

Perceptions of the social harms associated with khat use

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Independent Social Research

This report describes the findings from a study exploring the perceived social harms associated with the use of khat. The study comprised focus groups and interviews with: members of the Somali, Yemeni and Ethiopian communities; members of the wider community; and practitioners including those from health, education and enforcement fields. In addition, a short survey of Drug Action Teams (DATs) was conducted to gauge the availability of treatment service provision for khat users.

The study's key implications are as follows.

- **Khat use was widely found to be socially accepted** and its use was reported by practitioners and respondents from all three target communities to be widespread. However, frequent and heavy use was perceived to have negative consequences for the individual, his/her family and the community and was regarded as unacceptable.
- **There was widespread support for some level of Government intervention** from all groups of participants. Suggestions ranged from regulation of the import, distribution and sale of khat, to an outright ban. Some participants expressed an interest in seeing an increase in the availability of treatment services and support for heavy users of khat.
- **There were found to be few treatment or support services available for khat users.** Only a small handful of DATs had either dedicated services available for khat users or generic services that could be adapted to meet the needs of khat users.
- **There was some support for better quality information and data on khat.** A number of practitioners and community members felt that there was a need for good quality information on the extent of khat use and on the health and social effects of khat use.

Contents

1. Introduction	1
2. Khat – practices and trends	2
3. Cultural and religious attitudes towards khat use	5
4. Social harms associated with khat use	6
5. Attitudes towards Government intervention	8
6. Local treatment and support services	11
7. Conclusions	14
Appendix 1 Methodology	15
Appendix 2 Examples of khat-related services	17
References	19

Keywords

Drugs
Khat
Perceptions
Ethnic communities
Qualitative
Quantitative

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Research background

Khat is a vegetable stimulant grown and used (chewed) in the countries of East Africa and the Middle East and available through a variety of outlets in the UK. New data from the British Crime Survey¹ estimate that 0.2 per cent of the general adult population reported using khat in the last year although it is likely that use is higher in communities with a cultural history of khat use. Users report that it promotes alertness and relaxation. The Government's 2008-2018 Drug Strategy Action Plan seeks "improved understanding of the needs of khat users and their families" and culturally appropriate responses to users' needs. This research was commissioned to further inform policy in this area, refresh the evidence base on social harms associated with khat use, and address some key evidence gaps.

Objectives

This study examined: perceived social harms associated with khat; views on appropriate Government responses; services available to khat users; and the treatment service needs of khat users and their families.

Methods

The project combined qualitative and quantitative research methods including: focus groups with khat users and non-users in Somali, Yemeni and Ethiopian communities in England and Wales and with the general public in three sample areas; interviews with community workers and professionals; and a survey of Drug and Alcohol Action Teams in England. Fieldwork took place in London, Sheffield and Cardiff during May and June 2009.

Findings

Patterns of khat use

Khat chewing was reportedly widespread in all three communities and considered by users, non-users and many practitioners to be a normal, socially accepted practice, cutting across the social spectrum. Heavy khat use was perceived as problematic.

Respondents thought increasing numbers of people were using khat. Although users were mostly perceived to be men, khat chewing was also thought to be on the increase among women, young people and people born and brought up in the UK.

Perceived social harms

Perceived social harms of khat were mainly linked to heavy use, which some community and practitioner respondents also thought could be symptomatic of underlying social problems that were unrelated to khat use.

Perceptions of the harms associated with khat included harm to: physical and mental health; work and finances; and relationships, marriage and family life. Some respondents regarded khat as a barrier to community integration and progress in the wider UK society. Negative impacts were seen to arise from the manner, context and social settings in which khat tends to be distributed and consumed in addition to arising from the khat itself.

There were very few reports of associations between khat and crime or anti-social behaviour.

Appropriate forms of Government intervention

Some form of Government intervention in relation to khat was favoured by most community respondents and practitioners.

¹ British Crime Survey 2009/10.

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A range of suggestions for Government intervention were made including: regulation and control of import and sales; more education and awareness raising within statutory organisations; investment in the training of health professionals and community workers; funding research into the impacts of use and on effective treatments; funding local services to connect in appropriate ways with heavy users; and better national statistics on khat use. Some respondents favoured a total ban.

Services available to khat users

Few DATs reported services for khat users. Examples of local specialist services and activities were provided in a few areas and some other areas said they were able to provide support to khat users through general stimulant services but using staff with specialist knowledge of khat.

Some DATs said they had dropped khat specific services because of lack of funding or because too few people presented themselves to services to justify the investment. The vast majority of DATs who provided information had no specialist provision for khat users but said they would be able to cater for need through general stimulant services.

Demand for services for khat users

Expressed demand for treatment or support services was perceived to be low. Moderate users were unlikely to see khat as a problem and it was reportedly unusual for heavy khat users to come into contact with services except for health reasons possibly related to their use of khat.

Some community and practitioner respondents felt that existing treatment and service models were not culturally appropriate. Services with explicit links to other kinds of drug or alcohol treatment were seen as unlikely to appeal to khat users, particularly as it was thought that most khat users did not drink or take other drugs. Practitioners and community respondents also said that mainstream agencies were perceived to know little about khat and unlikely to have much to offer heavy users. Strong links with communities tended to be reported by DATs as crucial to effective service provision and developing and sharing 'best practice' models.

Most practitioners and some DATs felt that there was a continuing need: to raise awareness of the potential risks of harm; to provide information about harm minimisation; and to work with mafreshi (venues where khat is sold and consumed) to reduce public health risks and minimise any local nuisance.

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I. Introduction

This is the report of research into perceptions of social harms associated with the use of khat in Somali, Yemeni and Ethiopian communities in England and Wales. Views were sought from within these key communities, from professionals and practitioners directly involved with them, from mainstream drug and alcohol service providers and from members of the wider UK population. The research was carried out in London, Sheffield and Cardiff with fieldwork conducted during May and June 2009.

Research objectives

The research was to:

- explore the perceived social harms associated with khat affecting the user, his/her family and the wider community;
- explore differences in perceptions of harms by age group, country of origin and gender;
- investigate the level and type of service available to khat users and their families, and the expectations and needs of khat users from services;
- investigate views on the appropriate Government response to khat.

Background

Khat (quat, qat, chat) has been described as 'the most recent plant-based psychoactive substance to spread across global markets' (Anderson *et al.*, 2007) and is grown and consumed mainly in East Africa and the Middle East.

Users chew the leaves and stems over several hours to allow the active components to be isolated by enzymes in saliva and absorbed through the oral mucosa.

The alkaloid stimulant components of khat (cathine and cathinone) are Class C controlled substances² if extracted in their chemical form. However, it is legal to import, sell and consume khat itself in the UK.³ A distribution network ensures it reaches customers as soon as possible after harvesting. Freshness is important because the strength of khat starts to degrade 36 hours after picking.

