SaferLambeth

CHEWING IT OVER

KHAT USE IN LAMBETH'S SOMALI COMMUNITY

AAN U QAYILNO

London Borough of Lambeth -
Drug and Alcohol Team (LBL DAT)

The Report of LBL Needs Assessment for Lambeth's Somali Community in Relation to Khat Use and Other Issues

A partnership project between LBL DAT, Fanon Care, London Somali Development Partnership (LSDP) and East African Health Concern

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1.1 EXECUTIVE SUMMARY

BACKGROUND

- Over the last ten years, Streatham and Stockwell have emerged as centres for the Somali community in Lambeth with shops, cafés and other services. The sale and use of khat by Somalis was implicated as a factor in community tensions in 2004. In 2006, London Borough of Lambeth Drug and Alcohol Team (DAT) commissioned the Lambeth Khat Project, a partnership project between the DAT, FanonCare, London Somali Development Partnership (LSDP), and East African Health Concern (EAHC). The project consisted of two strands – a service delivery strand offering culturally appropriate advice, signposting and referral to those affected by khat misuse, and a research strand which aimed to gauge the extent of problematic khat use in Lambeth. Two research project workers were recruited and a steering group was also formed at the start of the project involving stakeholders from the community, voluntary and statutory sectors.

METHODOLOGY

- The research was conducted as a mixed-methodology study comprising quantitative and qualitative elements. Research tools (questionnaires, focus group and interview questions) were developed and tested before data was collected by the research workers and volunteers. In November 2006 a Somali youth volunteering stream was added in order to collect more information on the needs of young Somalis, and 8 volunteers were given basic training in data collection and analysis. A comprehensive literature review focusing on local and national sources was also carried out.
- A total of 354 respondents completed or were helped to complete questionnaires, one of the largest data sets of any khat study conducted in the UK. Focus groups were conducted with young men, young women, older men, older women, religious leaders, and *marfesh* (khat-house) habitués. Stakeholder interviews were also carried out with khat-users, as well as community workers and leaders. Respondents were selected using quasi-random and opportunistic sampling methods to try and avoid sample bias; stakeholder interviewees were selected on a purposive basis.
- Data gathered from questionnaires was subjected to statistical analysis and cross-referenced around important dynamics such as age, gender, employment, and education. A pared-down and simplified version of 'capture-recapture' methods was used to compare several data sets. Multiplier methods were also used to extrapolate likely population sizes and prevalence. Data from focus groups and interviews were analysed thematically.

PATTERNS OF KHAT USE

- The research sample demonstrated very high levels of regular khat use (77%) amongst Somali men and women of all ages that are not dissimilar to those found in similar London boroughs such as Brent or Haringey. The findings suggest that the Somali community in Lambeth is significantly larger than previously thought. It is likely that the Somali population in the borough is at least as high as 3000+, of whom at least 1000 are regular khat-users.
- Although problematic khat use has a significant number of negative impacts on the physical and mental health of users, it is a mistake to attribute the multiple deprivations and barriers to accessing services to khat use alone. In one

sense, khat can be seen as a nexus for a broad range of social exclusions that prevent both individuals and the community more broadly from making the most of their lives.

- From the data collected, it is clear Somali women are using khat at similar levels to their men-folk. Women in particular are very suspicious of accessing mainstream services around khat use, in part because of the taboo surrounding female khat use, but more substantially due to a perception that many mainstream services are not as appropriate or accessible as they might be.

HEALTH, WELL-BEING, AND TREATMENT

- Respondents reported a wide range of health impacts from khat use, including sleep disorders, paranoia, constipation, and loss of appetite. Although levels of direct reporting of sexual and mental health issues was low, a number of physical health effects reported can also be considered as symptoms of mental ill-health. This is likely to be, in part at least, a result of how mental ill-health is conceptualised in Somali culture. Stigmas around mental ill-health also mean that somatization of mental health issues can be a problem for treatment providers.
- Most Somali clients in mental health services in Lambeth use khat to one degree or another. There is evidence that dual diagnosis is a recurrent issue for these patients and also for the many users who do not access mental health support. Mental health services are usually only accessed at times of acute crisis, making treatment more difficult.
- Aside from the still embryonic service delivery strand of the Lambeth Khat Project, there are no treatment services to assist problematic users in addressing their Khat habit in the borough. Entrenched suspicion of services, the fear of the stigma associated with the term 'drug', and a general reluctance to accept that there is a problem are all obstacles to accessing help. Some community members seem to actively distrust Western medical/clinical approaches, especially in areas like mental ill-health.

THE KHAT MARKET

- There are at least 20 *marfeshes*[1] (or khat-houses) operating in the borough, with particular clusters around Streatham and Stockwell. *Marfeshes* are a dynamic business and one may close down only to reopen at a different venue.
- Khat use has a significant economic impact on users and their families. Approximately 50% of respondents were unemployed, with a further 23% as students. The average amount spent by each user was the equivalent of £780 per year. One implication of this is that any harm reduction strategy must incorporate diversionary activities and job-finding support.

COMMUNITY SAFETY

- There is no established relationship between khat use and crime in Lambeth. Such crime as can be attributed to members of the Somali community is predominantly being committed by young people. According to the police the crime generated by the Somali community is not above, and possibly below, average. However, a high proportion of respondents (41%) cited experience (direct or indirect) of domestic violence. Attitudes to and experiences of policing in the borough were mixed. Islamophobia was a concern, while generic hate crime (e.g. racism) was low.

