iyo waxii la mid ah) *Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)*	0	2	3	4	6
h. xashiish (coke, crack, iyo waxi la mid ah.) *Cocaine (coke, crack, etc.)*	0	2	3	4	6
i. hallucination (LSD, acid, mushrooms, PCP, Special K, iyo waxi lamid ah.) *Halluzinogenes (LSD, acid, mushrooms, PCP, Special K, etc.)*	0	2	3	4	6
j. Opioids (heroin, morphine, methadone, codeine, iyo waxi la mid ah) *Opioids (heroin, morphine, methadone, codeine, etc.)*	0	2	3	4	6
k. kuwo kale – sheeg *Other – specify:*.....	0	2	3	4	6

Haddii 'marnaba' tahay walaxaha dhan ee su'aasha labaad u bood su'aasha 6.
Haddii walxaha qaar ee suaasha labaad la isticmaalay saddexdi billood ee hore sii aad su'aasha saddexaad ,afaraad iyo shanaad ee walax kasto oo la isticmaalay.
If „never" to all items in question 2, skip to question 6.
If any substances in question 2 were used in the previous three months, continue with question 3,4 & 5 for each substance used.

Question 3

Saddexdi billood ee u danbeesay,meeqa mar ayaad laheed damac saa'id ah oo ku aadan isticmaalka walxahan.(daroogada koowaad,daroogada labaad,iyo waxii la mid ah) In the past three months, i.e. since (calculate 3 months back) how often have you had a strong desire or urge "Xaraaro" to use Khat.	marnaba *never*	Hal mar ama laba mar *Once or twice*	Bille ah *monthly*	Isbuucle ah *weekly*	Maalin kasto ama ku dhaw maalinkasto *Daily or almost daily*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,…)	0	3	4	5	6

Question 4

Saddexdi billood ee u danbeesay ilaa meeqa mar ayee isticmaalka walxahan kugu dhalisay caafimaad xummi,dhaqan ama dhaqaalo xummi.(daroogadda koowaad,daroogada labaad) During the past three months, how often has your use of khat led to health, social, legal or financial problems? Fill in EXAMPLES	marnaba *never*	Hal mar ama laba mar *Once or twice*	Bille ah *monthly*	Isbuucle ah *weekly*	Maalin kasto ama ku dhaw maalinkasto *Daily or almost daily*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,…)	0	4	5	6	7

Question 5

Saddexdi billood ee u danbeesay meeqa mar ayaad ku guul dareesatay in aad qabato waxyaalo aad qaban jirtay caadiyan sababo la xariira isticmaalka walxahan?(daroogada kooowaad,daroogada labaad) During the past three months, how often have you failed to do what was normally expected of you because of your use of khat? Fill in EXAMPLES	marnaba *never*	Hal mar ama laba mar *Once or twice*	Bille ah *monthly*	Isbuucle ah *weekly*	Maalin kasto ama ku dhaw maalinkasto *Daily or almost daily*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,…)	0	5	6	7	8

Su'aal su'aasha 6 iyo 7 ee walxaha idil ee la isticmaalo (tusaale ahaan suaasha 1)

Ask question 6 & 7 for all substances ever used (i.e. these endorsed in Question 1)

Question 6

Ma leedahay saaxiib ama qaraabo kale oo ka sheegtay isticmalkaada walxahan (daroogada koowaad,daroogada labaad? Has a friend or a relative or anyone else ever expressed concern about your use of khat ?	**maya, marnaba** *No, never*	**Haa ,saddexdi billood ee u danbeesay** *Yes, in the past 3 months*	**Haa ,laakiin ma ahan saddexdi billood ee u danbesay** *Yes, but not in the past 3 months*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,…)	0	6	3

Question 7

Waligaa ma isku dayday mana ku guuldareesatay in aad yareeso ama aad joojiso. (daroogada koowaad,daroogada labaad,iyo waxi la mid eh?). Have you ever tried and failed to control, cut down or stop using khat?	**maya, marnaba** *No, never*	**Haa ,saddexdi billood ee u danbeesay** *Yes, in the past 3 months*	**Haa ,laakiin ma ahan saddexdi billood ee u danbesay** *Yes, but not in the past 3 months*
a. Specific Miraa/Khat product (Chat, Giza, Alene, Magoca,…)	0	6	3

Question 8

	maya, marnaba *No, never*	**Haa ,saddexdi billood ee u danbeesay** *Yes, in the past 3 months*	**Haa ,laakiin ma ahan saddexdi billood ee u danbesay** *Yes, but not in the past 3 months*
Waligaa daroogo ma isku durtay? Have you ever used any drug by injection? (NON-MEDICAL USE ONLY)	0	2	1

Ogeysiis muhiim ah ***Important note:***

Bukaanka isku duray daroogo saddexdi billood ee u danbeesay waa in la weydiiyaa xilliyada uu isku duri jiray daroogada. Ogaanshaha xilliyaddan waxa ee sheegeeysaa heerka halista ee joogto iyo sida ugu wacan ee loo faragalin karo.