In February 2005, the Government invited the Advisory Council on the Misuse of Drugs (ACMD) to advise on the use of khat in the UK and associated risks (ACMD, 2005). The ACMD report compared the pharmacology of khat with that of amphetamines but with effects that were much less dramatic (in this study, users reported that khat helped keep them alert and also relaxed and talkative.) The report confirmed the main khat chewing communities in the UK are Somali, Ethiopian and Yemeni and also Kenyan. The ACMD found no information on prevalence in the general population. They reported various studies, but none using random sampling techniques, that had found high levels of occasional use of khat in the three main communities. Levels were highest among males and among Somalis. Among male Somalis, levels of well over 50 per cent were reported but again not through large-scale random sampling methods. The same studies found that percentages reporting they chew every day were much lower, in single figures.

² Misuse of Drugs Act 1971.

³ Khat is banned in the US and Canada, as well as in a number of European countries.

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On the evidence at the time, the ACMD identified a need for education about the risks of khat and about risk reduction, both within khat using communities and among health professionals and others working with people in those communities. It also recommended: that suitable advice, prevention and treatment should be available outside the addiction services; that voluntary agreements should be sought with retailers of khat about its sale to people under the age of 18; and that the health and safety risks associated with the main venues (*mafreshi*), where khat is sold and consumed, should be addressed.

Since then, the 2008 Drug Strategy was published with a commitment to “...consider further the individual and social harms that may be brought about by the use of khat”, improve “understanding of the needs of khat users and their families” and give particular consideration to culturally appropriate responses to the needs of khat users and their families.

This research was commissioned to explore perceptions of the social harms associated with khat use in more detail, with a view to informing policy and addressing some evidence gaps. For example, much previous UK-based research has focused on the views of the Somali community and also of adult male khat users (e.g. Griffiths, 1998; Fowzi, 2004; Havell, 2004; Patel *et al.*, 2005).

Methods

Further details of the methodological approach taken in this study are detailed in Appendix I.

Research was carried out in three main sample areas – London, Sheffield, and Cardiff – which have significant concentrations of the communities of interest. The project combined qualitative and quantitative methods comprising the following.

- Ten focus groups with khat users and non-users in each of the three target communities – Somali, Ethiopian and Yemeni (n=82) to explore views about khat, patterns of use, perceived social harms and benefits and views on Government intervention.⁴
- A focus group in each of the sample areas with members of the general public living in localities where khat use is prevalent to explore perceptions of local nuisance and anti-social behaviour linked to khat.

⁴ Respondents to these groups were recruited with the aid of community partners in order to access hard-to-reach groups such as older women, refugees and non-English speakers.

- Twenty-one face-to-face in-depth interviews with community representatives and professionals working in localities where khat use is prevalent to explore views about social harm and service provision.
 - A quantitative survey of Drug and Alcohol Action Teams in England to gauge the availability of treatment service provision for khat users.
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2. Khat – practices and trends

Introduction

This section discusses patterns in use reported by respondents. It outlines where and when khat was reported to be consumed, and points to the difference between khat use regarded as ‘normal’ and ‘problematic’.

Who uses khat and where

The participants suggested khat use in the UK was widespread within all three study communities – Somali, Yemeni, and Ethiopian – and across the social spectrum. The main users were reported to be adult males, but increasing use among women and young people was also reported.

According to respondents, khat is chewed mostly either at home with friends, or in a *mafresh* (khat house).⁵ Chewing at home was said to be common among both men and women, for example when watching football or getting together with friends for an evening. Respondents said women chewed mainly at home because *mafreshi* were usually all-male environments, and khat chewing among women was still often seen as taboo .

“Women users are not accepted. Women have to chew in their homes and cannot publicly say they use khat.”

Females aged 25 to 50 – Somali⁶

⁵ Some *mafreshi* are open to the public; others operate as private clubs with members paying weekly or monthly fees.

⁶ Throughout this report, illustrative quotes from focus groups are labelled to show which group they came from, but not which individual. If quotes from two individuals are included in the same illustration, their contributions are separated by quotation marks.

Chewing in a mafresh was reported as common among men of all age groups, with sessions comprised mostly of people from a single ethnic background. This was said to be part of the appeal for many people: to feel a sense of connection with their countries of origin and talk about community news or politics “back home”:

“Politics, Somali politics, education, employment, people will sit around and talk about things.”

Practitioner, Somali

Respondents described mafreshi as varying widely from large, well-appointed establishments with comfortable seating and widescreen televisions, to small, poorly ventilated and dingy rooms in private homes, flats sublet for the purpose or the basements of cafes or restaurants:

“It’s a place where there are twenty men, it’s like a pub, a small council house, no fire exit, smoking and drinking tea and chewing khat...”

Practitioner and anti-khat campaigner, Somali

Ethiopians in London mentioned a trend for Ethiopian restaurants to rent out well-furnished rooms for private functions where khat might be chewed.

In one area, there were reports of khat being chewed in open spaces such as parks or the street.

Where khat is sold

Khat was reported to be readily available in areas where khat user communities are concentrated. Some respondents said the number and variety of outlets trading khat had increased significantly in recent years. Respondents from all communities reported the local sale of khat directly from car boots, in local grocery stores, cafes, and restaurants, as well as dedicated mafreshi.

Some community practitioners believed that khat brought significant economic benefit to businesses, not only mafreshi but also cafes, restaurants and local shops. Some saw it as helpful in stimulating local economies and increasing community prosperity. However, focus group participants rarely made this case. They thought that few businesses relied solely or mainly on khat sales, and that the main beneficiaries of local khat sales were importers or mafreshi owners.

How khat is consumed

Khat is sold wrapped in banana leaves, referred to as ‘bundles’, and users chew between one and five bundles in a session. The cost is from £3 to £5 per bundle depending on the locality and the variety of khat.

Respondents said sessions could go on for several hours, because khat needs to be chewed for some time in order to have a stimulant effect, and sessions are occasions to chat and exchange news.

Smokers often said that they smoked more than usual when chewing khat – cigarettes and/or shisha pipes. A minority of users – usually younger people – mentioned drinking a caffeine drink or taking paracetamol (some varieties of which contain caffeine) during sessions to enhance the stimulant effect. Younger Ethiopians reported sometimes drinking alcohol while chewing khat:

“Some people use beer during and after khat.”

“It gives you balance, because khat is a stimulant and alcohol is a depressant.”

Males aged 18 to 24 – Ethiopian

Drinking alcohol alongside khat was, however, rare as most respondents were from a Muslim background and did not drink alcohol. Some younger Ethiopian respondents reported smoking cannabis to “come down” from the stimulant high.

When and how often khat is used

Most community respondents said they used khat after work, with longer sessions sometimes extending into the night or early morning. Weekends were reported as the most popular times for chewing khat giving users time to recover the next day. Khat is also used sometimes at work or during study:

“I used to chew a lot when I was studying at university. It helps me stimulate the mind and stay up.”

Females aged 25 to 50 – Yemeni

All-night sessions were not uncommon, but were seen as inadvisable or unacceptable by the majority of users. Frequent all-nighters were associated with problematic khat users:

“There are people who start chewing at the mafresh and later take the khat to their homes. These are the worst chewers, because they will continue to chew until the morning breaks.”

Males aged 25 to 50 – Somali

Among younger Ethiopians, patterns were slightly different. Several said they chewed khat with friends before going out for the evening, to a restaurant or night club (most Ethiopians interviewed were Christians, with fewer taboos around mixed sex socialising and drinking alcohol).