1.2 KEY RECOMMENDATIONS

- The multiple difficulties and barriers faced by many members of the Somali community derive both from their war-torn past, and current issues both here and in the Horn of Africa. The resolution of these problems, which involves healing of trauma as well as reducing barriers to accessing appropriate education and basic services, is beyond the resources of any local authority. It needs to be addressed on a London-wide, national and even international level.
- Continue resourcing the project at current levels and seek funding to expand the number of workers to two full-time staff
- Work more closely with other statutory health and mental health professionals, as well as those community and voluntary sector groups working in this field, to strengthen referral/signposting pathways, and develop an effective model of care for khat use that combines harm minimisation advice and culturally appropriate psycho-social interventions.
- Extend the existing partnership arrangement with the Fanon Resource Centre to include other stimulant services in the borough where possible and appropriate.
- Greater provision of diversionary activities targeting at risk groups within the community, notably women, carers, the unemployed, and young people.
- Coordinate more effectively with other agencies and departments within the Safer Lambeth Partnership (SLP) to address a broad range of needs within the Somali community and encourage the formation of a strategic-level group at borough level of SLP and Somali community members.
- Supported Housing providers need to ensure that Somali tenants are adequately supported to maintain their tenancies
- Access to skilled interpreters, especially in technical fields such as health and law, needs to be improved across a wide range of services, and made more localised. Many service providers source interpreters through specialist agencies, which tends to bypass significant capacity in the local community sector.
- Continue efforts to engage constructively with *marfesh* owners, promote good business practice and greater awareness of health and safety issues.
- Intensify efforts to engage young Somalis and develop initiatives to address potential khat and/or other drug use among this group, using innovative approaches– activities, events, etc.
- Support efforts to provide access to suitable community venues

2 INTRODUCTION

2.1 BACKGROUND TO THE PROJECT

The Lambeth Khat Project arose out of ongoing work by Lambeth Drug and Alcohol Team (DAT) and Community Safety Division (CSD) to address a number of issues facing the Somali and other communities in Streatham. Over the last ten years, Streatham and Stockwell have emerged as population centres for the Somali community. In particular, tensions arose in 2003-4 in Gleneagles Road (known locally as the 'Dip') around the use of street space by Somali men, and the perception that some of these men were behaving in an anti-social manner.

The use of khat (khat[3]) was implicated in this situation, in particular unlicensed trading of khat from vans or other vehicles. In consequence, in 2004 Lambeth DAT commissioned Drugscope to conduct a limited needs assessment of the Somali community in Streatham. This identified khat (mis)use by the Somali community as a major issue impacting the lives not only of individual users, but also their families, and by extension the wider community.

At the same time, a number of interventions were made to address the issues arising in Streatham. Trading Standards in conjunction with the police mounted raids on unlicensed trading of khat from vehicles, Health and Safety officers gave advice to owners of *marfeshes* (khat-houses), and regular joint patrols were set up between local police officers, street wardens, and Somali volunteers to ease any tensions arising between Somali and other residents in the area.

In Autumn 2005, the newly appointed DAT Substance Misuse Engagement Officer was tasked with continuing and expanding the DAT's engagement of the Somali community around khat use. This coincided with efforts of the police and Community Safety Team to maintain trust with the community following the attempted terrorist attacks in London on 21st July 2005. A number of ethnic Somalis were alleged to have been involved in these attacks and there was a very real concern on the part of the Somali community that they would be negatively affected by association. Indeed, there had been a number of articles in the London and national press over the preceding months, increasing after July, which negatively stereotyped Somalis.

In response, a coalition of local Somali community groups sought to build better relations with the local authorities. For example, an umbrella group of local groups, London Somali Development Partnership, organised a community reassurance meeting in Autumn 2005 that was attended by community members and representatives of the Streatham Town Centre Office, Police, and Community Safety Team. Here, community members were keen to disassociate the alleged perpetrators of the 21st July terrorist attacks from the Somali community, stressing the fact that the suspects were in fact Ethiopian Somalis who had been fostered in the UK with non-Somali families.

2.2 DEVELOPING APPROPRIATE RESPONSES TO KHAT USE

One of the recommendations of the Drugscope Streatham report was that a Somali outreach worker be employed to provide signposting and referral advice to khat users. Moreover, a number of drug and mental health treatment providers in the borough had expressed an interest in attracting khat-using clients into their services. Previous attempts to do so seem to have floundered for a number of reasons which will be more comprehensively addressed in this study, foremost among which were the perception

among Somalis that 'khat is not a drug', and the lack of culturally appropriate provision.
Following several months of negotiations over autumn and spring 2005-6, a pilot partnership project was established between Lambeth DAT, Fanon Care, London Somali Development Partnership (LSDP) in Streatham, and East African Health Concern (EAHC) in Stockwell.
The research project workers were based at the Fanon Centre (Fanon Care) in order to provide the structured staff support of a recognised provider, but would work on a satellite basis at LSDP and EAHC offices in Streatham and Stockwell.
The project consisted of two strands–, a brief service delivery strand focusing on signposting, referral and broad-based health promotion advice and a needs assessment strand, to determine levels and extent of need and thus the most effective model of service delivery. A dearth of hard data on the Somali community in Lambeth, as well as other practical considerations, meant that the latter strand took precedence between the summer of 2006 and January 2007.