Hand out "risks associated with injecting" card, if YES. Brief Intervention will be given only for KHAT

Sida loo xisaabiyo xadka isticmaalka walxaha qaar.

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE

Wadarta walax kasto (lagu calaameeyay a. illaa j.) waa su'aasha 2 ilaa suaasha 7.haku darin natiijada laga helay suaasha 1 iyo suaasha 8 jawaabaha.tusaale ahaan ,natiijada cannabis-ka waxaa loo xisaabinayaa sida tan Q2c +Q3c+Q4c+Q5c+Q6c+Q7c

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do

not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be

calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c**

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT''S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Diiwangelinta natiijada walxaha qaar record specific substance score	Malaha faragelin no intervention	La farageliyay wax yar receive brief intervention	Aad loo daaweeyay more intensive treatment*
a. Miraa/Khat		0-10	11-26	27+

OGOW: qiimeeynta dheeriga ah iyo daawooyinka saaidka ah waxaa bixinaya qabiiro caafimaad ee jooga agagaarkaaga ama qabiiro ku takhasustay daaweeynta daroogada ama khatka ee meesha yaala.

NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s)

within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

KAARKA JAWAABTA EE BUKAANKA ***RESPONSE CARD FOR PATIENTS***

KAARKA JAWAABTA-WALXAHA

Response card – substances

a.	Miraa/Khat (Chat, Giza, Alene, Magoca,...)
b.	Walxaha tubaakada (sigaarka,tubaakada lacalaanjiyo iyo waxii la mid ah) *Tobacco products (cigarettes, chewing tobacco, cigars, etc.)*
c.	Kaniiniyaasha hurdada sida (valium, serepax, Rohypnol, iyo waxii la mid ah.) *Sedatives or sleeping pills (valium, serepax, Rohypnol, etc.)*
d.	Cannabis (marijuwaana,pot,grass,hash,iyo waxii la mid ah) *Cannabis (marijuana, pot, grass, hash, etc.)*
e.	Alcoholic beverages (beer, wine, spirits etc.)
f.	Inhalants (nitrous, glue, petrol, paint thinner, iyo waxii la mid ah.) *Inhalants (nitrous, glue, petrol, paint thinner, etc.)*
g.	nooc Amphetamine ah(xawli, diet pills, ecstasy iyo waxii la mid ah) *Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)*
h.	xashiish (coke, crack, iyo waxi la mid ah.) *Cocaine (coke, crack, etc.)*
i.	hallucination (LSD, acid, mushrooms, PCP, Special K, iyo waxi lamid ah.) *Halluzinogenes (LSD, acid, mushrooms, PCP, Special K, etc.)*
j.	Opioids (heroin, morphine, methadone, codeine, iyo waxi la mid ah) *Opioids (heroin, morphine, methadone, codeine, etc.)*
k.	kuwo kale – sheeg *Other – specify*:.....

Kaarka jawaabta (ASSIST suaasha 2-5)	***Response card (ASSIST Questions 2-5)***
Marnaba:ma isticmaalin 3 billood.	Never: not used in the last 3 months.
Hal mar ama labo :1 ama 2 mar saddexdi billood ee u danbeesay.	Once or twice: 1 to 2 times in the last 3 months.
Bille: 1 ama 3 mar bishi.	Monthly: 1 to 3 times in one month.
Isbuucle: 1 ama 4 mar isbuuci.	Weekly: 1 to 4 times per week.
Maalinle ama ugu badnaan maalin kasto: 5 ama 7 isbuuci.	Daily or almost daily: 5 to 7 days per week.

Kaarka jawaabta (ASSIST suaasha 6-8)	***Response card (ASSIST questions 6-8)***
Maya,marnaba.	No, Never
Haa,laakiin ma aha 3 billood ee u danbeesay.	Yes, but not in the past 3 months
Haa,saddexdi billood ee u danbeesay.	Yes, in the past 3 months

KAARKA JAWAABTA EE BUKAANKA. ***FEEDBACK REPORT CARD FOR PATIENTS***

MAGACA *Name*..... TAARIIKHDA TIJAABADA *Test date*.....

NATIIJADA WALXAHA QAAR *Specific substance involvement scores*

WALXAHA *substance*	NATIIJADA *score*	HEERKA QATARTA *risk level*		
a. Miraa/Khat		0-10 11-26 27+	HOOS DHEXE SARRE	*low* *moderate* *high*

NATIIJADAADA MAXEE KU MACNO TAHAY? ***What do your scores mean?***

HOOS : waxaa ku jirtaa xaalad caafimaad ee hooseesa iyo dhibaatooyin kale ee keentay isticmaalkaaga walxahan.