A typical khat user might chew khat (one to three bundles) once or twice a week – once at weekends, and once during the week. This was regarded as non-problematic across all three communities.

Heavier users might chew four or five bundles of khat three or four times a week, or even every day. They tended to be regarded as dependent (at least by others, and sometimes by themselves in retrospect) – the word ‘addict’ was sometimes used – and at most risk from health and social problems (discussed in section 4 below):

“If it is chewed normally, then it is normal. But if it is chewed every day then it becomes not normal.”

Males aged 18 to 24 – Yemeni

Trends in the use of khat

Respondents perceived khat use in the UK to be increasing. This was attributed in part to larger numbers of migrants in the UK from all three origin countries where khat use is believed to be increasing. Participants also thought khat chewing was becoming more popular among the communities in the UK.

Across all three communities there was thought to have been a general increase in use among women and young people, including those born and brought up in the UK. Some focus group participants felt that khat use among women may be becoming more open. Instances were given, for example, of mafreshi where men and women chew together in public.

Young people tended to chew khat separately from the older generations, either in their homes, in parks or public places, or in mafreshi which were used mainly by the younger generation. Reportedly, parents from Somali and Yemeni communities would not necessarily be concerned if their children (i.e. over the age of 18) were chewing khat, because the practice would be regarded as more culturally acceptable than using either alcohol or cannabis. Some respondents also suggested young people were better off chewing khat at home or in the mafresh, among people from their own ethnic group, than roaming the streets and getting into trouble:

“A lot of people say our kids will be among the Somali community if they are chewing khat, so they will not be on the streets using drugs or alcohol.”

Practitioner, Somali

It was also pointed out that when young people visited their countries of origin, they would see khat being widely consumed and come to think of it as normal and acceptable:

“Many people use it and many young people see their fathers use it and follow their footsteps. When you see most people ... using, then it is kind of acceptable. I also saw many people using it in Somalia when I visited [a] few years ago during weddings and family get-togethers.”

Females aged 18 to 24 – Somali

Use of khat in the wider community

There were limited reports of khat use by people from other ethnic backgrounds (not Somali, Ethiopian or Yemeni). These might be young people who lived in multi-ethnic areas or people who socialised with Somalis or Yemenis and wanted to fit in with their group of friends. People from other ethnic backgrounds who needed to stay awake for work might chew khat if they lived in a multicultural area and had become aware of it.

“I have also met a White truck driver and two White students who said they had exams and wanted to stay up. The driver bought about three bundles. He said he was going on [a] trip and needed to stay awake.”

Males aged 25 to 50 – Somali

However, this was seen as unusual and few participants thought that khat use would spread to the wider community.⁷

Conclusion

Khat was widely used among all three communities in the research. It was seen as more common among men than women, but was thought to be increasing in popularity among women and young people. Chewing khat once or twice a week, as part of social life, was seen as normal and acceptable. Chewing large amounts of khat on a daily basis was seen as more problematic as discussed in section 4 below.

⁷ Mainly because khat takes a long time to chew and to have an effect.

3. Cultural and religious attitudes towards khat use

Introduction

This chapter outlines the social and cultural significance of khat use, and some differences between the role of khat in the three communities.

The social and cultural context of khat use

Khat chewing in all three target communities was described mainly as a *social practice*, carried out with friends and family as an adjunct and catalyst to conversation and relaxation. Users emphasised the pleasurable effects: the stimulation, sense of euphoria and the ‘buzz’.⁸ It was described as a ‘good way to relax’ and a help to social interaction:

“Family or friends getting together can be an occasion. If someone comes from the USA or Europe and visits, relatives and their friends will arrange a khat session to entertain the guest.”

Males aged 25 to 50 – Somali

“It is used mainly for socialising. You feel good when you chew with close friends and talk about issues you want to solve.”

Males aged 25 to 50 – Yemeni

Among community workers and professional people, khat use was associated with long meetings and problem solving activities. This was said to be common both in the countries of origin and the UK:

“During community meetings, when community representatives or leaders meet, khat will be brought. It will help the men to sit longer hours to find a solution to the problems or issues.”

Males aged 25 to 50 – Somali

Across all three communities, use of khat – especially by men – was widely regarded as socially acceptable and no stigma was attached to moderate consumption.

The Yemeni and Somali focus group participants were almost exclusively Muslim while the Ethiopian participants were more mixed with both Muslims and Christians included. There was some discussion of acceptability of khat in the Muslim and Christian religions, although no consensus on whether or not it was permitted.

Yemeni community

Of all the focus group respondents, those originally from the Yemen were most likely to regard khat chewing as an important and integral part of their culture and history. Most came from the north of the country where khat chewing was reported to be more common, and said they felt chewing khat was a link with their family and cultural heritage:

“It is our identity. It is like English people when someone visits them they give beer or wine. Khat is like that for Yemenis.”

“It is connecting us to Yemen. My father chewed, my grandfather chewed, I’m chewing and my son will chew. So it is an identity, culture and tradition of generations.”

Males aged 25 to 50 – Yemeni

Yemeni respondents were more likely to take the view that khat could keep young people out of trouble and prevent them experimenting with alcohol and drugs to which they are exposed within the wider UK society:

“Many young people chew khat during weekends and stay at home. Otherwise, they would have been fighting in the streets.”

Males aged 18 to 24 – Yemeni

Somali community

Among Somali participants, there was little consensus about whether khat was an important part of Somali culture. Some participants felt there was a cultural link and saw khat as being central to family events, religious festivals and celebrations:

“Yes, during weddings there must be khat. People cannot imagine weddings without khat.”

Females aged 18 to 24 – Somali

Others rejected such characterisations and suggested khat chewing was merely a bad habit:

“You cannot call it part of Somali culture. Somali culture is nomadic and nomads don’t chew khat. Khat use is something new and it is a bad culture.”

Males aged 25 to 50 – Somali

⁸ A few community practitioners said that khat was sometimes used as an aphrodisiac, especially by women, but this was never raised or discussed in the community groups.

Ethiopian community

Ethiopian respondents – many of them from the Amhara community -- on the whole did not see khat as part their cultural identity. Instead they tended to view it as a relatively new social practice introduced to general society by students in Ethiopia in the late 1980s and 1990s who used khat to help them with their studies:

“Fifteen years ago, no one used khat. Even ten years ago, few people used khat. So khat is not part of Ethiopian culture. I see now it is becoming popular among young people.”

Females aged 25 to 50 – Ethiopian

Conclusion

Khat chewing was part of many social occasions. Yemeni participants were likely to view khat as an important part of their culture and tradition; Somali respondents were divided on this issue, and Ethiopian participants were unlikely to view khat as central to their cultural traditions.

4. Social harms associated with khat use

Introduction

Using khat was associated with both positive and negative social impacts. At one end of the spectrum it was presented by respondents as a normal and pleasurable social practice and at the other as a harmful, addictive drug with socially destructive consequences. This chapter describes mainly what respondents thought or believed the negative consequences of heavy khat use to be – including received wisdom and folklore. These views are important to understanding the controversy surrounding khat but they are not scientific evidence of cause and effect, especially in relation to perceived links between khat and physical or mental health. In the case of social impacts there is debate over the direction of the cause and effect relationship between social problems and khat use, and again the views found here are not evidence on that point.