This report sets out the findings of the needs assessment strand of the Lambeth Khat Project, and makes recommendations for future work both in terms of treatment services, and also for broader service provision across all sectors of the Local Strategic Partnership.

2.3 THE SOMALI COMMUNITY IN THE UK – A HISTORICAL PERSPECTIVE

In order to understand fully the issues facing Lambeth's Somali community, it is important first to appreciate the situation of Somalis in the UK. Somalis make up one of the oldest immigrant communities in Britain, and arguably form the largest Somali community in Europe. Somali men, recruited as seamen, began to settle in the maritime centres of England and Wales like London, Cardiff and Liverpool in the late nineteenth century. They were recruited as cheap labour, and undertook dirty and arduous – and unpopular – work as stokers firing ships' boilers. These seamen spent long periods at sea and away from home as they worked mostly in what was called the 'tramp steamer trade' on ships that sailed from port to port following the availability of cargo.

Most of these seamen came from what was then the British Protectorate of Somaliland. They also worked under the protectionist laws passed in 1894, in which they were paid less than the British nationals, could only work in the seafaring trade and could expect to be forcibly removed from the country at the end of their contracts. They did not have any entitlement to domicile rights in Britain, which would have – at least theoretically – given them the same rights as Britons.

Despite all these formidable barriers, some Somalis managed to set up and operate boarding houses that provided a shelter and refuge for their countrymen during shore leave or 'down time' (Farah 2000). Others moved inland to work at factories at industrial towns such as Birmingham,

Sheffield, Derby and Manchester. Considerable number of Somali men joined the army and saw active military service in the First and Second World Wars and even much later in the southern Atlantic conflict of the Falklands. The immigration out of Somalia took unprecedented proportions in the late 80s and early 90s, when the political situation exploded into full-scale war in the north and later in the south. This caused mass exodus into neighbouring countries and as far as Europe, north America and Australia. After the collapse of Siad Barre's regime in Feb 1991, southern part of the country descended into clan conflict with warlords holding sways in different parts of the capital and other important cities.

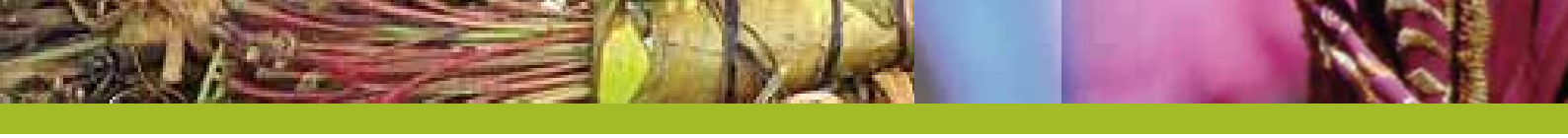
This conflict was to last the better part of 15 years, until the uneasy peace imposed last year on areas under the respective control of the UN-backed Transitional Government (based in Baidoa) and the Islamic Courts Union (based in Mogadishu). Most recently, Ethiopian forces supporting the Transitional Government, with some US support, have overthrown the Islamic Courts Union government. Ostensibly, Mogadishu is now under the control of the Transitional Government but it is unclear how firm its grip will continue to be without a substantial multi-national peace-keeping force to support it.

2.4 LAMBETH'S SOMALI COMMUNITY

The first Somali refugee families settled in London Borough of Lambeth in the late 80's and early 90's, though it was not until the late 90's that there developed a nascent 'community' focused around Streatham and Stockwell. Indeed, in comparison with other London boroughs, Lambeth's Somali population is relatively small – in the order of 3,000-6,000, compared to 7,000-10,000 in Haringey for example. While there are significant population clusters in Streatham and Stockwell, Somalis live in almost all areas of the borough.

Like all new communities settling in a foreign country through circumstances outside their control, Somalis in Lambeth comprise of a cross section of a displaced population; predominantly families headed by single parents widowed in the civil war, senior citizens, unaccompanied children and disabled people. Their previous occupations, educational background and lifestyles range from those of rural nomadic people to urban upper class from both private and public sectors. Levels of poverty and social exclusion of the community are significantly higher than those found amongst some other BME groups in the area, for a number of reasons including language barriers, legal restrictions on employment, lack of appropriate (or convertible) skills or training, cultural dislocation, family breakdown, social isolation, racism and islamophobia. Khat use – the object of this study – is commonly cited as another factor that hinders Somalis economically and socially.

Despite the difficult conditions they live in, Somalis in Lambeth (like their compatriots in the Somali Diaspora in Europe and North America) manage to support their relatives back home financially. It is argued that this is necessary as there is no effective central Government in Somalia and that this has resulted in mass unemployment, lack of basic services etc. Without the remittances Somalis abroad send home every month, the humanitarian crisis in Somali would be far worse. Similarly, there has been a huge attempt by the Diaspora to rebuild their homes damaged in the civil war, or build new ones in all cities and major



towns in the country. Somali residents in Lambeth have had their share of that toil.

The Hagba or Xawaala (pronounced 'hawaala') is an indigenous systems of raising ready cash and money transfer mechanisms unique to the circumstances of the Somali Diaspora, where all conventional methods of bank transactions and postal services cannot be applied to a country with out such institutions. Similar systems operate in other diasporas (e.g. amongst Afghanis and Pakistanis), but it is arguable that the importance of Hagba and Xawaala has underpinned the growth of the telecommunications sector both in Somalia and also here in the UK.