DHEXE: waxaa ku jirtaa xaalad caafimaad oo Qatar ah iyo dhibaatooyin kale oo ee keentay isticmaalkaaga walxhan

SARRE: waxaa ku jirtaa xaalad cafimaad oo darran oo aad kula kulmi kartid caafimaad xummi darran dhanka (caafimaad,bulsho,dhaqaale, xiriir sharci ah) oo ee kaliftay isticmaalkaaga walxahan

Low: *You are at low risk of health and other problems from your current pattern of use.*

Moderate: *You are at risk of health and other problems from your current pattern of substance use.*

High: *You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent*

Ma ka walwalsantahay isticmaalkaaga walxahan? ***Are you concerned about your substance use?***

b.khat	khatarta kaaga imaan karta waxa ee tahay... **Cunnida khatka si joogta ah waxaa la xariira**	hoose O	dhexxe O (sax hal)	sarre O
	Hurdo la'aan, cuntada oo kaa xiranto, miisaankaaga oo yaraada, caloosha oo ku socoto.			
	Caloosho ku fadhidhiisato, khal xanuun, madax xanuun, murqo xanuun.			
	Isbadal dabeecadeed, xanaaq, walaac, murugo, kacdoon, wali, qalqal, tuhun.			
	Ilkaha oo bolola, gargariir, wadno qaraac, neefta oo yaraato, galmada oo yaraato ama damac yari.			
	Xoogeysi, dabeecad dagaal, wadno xanuun, tusaale wadno qaraac.			
	Waali loo sababeenaayo ku celceliskadaawada.			
	Dhaawac maskaxeed joogta ah.			
	Beer xanuun, dhiig bax maskaxeed, kansarka afka.			

a. miraa/khat	your risk of experiencing these harms is... **regular khat chewing is associated with:**	low O	moderate O (tick one)	High O
	Difficulty sleeping, loss of appetite and weight loss, dehydration			
	Constipation, jaw clenching, headaches, muscle pain			
	Mood swings – irritability, anxiety, depression, agitation, mania, panic, paranoia			
	Teeth delay and loss, Tremors, irregular heartbeat, shortness of breath, impairment of reproductive function and sexual performance			
	Aggressive and violent behaviour, heart problems, e.g. palpitation			
	Psychosis after repeated use of high doses			
	Permanent damage to brain cells			
	Liver damage, brain haemorrhage, mouth cancer			

			Haa	Maya
24	Ma umaleeneesaa in aad yareysay isticmaalkaga khatka 4tii isbuuc ee lasoo dhaafay? *Do you think, you reduced your khat use in the past 4 weeks?*		□	□
25	**hadii maya tahay,sabab?** *If no, why?*			
	Lack of alternative activities (no job, no hobbies)	Howl lagu bedelo la,aan(shaqo la,aan-hiwaayad al,aan-koox kale)	□	□
	Failure to disclose to family	ku guuldareysi inay usheegaan qoyska	□	□
	Lack of family support	caawinaad qoyska la,aan	□	□
	Failure to disclose to friends	ku guuldareysi inay usheegaan asxabta	□	□
	Lack of support of friends	caawinaad la, aan asxaabta	□	□
	peer pressure	asaagaaga	□	□
	Not concerned about use	aan kawalwaleyn isticmaalka	□	□
	Need awakening effect for work	ubaahan saameyn baraarujin ee shaqo	□	□
	Fear withdrawal symptoms (headache…)/ don´t want to miss stimulating effect	cabsi astaamaha ka dhexbixis (haadache..) aan rabin waxyeelada takoorida	□	□
	Many environmental khat-related cues	Intabadan Deegaanka oo khat laxiriira	□	□
	No other coping strategies for problems	aan leheen xeelado kale oo tacaalid dhibaatooyinka	□	□
	Other, please specify	kuwa kale fadlan qeex _____ _____ _____	□	□
26	**haday haa tahay xeelad noocee ayaa kucaawisay?** *If yes, which strategy helped you?*			
			Haa	Maya
	Alternative activities? Please specify:	howlo/waxqabadyo kale?fadlan qeex: a.)_____ b.)_____ c.)_____ d.)_____	□	□
	Disclosure to family / Family support	usheegid qoyska/caawinaad qoyska	□	□
	Disclosure to friends / friend´s support	usheegid asxaabta /caawinaad asxaabta	□	□
	Changing social setting (avoiding chewing friends)	bedelid goobaha bulshada(kafogaansho asxaabta qayisha	□	□
	Other, please specify	kuwa kale fadlan qeex _____ _____ _____	□	□