Perceptions of acceptable use versus problematic use

Most khat users in the sample said they did not consume large amounts and their jobs, health, family and social lives were unaffected. They did not see their own use of khat as a problem and thought they were typical among khat users.

In contrast, problem users were regarded as uncommon and were generally disapproved of. The heavy user was characterised as chewing large amounts of khat every day or most days and often staying at the mafresh late into the night – or even all night. The heavy khat use itself and the lifestyle surrounding it were perceived to result in difficulties holding down work, and in ill-health, personal neglect, social isolation and family problems:

“I think it is when the person neglects his job and his family and turns his back on everything. Also when they become unproductive, shabby looking, lazy and isolate themselves from the rest of the community.”

Females aged 18 to 24 – Ethiopian

Perceived social harms associated with khat use

Impact on health

Respondents across all sample communities identified health impacts perceived to be associated with khat use; the heavier and more frequent the use, the greater the risk was seen to be. It is important to repeat: these perceptions do not constitute evidence of links with health problems.⁹

Perceived impacts on *physical health* frequently reported in community focus groups included loss of teeth, gum disease and ‘mouth problems,’ “Every khat chewer I know has lost a tooth or more.” Males aged 18 to 24 – Somali); constipation and stomach problems; weight loss and sleeplessness. Less frequently, respondents mentioned: cardiovascular problems such as heart attacks, high blood pressure and stroke; diabetes; respiratory problems and the spread of TB in mafreshi; male impotence and bowel cancer from the chemicals sprayed on khat.

⁹ The ACMD report (2005) refers to reports, in the UK and internationally, of associations of khat with: psychiatric and cardiovascular problems, oral cancers, and concerns about residual pesticides and dependency effects (which the ACMD likened more to those from caffeine than controlled drugs). However, there were few clear results from controlled studies.

Community practitioners also mentioned many of the above. In addition they commented on possible health risks associated with the *manner* in which khat is used. For example heavy consumption of sweet fizzy drinks while chewing (increased risk of tooth decay, possibly diabetes); heavy smoking while chewing (smokers were reported to smoke more while chewing) and smoky atmospheres in some mafreshi; and sharing of 'shisha' pipes while chewing with associated risk of infection.

Some focus group participants thought the heavy use of khat could affect *mental health*, inducing, for example, paranoia, phobia and hallucinations; mood swings, aggression and 'bad attitude'; schizophrenia and depression:

"It is a stimulant. Initially it relieves stress, depression, worries and tiredness. But once you are finished, you will have more worries and feel depression and anxiety."

Males aged 25 to 50 – Somali

Participants in the general public focus group in one area also suggested that heavy khat users behaved in erratic ways and suffered from mental health problems.

Some community practitioners also thought there were potential mental health risks for heavier khat users. Lack of sleep and overstimulation among heavy users was regarded as an important factor that could adversely affect mental wellbeing.

Impact on employment and finances

Many focus group respondents and community practitioners thought heavy khat users could experience problems finding or keeping a job. Most commonly this was attributed to disrupted sleep patterns caused by staying up late and by the stimulant effect of khat:

"They sleep all day and chew all night. Many have been sacked from their jobs for falling asleep on the job."

Practitioner, Somali

Heavy users were said to be often late for work or absent. They were also said to be often unavailable for work or for looking for work because so much of their time was taken up with chewing.

Impact on relationships, marriage and family

Heavy use of khat among men in particular was often regarded as a cause of friction in khat user families, especially by Somali focus group respondents and practitioners. Men were thought to neglect their partners and children, absenting themselves physically and

psychologically from their role as husband and father, and in some cases using family money to buy khat:

"Now, men who do not work take money from their wives by force to buy khat. The problem creates family problems and in some cases divorce at the end."

Males aged 25 to 50 – Somali

Some focus group participants suggested that domestic tension could result from moodiness and irritability linked to heavy khat use:

"My father used to chew khat and had mood swings. He was aggressive and had fights with my mother when he does not get khat."

Females aged 25 to 50 – Yemeni

Some Somali women and practitioners thought that children (and their education in particular) were being neglected because of khat, and that Somali wives were being left to manage alone because of male absorption in this 'new culture' of khat use. A Yemeni practitioner said that men were now chewing in each others' homes rather than the mafresh because of the smoking ban, and that this could cause domestic problems by disrupting normal family life:

"If a man is bringing people to chew in his house it can create tension. The kids can't do their schoolwork. The woman will have to just hide in the kitchen or go to someone else's house."

Practitioner, Yemeni

The practitioner also reported that Yemeni women in one area had staged protests against khat outside local 'khat houses'.

Impact on the community

Some respondents were concerned about the impact of khat on users' communities. Some community practitioners, for example, thought khat could be a barrier to the integration of individuals and communities into wider UK society:

"When a person is a khat user, it's most likely that while he's there, he's speaking Somali language, talking about issues in Somali or the Muslim world... So the first thing that happens is he doesn't pick up the language. He is here in the UK but mentally he is far away."

Practitioner, Somali

It was also feared by some that communities and individuals were being 'held back' by khat which was seen to 'limit what people can achieve':

"Khat limits what people can achieve and they end up sweeping the road, very minimum wage. If they go to college and get education they can achieve much more. We don't want them to have an excuse because we want them to be a good citizen."

Practitioner, Ethiopian

Crime and anti-social behaviour

Crime was thought to be rarely associated with khat use. A minority of focus group participants said that khat users might become aggressive or behave unpredictably after using khat. Some suggested that knife crime and gang fights could be related to khat misuse, though little was said to justify this view. There were reported problems of street robbery and gang violence perpetrated by Somali young men, but whether this was associated with khat use was not clear. Indeed, several respondents suggested that khat users were more likely to be passive or "spaced out" than to commit violent crimes.

There were very few reports of anti-social behaviour linked to khat. Problems mentioned by focus group respondents were associated mainly with the buying, selling and consumption of khat, which reportedly caused considerable inconvenience for local residents. This was most notable in one of the general public focus groups. Participants described large numbers of cars blocking the roads, groups of men hanging around buying khat, chewing on the street resulting in litter and mess in the form of plastic bags, drinks cans, plastic cups and banana leaves. Some khat users were also said to spit while chewing khat and to urinate in public places during extended khat sessions, causing annoyance:

"They block the roads with their cars when they are selling, and when you ask they get abusive. They are throwing it all, when they have finished chewing it. If they bought it and went where they lived that would be bad enough, but they are sitting and chewing it in our area and throwing it all over the place."

Cardiff, General public group

Police officers and local residents mentioned khat chewing in the stairwells or corridors of blocks of flats or social housing. This was strongly criticised by local residents, who found it annoying and intimidating, and was more associated with younger khat users:

"We had incidents where a number of Somali males were using certain local housing to engage in khat use, which basically comprised 10-15 using a flat to sit around and chew khat during the night-time. You've got groups of young males, throughout the night, shouting, swearing, talking loudly, and keeping families awake. There was debris, the twigs that have been chewed, there was vomit, urine, human excrement, and there was graffiti, general damage and disorder caused as a result of the activities."