Local business start-up for the community in Lambeth has taken its first tentative steps in the last five to ten years or so. At the time of this research there are number of small shops, cafes, restaurants, internet-cum-telephone-cum-money transfer cafes (for communication and remittance purposes to Somalia), and travel agencies in Streatham and Stockwell areas. This enterprise growth is encouraging, as the bulk of these businesses took off the ground in the last 5 years or so. However, most of these embryonic businesses are at this stage largely targeting Somali clientele only, selling Somali cuisines, clothes, money transfer to Somalia etc. This reinforces the isolation experienced by the community as well as causing tensions with other communities.

Being a predominantly Muslim community and a closely-knit society inter-connected by extended family relations and kinship, Somalis in Lambeth try hard to maintain their unique cultural identity. To ensure that the Islamic faith and ritual practices, as well as the Somali language knowledge, are passed to smaller children, several Malcaamas (Quran and Somali language supplementary schools) operate in Lambeth. On top of this extra-curricular activity, these weekend classes also provide social forums for community cohesion and socialising for children and for parents. In the absence of mainstream funding, parents pay for each child attending these community schools to pay for teachers' salaries (although many teach on a voluntary basis), and other essential sundry expenses. To fully augment their commitment to education for their underachieving children, some parents also pay private tutors to provide once-a-week home support for their children's curricular education, and pay up to £20 or £30 a week per child, depending on the number of children being tutored for a family.

Newly arriving Somali asylum-seekers flow into the pool of other more established ones in Lambeth. These new arrivals nowadays take epic journeys crossing the Mediterranean Sea in 'death boats' (as reported by the international media in the last year or so), and enter southern European countries like Italy, Malta and Greece. Some of these people reach UK, albeit with great difficulty, and seek asylum here. But as a result of racist incidents affecting refugees and asylum seekers that were scattered through out the country as a result of the Dispersal Policy practiced by the National Asylum Support Service (NASS), many asylum seekers, in fear for their safety, are discouraged from accepting this dispersal, and remain in Somali populated cluster areas in London, mainly staying with friends and relatives. The implications for this can only be imagined not only for its overcrowding effect on already large households, but also for its impact on the health and economy of the host. Thus a situation of trying to help a relative/friend in need, over time becomes a burden for many residents in Lambeth. The Somali community in the UK is rated as suffering from a number of tropical diseases and other illnesses including Tuberculosis, Malaria, and Stroke etc. (NHS census 2000)

2.5
KHAT –CATHA EDULIS – THE 'LEAF OF ALLAH?'[3]

Khat (*Catha edulis*; family Celastraceae, Ge'ez č̣āt; Arabic: qat also known as gat, khat, chat, and miraa), is a flowering plant native to tropical East Africa and the Arabian Peninsula. Believed to have originated in Ethiopia, it is a shrub or small tree growing to 5–8 m tall, with evergreen leaves 5–10 cm long and 1–4 cm broad. The flowers are produced on short auxillary cymes 4–8 cm long, each flower small, with five white petals. The fruit is an oblong three-valved capsule containing 1–3 seeds.

Khat contains the alkaloid cathinone, an amphetamine-like stimulant which causes excitement and euphoria. In 1980, the World Health Organization classified khat as a drug of abuse that can produce mild to moderate psychological dependence, and the plant has been targeted by anti-drug organisations like the DEA.[4]

The origins of khat are often argued. Many believe that they are Ethiopian in nature, from where it spread to the hillsides of East Africa and Yemen. Others believe that khat originated in Yemen before spreading to Ethiopia and nearby countries. Richard Burton (1844) explains that khat was introduced to the Yemen from Ethiopia in the 15th century. There is also evidence to suggest this may have occurred as early as the 13th century. Through botanical analysis, Revri (1983) supports the Yemeni origins of the plant.[5] From Ethiopia and Yemen the trees spread to Kenya, Somalia, Malawi, Uganda, Tanzania, Arabia, the Congo, what are now Zimbabwe and Zambia, and South Africa.

Khat has been grown for use as a stimulant for centuries in the Horn of Africa and the Arabian Peninsula, where chewing khat predates the use of coffee and is used in a similar social context. Its fresh leaves and tops are chewed or, less frequently, dried and consumed as tea, in order to achieve a state of euphoria and stimulation. Due to the availability of rapid, inexpensive air transportation, the drug has been reported across Europe, North America, and Oceania – essentially wherever Somali and Yemeni diasporas are to be found. Khat use has traditionally been confined to the regions where khat is grown, because only the fresh leaves have the desired stimulating effects and the active ingredients only last for about 3 days.. In recent years improved roads, off-road motor vehicles and air transport have increased the global distribution of this perishable commodity.

Traditionally, khat has been used as a socialising drug, and this is still very much the case in Yemen, Somalia, and Ethiopia where khat-chewing is a predominantly male habit. It is mainly a recreational drug in the countries which grow khat, though it may also be used by farmers and labourers for reducing physical fatigue and by drivers and students for improving attention.

Khat is used for its mild euphoric and stimulating effects. In Yemen it is so popular that 40% of the country's water supply goes towards irrigating it, with the percentage increasing by about 10% to 15% every year.[6] [The water supply of Sana'a is so threatened by the crop that government officials have even proposed relocating large portions of the city's population to the coast of the Red Sea.

In Somalia, the Islamic Courts Union (or ICU), which took control of much of the country in 2006, banned khat during Ramadan, sparking street protests in Kismayo town. In November 2006, Kenya banned all flights to Somalia, citing security concerns, prompting protests by Kenyan khat growers. The Kenyan MP from Ntonyiri, Meru North District stated that local land had been specialised in khat cultivation, that 20 tons worth US$ 800,000 were shipped to Somalia daily and that a flight ban could devastate the local

economy.[7] With the surprise victory of the Provisional Government backed by Ethiopian forces in the end of December 2006, khat has returned to the streets of Mogadishu, though Kenyan traders have noted demand has not yet returned to pre-ban levels.

2.6 EFFECTS OF KHAT ON USERS

Khat consumption induces mild euphoria and excitement. Individuals become very talkative under the influence of the drug and may appear to be unrealistic and emotionally unstable. Khat can induce manic behaviours and hyperactivity. Khat is an effective anorectic and its use also results in constipation. Dilated pupils (mydriasis), which are prominent during khat consumption, reflect the sympathomimetic effects of the drug, which are also reflected in increased heart rate and blood pressure. A state of drowsy hallucinations (hypnagogic hallucinations) may result coming down from khat use as well. Withdrawal symptoms that may follow prolonged khat use include lethargy, mild depression, nightmares, and slight tremor. Long-term use can precipitate the following effects: negative impact on liver function, permanent tooth darkening (of a greenish tinge), susceptibility to ulcers, and diminished sex drive. Khat is usually not an addictive drug, although there are some people who cannot stay without it for more than 4-5 days. They feel tired and have difficulty concentrating.[8] However, a recent House of Commons study study found khat to be less dangerous than tobacco and alcohol.[9]

3 METHODOLOGY

The needs assessment was conceived of as a mixed methodology study which comprised quantitative and qualitative elements. This was important if the study was to capture both the modalities of khat use in Lambeth and the extent of use.[10] A steering group was set up at the start of the project to provide strategic oversight around both the service delivery and needs assessment strands of the project. This was composed of the research team, DAT and Community Safety staff, and representatives from FanonCare, LSDP and EAHC staff, the police, and other health providers.

The quantitative element was guided by epidemiological approaches including direct and indirect estimation of prevalence. A short questionnaire aimed at members of Lambeth's Somali community was developed with the assistance of the steering group, which could be completed by respondents on their own or with assistance from project workers and volunteers. The questionnaire collected basic demographic data, information on respondents' use of khat and other drugs, attitudes to drug use, and experiences of khat use (direct and indirect). Questionnaire sampling was done a quasi-random and opportunistic basis at a range of locations in the borough including *marfeshes*, community organisations, mosques, and even people's homes.

Qualitative data was collected through a number of focus groups and one-to-one interviews with community members, as well elite stakeholder interviews with professionals involved in the health field locally. Attempts were also made to map the number of *marfeshes* (khat houses) operating in Lambeth and engage with the owners.

3.1 LITERATURE REVIEW

Khat use is not an under-researched area – in the words of a former UNICEF country director for Somalia, "there has almost been too much research done on khat."[11] The research team conducted a comprehensive literature review, drawing on work done in the UK and worldwide, to look at the implications of khat use for physical and mental health, access to services, and models of treatment/intervention, as well as the broader socio-cultural impacts.

There is disagreement in the literature around the health impacts of khat use, especially in terms of mental health problems linked to khat use. A number of studies have shown evidence of khat use being linked to a range of mental health conditions ranging from paranoia to psychotic episodes.[12] This is a somewhat controversial (or controversialised) subject. Most of these studies were conducted on very small sample of users who were almost all already within treatment services. However, as Warfa (2006) points out, there is no evidence of any causal link between khat-use and mental ill-health, and in this sense the debate closely mirrors that surrounding cannabis, and especially 'skunk' use.

3.2 RESEARCH ETHICS AND CONFIDENTIALITY

Previous experience of the research team, and other studies done on khat use, showed that ensuring complete confidentiality was crucial if representative data were to be collected. All respondents were informed that any information they gave would be treated in the strictest confidence, and would be used by the research team only for the purposes of this study. Respondents were asked to give their consent to participating in the research, either by means of a tick-box on the questionnaire or verbally in the case of focus groups and interviews. Moreover, data collected were stored in secure locations during the course of the project, and will be destroyed at the end of the needs assessment phase of the project.

3.3 QUANTITATIVE NEEDS ASSESSMENT

To assess the magnitude of health and other problems related to drug use, and to plan the services needed to address these, an estimate of the total number of drug users in the population is required. The prevalence of drug use is normally expressed as the number of users per 1000 head of population, aged 15 – 44 years. However, researching khat use differs somewhat from research into other drugs for a number of reasons. Firstly, there is no systematic collection of data on khat use as there is for other drugs, and common indicators such as the number of drug-related deaths do not apply. Similarly, treatment data from services submitted as part of NDTMS (National Drug Treatment Misuse Service), or data on crime (e.g. British Crime Survey) do not report khat use, directly or indirectly.

Secondly, there is a real lack of quantitative data on Somali communities in the UK, and in Lambeth specifically. This situation is further complicated by issues of under-reporting; many Somalis are either unable or unwilling to participate in surveys such as the national census, and subsequently there is a significant 'invisible' population. Thirdly, there is a widespread distrust within some sections of the Somali community about being 'researched' – where will such information go, who will have access to it, and what will it be used for, are not uncommon concerns.