Police Officer

Conclusion

A range of social and physical harms were perceived to be linked with the use of khat: mouth and stomach problems; mental health issues; family tension and breakdown; unemployment and underachievement in education; and social isolation from mainstream UK society. Only in one area were specific problems of low level anti-social behaviour mentioned, and in other locations khat use was not thought to be associated with crime. Some social harms mentioned by respondents were linked directly to khat itself, whilst others derived more from the context or manner of its use, suggesting the need for a range of responses.

5. Attitudes towards Government intervention

Introduction

This chapter describes attitudes towards Government intervention in the use of khat. Participants were asked whether they thought khat use was something the Government should be concerned about, and if so, what sort of Government responses were needed.

Many community respondents were in favour of some Government intervention in the import, sale and consumption of khat, especially Ethiopian and Somali participants. Practitioners and DAT respondents also tended to favour some Government intervention. Yemeni focus group participants were more divided: some favoured Government involvement, others regarded it as potential interference in a Yemeni cultural tradition.

Views on prohibition

The idea of a ban on khat was often raised by respondents, but although views on the subject were sometimes strongly expressed, there was no clear consensus. Among focus group respondents, views varied between men and women, and different ethnic groups. The Ethiopian respondents in the sample were least likely to have strong views one way or the other. They were not heavy users of khat and did not think that a ban on khat would make much difference to their lives. Neither were they particularly protective of the practice of chewing khat from a wider cultural perspective:

“Community will not feel targeted... It is only khat and it was not very popular in the first place.”

Males aged 18 to 24 – Ethiopian

Opinion on prohibition among Somali focus group respondents was more mixed. Women tended to be more strongly in favour of prohibition than men, highlighting the perceived benefits of a ban for the Somali community. Examples of arguments made by women respondents are given below:

“People will get back to their normal lives, look for work and help their families that they have neglected for so long.”

“If banned, people will get back to education, get skills and help the community.”

Females aged 18 to 24 – Somali

“Actually, it is a favour for our community. We want the Government to ban it.”

“Intervention will not be seen as targeting us, but a move to save Somalis, because many of us are addicted to khat.”

“If khat is banned, people will be upset for few weeks, but they will get used to it.”

Females aged 25– to 50 – Somali

Some Somali men, including some community workers who themselves used khat, argued that khat was a benign, culturally specific alternative to alcohol (which was often seen to be far more harmful than khat).

Yemeni male participants were mostly opposed to the prohibition of khat, although views among Yemeni women were more mixed:

“The Government should ban khat. Yemeni people need help. They cannot rid off this bad habit of wasting their time and money.”

Females aged 25 to 50 – Yemeni

As noted earlier, Yemeni respondents often viewed khat use as an important part of their cultural identity, and some respondents felt its criminalisation would be an attack on their community and traditions:

“No. No. This is a Yemeni cultural thing and Government has no business to interfere. This is Yemeni cultural identity and Government should stay away.”

Males aged 25 to 50 – Yemeni

“I think no need to intervene. The Government is not banning alcohol which is more harmful. Khat user is not intoxicated and can work and drive a car without a problem. So why not ban alcohol first?”

“Khat gives me benefits such as it helps me study and do my house chores. I don’t drink alcohol or smoke. So why ban khat first.”

Females aged 25 to 50 – Yemeni

Concerns were expressed by some respondents, including DATs and police practitioners, about the possibility of prohibition criminalising large numbers of ordinary citizens within khat using communities and having a negative impact on community relations. Some respondents thought that with the creation of a criminal market in khat, there was potential for links with organised crime gangs:

“... you create criminals. You will criminalise those who smuggle or use it and you will have more criminals and people in jail.”

Females aged 25 to 50 – Yemeni

One police respondent commented that a ban would be possible to police, but only if it was a properly resourced priority:

“If they want to criminalise khat, it’s the resources. If the public want us to focus on that, we can solve it.”

Police Officer

Other suggestions for Government intervention

In addition to the discussion of whether or not khat should be banned, a range of other suggestions for Government responses were also made.

Awareness-raising for communities and professionals

Many participants felt that the Government should help raise awareness of the harms associated with chewing khat. It was suggested that this could take place in schools, as well as in the community more widely. Khat users themselves might not realise they had a problem, or might be in denial, so it would be important to reassure them that help and advice were available.

“People usually hide their problems until they are very sick. They need to be advised and told that it is OK to talk about it.”

Males aged 18 to 24 – Somali

It would also be important to raise awareness among professionals particularly in the drugs field, so they would be better equipped to identify and help dependent khat users. One Somali community worker felt many Somali people who had problems associated with employment, housing or mental health, were also heavy khat users, but that mainstream professionals might not identify this aspect of the problem.

Support services specifically targeting khat users

As discussed in the next section of this report, there were very few specific services targeting khat users to help them quit or reduce their habits. Participants commented that such services, including residential rehabilitation centres, were available for users of other drugs, but not for khat users. It was thought that the Government could appropriately provide or fund such services for those who wanted to stop using khat. This should also include mental health support and help with wider social issues, such as housing and unemployment problems.

“There are some centres that give advice and make people aware of the dangers of khat. But they do not do rehabilitation or give direct help to the khat chewers.”

“There are no centres that rehabilitate khat users. This is important and Government should establish a centre that can help khat users.”

Males aged 25 to 50 – Somali

Nevertheless, there were questions about the extent to which such a service would be used.

Regulation

It was also frequently suggested that khat and its consumption could be regulated by the Government. This might involve: assessment of the quality of khat and rules about use of chemicals in its production; regulation of the hours and places of sale; and health and safety rules for mafreshi where khat was consumed, covering issues such as smoking, ventilation and general safety. Some participants suggested that the import and sale of khat could be taxed, as with any normal product legally on sale in the UK.

“It’s just to check whether things are healthy or not. It is imported, it should be treated as imported fruits and vegetables - if they don’t want to view it as drugs - just to make sure that it is healthy.”

Practitioner, Yemeni

Information gathering and co-ordination

Finally, it was suggested that the Government had a legitimate role to play in gathering information about khat use – its prevalence, impacts and the most effective treatments. Best practice could then be shared among professionals to improve treatments available to khat users. More flexibility could be introduced into the National Drugs Strategy to allow DATs to place greater priority on khat use, and local services could be funded to engage with heavy users and their families.

Conclusion

Views on appropriate Government responses to khat use were mixed, as were perceptions on the degree of ‘problem’ it represented. The issue of banning khat provoked strong views on both sides, with some people strongly in favour of a ban, whilst others would view this as an unwarranted intrusion in a long-standing cultural practice. There was, however, a degree of consensus around the need for some Government response, often focusing on awareness raising, providing information, funding culturally appropriate services and conducting research into the most effective treatments for dependent khat users.

6. Local treatment and support services

Introduction

This chapter examines treatment and support services currently available to khat users and their families in England through local Drug and Alcohol Action Teams, based on the quantitative survey of DATs and follow-up telephone interviews. It then draws together views from different respondent groups on service needs, and on the availability and appropriateness of current services. Finally it considers the issues facing DATs and service providers.