Data sources consulted by the research team included a national study of khat use in four British cities carried out by the Home Office and Turning Point, two small-scale local needs assessments examining drug use in African communities carried out by UCLAN/ACCHRO and East African Health Concern, as well as the aforementioned Drugscope report, and research carried out by UCLAN on khat use in Brent, Haringey, Greenwich, and Harrow.

3.4 PREVALENCE ESTIMATION

Estimating the prevalence of any drug use using population surveys is problematic, due to its legal status, underground nature, and social taboos regarding most forms of drug use. This limits the use of direct estimation methods such as extrapolation from national surveys, and consequently indirect methods are more effective.

There are two main methods for estimating 'hidden' populations. Multiplier methods take data on numbers of users in contact with a given data source (a 'benchmark') and using the proportion of users given in the data source it is possible to derive an estimate of the total population. Capture-recapture methods (CRM) involve using

two or more data sources to analyse the overlap between the data sets in order to estimate what proportion of the population is observed, and thereby derive an estimate of the total population from this.[13] CRM has been widely used in the fields of drug misuse, in epidemiological estimates and in animal ecology studies.[14] Both methods have their limitations in this context, not least the paucity of data on Somali populations in the UK mentioned above.

3.5 MULTIPLIER METHODS

An estimation of the total number of khat users was obtained by applying an estimated multiplier (prevalence of khat use in Lambeth's Somali community) derived from the questionnaire data to the estimated Somali population in Lambeth. An approximate 'benchmark' was calculated as mean of the rates of prevalence of khat use from these sources and applied to the estimated Somali population in Lambeth. This benchmark was further compared with prevalence estimates derived from the national, regional, and local data sources given above.

3.6 CAPTURE-RECAPTURE METHODOLOGY (CRM)

Normally, overlapping lists of users collected from different sources would be used to undertake CRM. In the absence of such lists, a pared-down or 'internalised' version of CRM was adapted for the purposes of the study.[15] Questionnaires were distributed across a number of different sites across the borough, distributed both geographically and in terms of different venue; each questionnaire was individually coded to reflect this. Respondents were not allowed to complete more than one questionnaire. The resulting 'sub-samples' were then tested and adjusted for variance by combining two samples and comparing prevalence rates; by estimating different combinations of two-by-two samples; and by log-linear regression analysis (i.e. finding the simplest model with the best fit). While applying CRM methods in this context was not unproblematic, this enabled researchers to test the distribution of khat users to non-khat users across the different 'sub-samples' and ascertain a more accurate estimate of prevalence.

3.7 QUALITATIVE NEEDS ASSESSMENT

The research team identified key groups within the Somali community for qualitative assessment by focus groups: young people, men, women, older men and women, and Somali religious leaders. A short list of questions or prompts were developed and piloted. Focus groups were composed of between 5 and 10 people and lasted no more than one hour. Additionally, a number of semi-structured one-to-one interviews were conducted with khat users, community members involved in the health or mental health fields, health professionals, and *marfesh* owners.

In both the focus groups and the interviews, respondents were asked permission for sessions to be recorded to facilitate data collection; in almost all cases, however, this permission was refused, for fear of confidentiality being breached. This forced researchers to rely on written notes, which obviously impacted the amount and quality of data collected. Data from focus groups and interviews was analysed thematically and by content analysis.

Finally, information was sought from other London boroughs doing work on khat use, and in particular areas where there are projects working to address problematic use of khat, to determine what models of care already existed around khat use, and what levels of service provision there are.

3.8 YOUNG PEOPLE'S VOLUNTEERING STRAND

By November 2006 it was becoming evident that there were a number of barriers to researchers collecting data on young people. In order to address this, and as part of the DAT's commitment to engaging young Somalis around substance misuse, a volunteering scheme was established in partnership with Somali Centre for Information and Advocacy (SOCFIA). Eight young Somalis, aged 15-18, were recruited to work as volunteer researchers, and provided with basic training in substance misuse issues and data collection by the DAT Community Engagement Officer and Kofi Asante from the Drug Education Department. They were then tasked with collecting data from their peers using questionnaires, interviews and focus groups. Although due to practical considerations no focus groups could be carried out, a significant number of questionnaires and interviews were completed.

4 RESULTS

4.1 QUANTITATIVE DATA – RESULTS FROM QUESTIONNAIRES

Results from questionnaires given in this section are given thematically, in line with the different sections of the questionnaire. A total of 354 questionnaires were collected, a considerable achievement given the difficulties of research in this area. However, prevalence rates are discussed first as these are in some ways the most problematic aspect of the data collected.

4.2 PREVALENCE ESTIMATION

272 respondents cited regular use of khat on at least a weekly basis, i.e. 77% of the total sample size. Note that this does not include those who may use khat on a less regular basis (e.g. monthly, or on special occasions) – something highlighted in some interviews. If we exclude khat-using respondents who are not Lambeth residents (23 respondents), this figure drops to 76%. It should also be noted that there was no appreciable difference between the prevalence rates among men (76%) and women (75%), although men made up roughly two thirds of the total sample. Although there is plenty of anecdotal evidence for the use of khat by women, this is significant in as much as this is the first time such data has been collected in a UK study.

Similarly, khat use was fairly consistent across different age sets. The highest rates of khat use were found among those aged 21-25 and 31-35 (84% and 82% respectively); the lowest among those aged 26-30 and 46+ (64% and 55%). Khat use by the 16-20 age group was higher than anticipated at 83%.

4.3 IMPLICATIONS OF PREVALENCE ESTIMATION FOR TOTAL POPULATION SIZE

According to the 2001 Census, there were 982 individuals resident in Lambeth who were born in Somalia. However, this is certainly a significant under-estimate, as the Census does not record Somali ethnicity, in addition to the problems of under-reporting noted above.

Data on school registrations gathered by Demie's research on educational under-achievement among Somali and Portuguese pupils in Lambeth shows that the number of Somali pupils has grown between 2001 and 2005 from approximately 500 to 900 pupils.[16] Whilst this excludes Somali pupils who attend schools outside Lambeth, this gives an indication of the rate of growth in the size of the Somali community in the borough, i.e. roughly 180%.

If we factor in a 10% rate of under-reporting – a conservative estimate derived from the percentage of questionnaire respondents who were not British citizens or who had not been granted Exceptional or Indefinite Leave to Remain (ELR/ILR) by the Home Office – this indicates that the Somali population in Lambeth is at least 2000. If we assume that two-thirds of these are aged 15-44, direct estimation of the prevalence of khat use by multiplier methods suggests that there are approximately 1140 regular khat users in Lambeth's Somali community.

Despite the attempts to obviate sample bias, it is possible that the prevalence estimate of 76% is slightly inflated. Using a linear-log progression model (best-fit) suggests a prevalence of 68%, which still suggests a using population of at least 1000 individuals. However, when we compare the

prevalence estimates generated by this study with other UK studies, another picture emerges. Based on six studies carried out nationally, regionally, and locally, a mean prevalence rate was established of 42% (Table 1).

TABLE 1: INDIRECT PREVALENCE ESTIMATES FOR LAMBETH USING MULTIPLIER AND CAPTURE-RECAPTURE METHODS (CRM)

Indicator	Data source	Rate per 100a	Mean rate per 100a	Overall estimate (range)
Prevalence of khat use in other UK studies	HomeOffice/TP UCLANHaringey UCLANBrent UCLANLambethA UCLANLambethB EAHCLambeth	60 44 77 18 30 27	42	**630** (405 – 1115)
Questionnaire sub-samples, adjusted by linear-log regression model	Stockwell Streatham Norwood Brixton Kennington	63 77 60 72 68	68	**1020** (945 – 1115)

[a] Lambeth Somali population 16+ = 1500

Supposing that the Somali population aged 16+ is 1500 individuals (a1), then this study (a2) sampled 24% of this figure. If b=24%, and a3= the number of Lambeth-resident khat users sampled (249), and c= the extrapolated number of Somalis aged 16+ of which a3 is 42%, i.e. 1500x 0.42= 593, then the total number of Somalis aged 16+ is likely to be c/b= 2471. If we assume that Somalis under 16 make up a quarter of the total population, this suggests that the total Somali population of Lambeth is approximately 3088 people.

Even if the prevalence rate is between 42 and 68% (a significant disparity), it is reasonable to assume that the khat using Somali population is at least one thousand individuals, and the total Somali population of the borough is at least 3000. It should also be stressed that the assumptions underpinning these calculations have been made as conservative as possible, and it is probable that the actual number of Somalis living in Lambeth – and the number regularly using khat – is still significantly higher than this.

4.4 DEMOGRAPHICS

This section details the basic demographic data collected from respondents. Unless stated otherwise, all percentages given are of the total sample (i.e. n=354)

AGE (Figure 2) – The over representation of 16-20 year olds within the total sample can be attributed to the introduction of the young people's volunteering scheme relatively late in the project to ensure data on this group were collected

GENDER – 63% of those sampled were male, while women made up 37% of the total.There are considerable barriers to sampling women as part of any survey into taboo areas like drugs. This is the largest number of women sampled in any UK study of Somali communities.

DISABILITY – Levels of disability are generally in line with, or slightly higher than, disability in the general population. 10% of the sample stated they were disabled. Disabilities specified included blindness, deafness, lack of mobility, and diabetes. Data collected on Muslim communities in Lambeth (24% can be considered disabled) suggests sample bias may be an issue here.

AREA OF RESIDENCE (Figure 3) – Although there are obviously population centres for Lambeth's Somali community in Stockwell and Streatham, Somalis live throughout the borough.

LANGUAGE AND LITERACY (Figure 4) – Somali and English were the main languages spoken and written. Literacy levels of respondents (59% for English and 80% for Somali) were higher than expected, in comparison with other London studies. There was little disparity between genders around language and literacy. Other languages mentioned included Kiswahili, French, Russian, Dutch, Finnish, and Swedish.