Khat-related treatment services available through DATs

Table 1 summarises the khat-related treatment services provided by DATs across England. Four main groupings are shown, based on the types of service provided and whether there is known khat use in the DAT area. The boundaries between the groupings are not always precise (table notes provide further details), but the groupings allow an indicative analysis of the range of practices in different areas. The table is based on a response of 121 of 148 DATs.

Overall, only 15 of the 121 DATs that responded to the survey said they offered services for khat users and/or their families or communities. This represents half of all DATs that were aware of some khat use in their area. Some DATs said they were looking into the possibility of developing services for khat users, but others had recently closed services suggesting little by way of major overall movement in the current situation.

Table 1 Summary of khat-related service provision across England

Grouping	No. of DATs	Details
1 Fund/provide khat-specific services	7	Examples of services/activities: specialist khat service; dedicated khat worker; training for volunteers in the community; community-based workshops; funding and support for community groups; production of leaflets and other materials; work with mafreshi owners and visitors.
2 Fund/provide generic services using knowledge of khat ^a	8	Examples of services/activities: specialist stimulant service; services targeted at Black and Minority Ethnic (BME) groups; community drug education projects; community workshops; other community engagement work. Two DATs in this group used to provide services that focused specifically on khat, but no longer do so.
3 Fund/provide no khat-related services, but there is known khat use in area	16	Three DATs in this group used to provide khat-related services (such as a dedicated programme for khat users, a dedicated khat worker, and outreach work) but no longer do so. These services ended because of funding pressures or insufficient demand. Five DATs in this group are planning or looking into potential services. One of these had provided a small amount of funding towards the development of a local project, with a view to assessing future needs. Two of these DATs noted that the Somali community in their area was increasing, and khat was therefore likely to become more of a priority.
4 Fund/provide no khat-related services, and there is no known khat use in area ^b	90	DATs in this group (and in Group 3) provide services that would in theory be available for khat users (e.g. a stimulant service), but services are not tailored towards khat and do not include staff with specialist knowledge.
Total	121 ^c	

a Some DATs mentioned 'specialist' knowledge in their responses and have, therefore, been included in this group; however, some of the DATs in Group 3 may have had specialist khat knowledge but did not mention this in their response.

b DATs in Group 4 said they were not aware of khat use in their area, but as noted in this report, information on khat use is often very limited.

c The total number of DATs in England is 148. In another eight cases, the relevant Government Office lead reported that they did not think there was any khat use in the DAT area. No information is available for the remaining 19 DATs in England.

Demand for services

DATs perceived low demand by khat users for treatment or support services – as distinct from a possible need for such services. Practitioners and community members said that it was highly unusual for heavy khat users to seek help of any kind. Indeed, across the whole sample, none of the community members were aware of anyone who had asked for or received help to quit khat:

“People I know who have given up have done it by themselves, I haven’t encountered anyone saying ‘I want to give up, what can I do?’”

Practitioner, Somali

Respondents said moderate khat users were unlikely to see khat as a problem or to feel the need for any kind of treatment or support, and heavy khat users rarely acknowledged dependency and were therefore unlikely to seek help until forced to do so for health reasons:

“People do not recognise that they have a problem. They will keep it to themselves and try to solve in the next khat session.”

Males aged 25 to 50 – Ethiopian

Former heavy users in the study sample said they personally had quit khat after presenting to their GP or the mental health services with health problems of different kinds (that they believed to be linked to khat):

“There is only help out there for mentally ill people. But that is after it damaged their health.”

“The GP can help by telling them to stop to chew. But there is no other help. I think it is only after the person gets sick. People don’t contact their doctors before they are sick.”

Males aged 18 to 24 – Somali

It was also often suggested that problematic khat users would not want to discuss their problems or reveal themselves to other people. Some community respondents thought this would be a significant barrier to attending any services, especially any with explicit links to other kinds of drug or alcohol treatment:

“The people will not go to the centre, because they don’t want to talk about their problem.”

Males aged 18 to 24 – Somali

Similarly, we did not come across any examples of the families of heavy khat users seeking help or support from drugs advice agencies or other service providers. Given the reports of the impact of heavy khat use upon family life, it seems unlikely that this reflects a lack of need in this area. Rather, it may be a consequence of the same factors which inhibit users from seeking help: low awareness of services; low provision; shame; and denial of the problem.

Transferability/suitability of mainstream drug and alcohol services

Community practitioners and DATs often expressed doubt about the value for heavy khat users of treatment and support offered through regular drug and alcohol services.

They also commented that existing service models were not necessarily culturally appropriate, offering what one DAT described as “*White British treatment services*”, both in terms of cultural approach and language:¹⁰

“If I say to them ‘go to the agency, there are services there to help you’, they will say ‘no, they just tick the forms, what are they going to do for me?’ There is language barrier; there is ignorance, and cultural issues. I’m sure the help is available, but the best answer is not I go to a White English man and say ‘Please I have a drug problem’. Because I am thinking, he’s just going to look at me and say ‘khat, what is that?’”

Practitioner, Somali

Practitioners and focus group respondents from the target communities said that mainstream drugs and advice agencies were often perceived to know little about the use of khat and to be unlikely to offer well-informed support for heavy users:

“When I quit I went to the addiction services, I said ‘I have a drug problem, can you help?’ They said ‘Yes, what’s the problem?’ I showed them the khat and they said ‘We don’t know nothing about this’. They want to help, they would like to help, that’s what they do, but the question they are asking is, what is the best way forward...?”

Practitioner, Somali

This view tended to be confirmed by DATs. Figures on numbers of clients presenting to mainstream treatment services included very few khat users, for the reasons noted above. As a result, knowledge about local khat use tended to be limited.

¹⁰ Previous research reported an “active distrust of Western medical/clinical approaches, especially in areas like mental ill-health”. London Borough of Lambeth Drug and Alcohol Team (2007) *Chewing it Over: qat use in Lambeth’s Somali community*.

Development of culturally appropriate khat services

Some DATs with concerns about khat use in their area said they were feeling their way with an issue about which they have little first-hand knowledge and where there is a lack of confidence, as well as a lack of resources and organisational will (because of other targets and priorities). These respondents often showed interest in finding affordable, practical and sustainable forms of ‘best practice’ (some examples of best practice can be found in Table A2, Appendix 2).

Knowledge about khat within DATs was often said to be acquired through outreach work. Some DATs also obtained information from stakeholder or network groups (e.g. practitioners and third sector organisations), or through local research studies. Strong links with communities tended to be reported by DATs as crucial to effective service provision. Some DATs said they had successfully engaged with communities and involved them closely in the planning and delivery of services. Important to this was the ability to identify key individuals within communities, flexibility in responding to issues, and commitment from senior staff within the DAT or funding organisation.

In some areas where khat use is widespread, the impetus for service provision was reported to have come initially from community groups and practitioners communicating the problems associated with heavy khat use to local authorities and DATs. Individual community workers have also taken the initiative to develop khat services within drugs advice agencies. In one area, two agencies working in the fields of drugs misuse and mental health reportedly offered advice specifically for problematic khat users.

Most community practitioners and some DATs felt more work was needed, especially on an outreach basis, to:

- raise awareness among users of the potential risks of harm associated with khat use;
- provide information to users about harm minimisation;
- liaise with mafreshi to reduce public health risks and encourage moderation of use among customers;
- encourage mafreshi to work with local neighbourhood and environmental teams from all agencies to minimise any nuisance to local residents;

“One level is how to raise awareness of the negative impact of khat; how to support people who need it, especially in terms of mental health – same as for a person who is using excessive in terms of alcohol. There is a need for a service, how to use less khat, and maybe advice on good chewing guide. Eat food, after chewing, drink milk, drink water.”

Practitioner, Somali

While some DATs appeared to have engaged successfully with local communities, others noted difficulties building relationships of trust, particularly in the absence of existing links and dedicated resources. One DAT described ‘dipping in and out’ of consultation with communities, where work started but then stalled or was sidelined by other priorities. DATs also noted the fragmented nature of some communities. Examples were given of numerous different Somali groups in a DAT area each competing for funding, with many claiming to be “the community group”. With no forum or platform for working with the different groups, and with the perception that the groups would not necessarily want such a forum, some DATs said they found it hard to work with the community as a whole. One DAT had managed to get two community groups (each of whom had applied separately for funding) to work together on a project (thereby extending the reach of the service), but this appeared to be an isolated example.

Problematic use of khat was seen by some DATs to be closely linked to social problems like housing, family problems and unemployment, requiring a holistic approach. Some DATs said they had managed to offer wider support through dedicated projects or workers, but they had found it expensive and difficult to deliver effectively.

Conclusion

Services targeting khat users were limited, both from DATs and from other organisations. A small number of DATs had developed culturally appropriate services, usually by working with members of the relevant communities and conducting outreach work to raise awareness of their services. However, in general, service provision was limited and DATs seemed to lack expertise or knowledge in the area of khat treatment. Khat users, on the other hand – even the arguably small proportion who are heavy users – were reportedly very unlikely to seek help. Identified reasons for this included lack of awareness of services, shame at their predicament, and a refusal to recognise that they had a problem with which they needed help. This meant that, in practice, there was little demand on DATs to provide services for khat users.

7 Conclusions

Khat is reportedly widely used in all three communities included in this study, by ordinary people from all walks of life. In the opinion of some respondents its use is on the increase, although it is beyond the scope of this study to confirm or deny these assertions. Women and younger people in particular were said to be using khat more (and more openly) than in the past. For many if not most users in the sample, khat plays a modest but pleasurable part in their lives and is perceived to be a normal – even conventional – adjunct to relaxing, socialising and celebrating. There is some indication that khat is being used by some groups of young people in conjunction with alcohol and cannabis.

Respondents reported little evidence of crime linked to khat and most reported only low levels of associated anti-social behaviour, generally related to the buying and selling activities.

According to many focus group respondents, excessive use of khat is not very common and is not socially acceptable, and there is general recognition by users and non-users alike, and by practitioners, that heavy and frequent use of khat has negative consequences for the individual and potential knock-on effects for their family and community. Such ‘problematic’ use is generally regarded as needing to be addressed through prevention, treatment and wider types of social support.¹¹

There is some controversy over even moderate levels of khat use, with some community members being totally opposed to the practice. This was especially evident among Somali women participants but less so among Yemenis and Ethiopians. Vocal groups would like to see khat banned altogether, and use a range of arguments to make their case – from health to culture and religion.

There is widespread support from within the communities and from professionals for broad types of intervention in the issue of khat. Possible areas for intervention range from regulating the trade itself – the import, distribution and sale of khat – to specific treatment services and support for heavy users.

There is broad consensus from all respondent groups about the need for better and more widely distributed information about khat. This includes for example:

- reliable national epidemiological information about prevalence of use – to provide a firm foundation for the planning and delivery of services and as part of a case for funding and resourcing;
- scientific evidence about the effects of khat on physical and mental health;
- information and education about khat outside the communities that use it, especially statutory authorities and professionals working in locations where khat is used;
- information and education within khat using communities to minimise harm including work with users and potential users, as well as those involved in the sale and distribution of khat – especially mafreshi.

There is agreement that there is a lack of conventional services to treat the minority who use khat excessively. Professionals as well as community members recognise the need to work together to fashion approaches that are culturally appropriate and effective. These need to offer preventive services; help raise awareness (and self-awareness) of problem use; draw heavy users in before they reach crisis point; and offer treatment and support that is helpful and effective. Where DATs and local communities have made progress together in these areas, there is a strong case for the sharing of good practice to avoid duplication of effort and to speed progress.

Respondents were often in agreement that social, economic and emotional vulnerability may predispose some people to turn to heavy use of khat, further disadvantaging them. In these cases there may be a need for holistic approaches that address not only how much khat is being consumed but also its co-factors such as unemployment, housing problems and social or cultural isolation.

Many of the harms commonly linked to khat are not a direct product of khat itself but rather of:

- how khat is consumed – the amount of time it takes up and the fact that consumption is generally accompanied by heavy smoking and sweet sugary drinks ;
- the environments in which khat is used – especially smaller, informal mafreshi with poor health and safety standards, but also public open spaces where there may be a risk of ASB;

¹¹ Though not always by heavy users themselves (see Chapter 6).

- how it is sold and distributed – especially lack of quality control of the product (in terms of pesticides and microbes), its sale to younger people, and its sale from car boots and informal markets (again with the potential for ASB mentioned by the general public groups in one area, and traffic congestion).

There are opportunities in all these areas to reduce the risk of harm through a combination of measures, for example: health education and promotion; health and safety regulations; licensing and sales tax; and import quality controls.

Practitioners and DAT respondents agreed that any systematic, comprehensive and sustained approach to problems associated with khat depends for success on a commitment from the –Government backed by dedicated resources.

as older women, refugees and non-English speakers. One paired interview was conducted due to difficulties in recruiting to some focus groups.

There were a total of 82 respondents in the community groups, an average of between seven and eight per group.

Discussion covered views about khat, patterns of use, perceived social harms (and benefits), local service needs and views on what the Government's role should be. The groups were conducted in a mix of mother-tongue and English, depending on the needs of the group. All transcripts were produced in English.

In addition, in each of the sample areas one focus group was carried out with members of the general public living in localities where khat use is prevalent, to explore their perceptions, if any, of local nuisance and anti-social behaviour linked to khat. Respondents were recruited who had some prior knowledge or awareness of khat use. A total of 26 respondents took part in these groups, an average of between eight and nine per group.

Qualitative interviews with community leaders and professionals

Across the sample areas – Cardiff, London and Sheffield – twenty-one face-to-face in-depth interviews were carried out with community representatives and professionals working in localities where khat use is prevalent, for example, a community worker in a Crime Reduction Partnership, a Neighbourhood Police Officer, a community business adviser, a drugs adviser, a police youth education worker, a community health worker, a counsellor for community members with emotional problems. These

Appendix I Methodology

Focus groups with khat users and non-users in targeted communities and the general public

A total of ten focus groups were conducted with a mixture of khat users and non-users in each of the three target communities – Somali, Ethiopian and Yemeni (see Table A1). These groups were men-only, women-only or young people-only (one group of young people was mixed sex). Respondents were recruited with the aid of community partners in order to access hard-to-reach groups such

Table A1 Community focus groups

Focus group number	Community	Sex	Age	Location
1.	Somali	Female	18-25	Cardiff
2.	Somali	Male	18-25	Cardiff
3.	Somali	Male	25-50	Cardiff
4.	Somali	Female	25-50	London
5.	Yemeni	Mixed sex	18-25	Sheffield
6.	Yemeni	Male	25-50	Sheffield
7.	Yemeni	Female	25-50	Sheffield
8.	Ethiopian	Male	18-25	London
9.	Ethiopian	Male	25-50	London
10.	Ethiopian	Female	25-50	London
Paired interview	Ethiopian	Female	18-25	London

explored views about social harms associated with khat and helped to flesh out the picture of service provision outside the remit of the DATs.

Survey of Drug and Alcohol Action Teams in England

Information about services available to khat users and their families through DATs was collected in two stages beginning with an email survey sent to all DAT co-ordinators in England. The survey achieved a response rate of 82 per cent with 121 out of 148 DATs responding. Responses to the email survey were used to identify DATs that reported local use of khat or services provided locally for khat users. Fifteen such DATs were identified and from among these 13 telephone interviews were achieved with co-ordinators (or other nominated respondents) in order to explore their experiences and views in more detail.

A note about methodology

All reported findings from the qualitative research are grounded in the discussions conducted in the groups and interviews. This study offers an insight into the range of experiences, attitudes, understanding and behaviour of sample respondents. However, this is a relatively small study, conducted in only three areas. The findings, therefore, are not capable of providing estimates of prevalence or patterns of khat use, nor are they able to provide an overview of all harms perceived to be associated with khat use. This research cannot provide conclusive data on differences between sub-groups.

As noted above, the DAT survey does provide a representative picture of khat services, although it should be noted that these services will be limited to those which DATs are responsible for, or are aware of, in their area. In addition, this survey was designed to provide an overview of service provision, rather than to collect detailed statistics (e.g. on numbers of service users).

Appendix 2 Examples of khat-related services

Table A2 Details of khat-related services

Service or activity	Key elements	Good practice
Specialist services for Khat users	Treatment: key work sessions, clinical psychology, group work, dual diagnosis, complementary therapy.	This type of service requires skilled professionals . Services need to be delivered in an appropriate method and setting which may differ from mainstream services.
	Related support: diversionary activities (arts, sports), advice on employment, education and training; one-to-one support on personal/family issues.	This type of service provides holistic support, with an emphasis on structured activities and social inclusion. This can help users to stop or at least reduce the amount of time spent chewing. Encouraging a more structured lifestyle is seen as an important element of success. A package of support can also make it easier to attract users (e.g. by including a khat-awareness workshop as part of broader activities).
Dedicated Khat worker	Dedicated community-based khat worker, working with communities to provide a range of support activities.	This may be difficult to resource, although some DATs have looked to identify ways of funding (e.g. joint bids with neighbouring DATs, Migration Impact Fund)
Khat group for women	Community-based project using female staff and translators (where appropriate).	This project uses discreet premises not recognisable as a 'drug service'. It also offers different contact methods (including telephone, home visits) to encourage use. It also includes outreach work in places where women can be reached (e.g. markets, GP surgeries)
Training for volunteers in the community	Training on drug awareness and prevention.	Some DATs include a more formal 'reward and recognition' scheme for volunteers or National Vocational Qualification (NVQ)-accredited training. This work helps to "skill up" community workers, building capacity within communities to deal with some khat-related problems themselves. It is possible to include other capacity building activities within communities at the same time (e.g. establishing a team of translators).
Community workshops	Workshops targeted at key groups, e.g. young people, women.	Workshops often cover other substances, drugs or alcohol, to give more complete advice and broaden the appeal of the workshop.
Funding or support for community groups	Provide funding or support for community groups to do their own work. This approach allows independence and acknowledges that communities are best placed to understand and deal with local issues, although there is a risk that the focus of the work may shift on to other community concerns.	Part-funding of local projects can be a good way for DATs to increase their knowledge and develop links with communities, while dedicating a relatively small resource. As well as providing funding, DATs can also support community groups by advising them on alternative sources of funding . In addition, consortium bids (for local authority or Primary Care Trust (PCT)-funded services) can be encouraged (e.g. with a larger service provider sub-contracting to a specialist or community-based group).
Work with third sector organisations	Build links with communities through liaison with third sector organisations who already work with the communities.	This approach makes use of existing knowledge and can provide a 'way in' to communities where DATs are finding it difficult to develop a relationship.

Service or activity	Key elements	Good practice
Outreach work with communities	Work can include consultation aimed at identifying pathways to existing services; this acknowledges the reluctance of users to use mainstream services.	<p>Outreach workers and community groups can refer users to DAT services (provided that specialist/appropriate services are available).</p> <p>Consultation work can also identify individuals that are based within communities and have a position of trust or influence.</p>
Work with professionals	<p>Training/workshops on khat for health professionals.</p> <p>Liaison with professionals in different sectors (e.g. housing, social services).</p>	This type of work builds combined knowledge on khat and helps to raise its profile in the context of broader issues such as housing, health and employment.
Information materials	Leaflets, posters, advertisements on buses and in community centres to raise awareness of khat-related problems.	The impact of the materials can be increased by working with community groups on the design and wording, and by distributing leaflets via community workers . It is also important that materials are translated into relevant languages .
National conference	This brought together local and national expertise.	This conference helped to increase the knowledge-base on different issues related to khat.
Work with mafreshi	<p>Work with mafreshi owners to raise awareness of neighbourhood nuisance, environmental health, and to disseminate risk reduction messages to chewers.</p> <p>Talking to chewers using mafreshi.</p>	<p>One project included a steering group comprising community safety officers, street environment managers and public health professionals, to ensure the key issues were communicated to mafreshi owners. One DAT suggested a 'responsible retailers scheme' for mafreshi.</p> <p>One project distributed a small bag/package to chewers at mafreshi, including a toothbrush, toothpaste and a mint tea-bag, as well as an information leaflet.</p>
Local research studies	Qualitative and/or quantitative studies in relevant communities, to increase knowledge of prevalence, demand for services and other khat-related issues.	Research studies can improve knowledge about khat use and related issues, and thereby build evidence on the need for further services/activities . It is important to involve community groups in the design and conduct of the study where appropriate. The use of sound research methods is crucial in obtaining reliable evidence.
Specialist stimulant services	This type of service reflects a growth in stimulant use in many areas. Although not targeted primarily at khat users, the service can include staff with specialist knowledge of khat.	<p>This type of service can provide the basis for greater specialist knowledge and training on khat.</p> <p>One DAT had extended opening hours into the late afternoon/evening as this was felt to fit in better with users' preferred visiting times.</p>
Learn from existing work	Some DATs and other organisations have developed a range of activities.	DATs can visit or talk to other DATs who have done khat-related work, and also learn from other active organisations, such as the Drug and Alcohol Services for London (DASL), or the Centre for Ethnicity and Health (University of Central Lancashire) which has produced a model of community engagement.

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