FIGURE 2: AGE OF RESPONDENTS

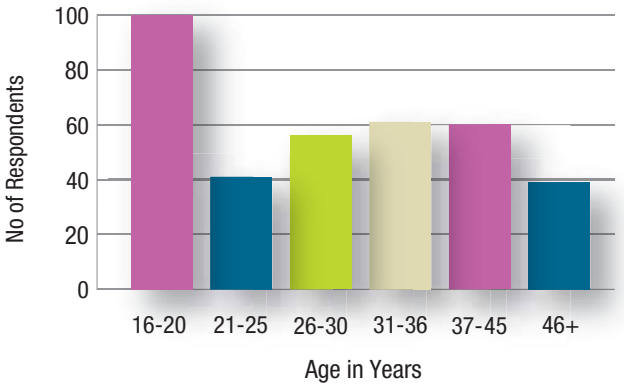


FIGURE 3: AREA OF RESIDENCE

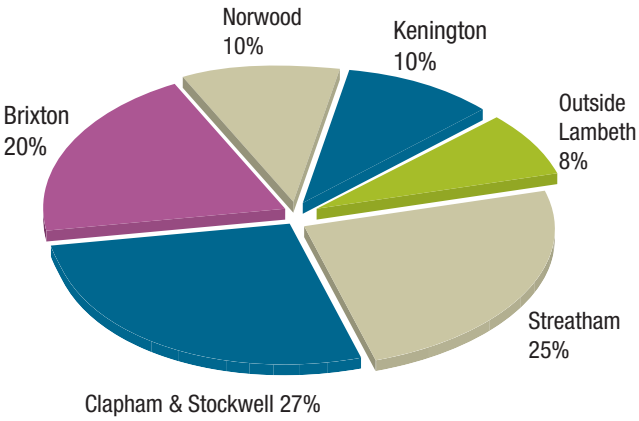


FIGURE 4: LANGUAGE AND LITERACY

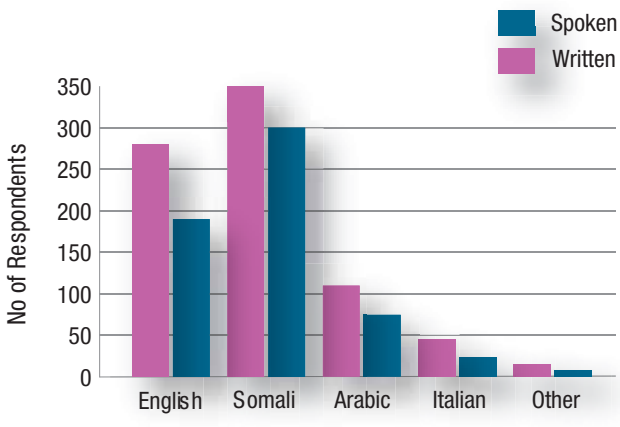


FIGURE 5: EDUCATION

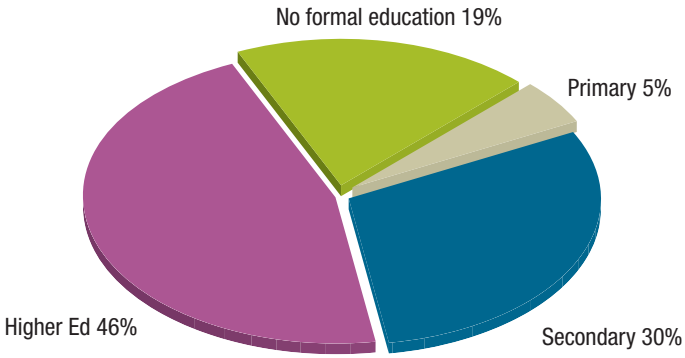


FIGURE 6: EMPLOYMENT STATUS

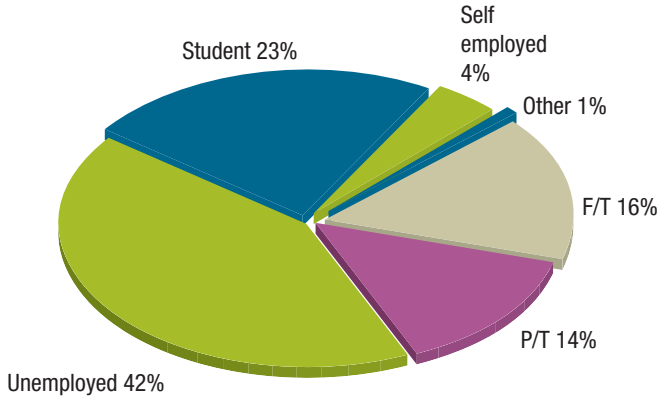
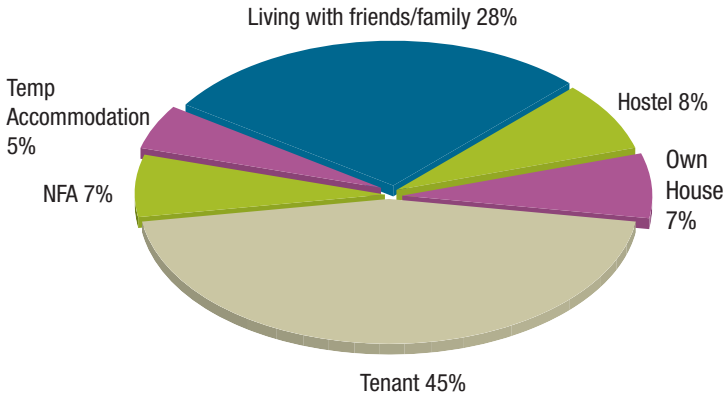


FIGURE 7: HOUSING



LANGUAGE AND LITERACY BY GENDER (%)

	English spoken	English written	Somali spoken	Somali written
Males	79	85	97	87
Females	72	80	99	79

There was also a clear correlation between age and levels of literacy, primarily in terms of English. Predictably, the younger a respondent was, the more likely they were to speak and read English. Note that the questionnaire did not differentiate between different levels of spoken and written language

EDUCATION (Figure 5) – A high proportion of the sample were educated to degree level and above. This is consistent with other new communities from east Africa.

EMPLOYMENT STATUS (Figure 6.)- Unemployment levels were high (42%), but not as high as suggested by some other studies of Somali communities in London (e.g. 80% in Brent).[17] Women were roughly twice as likely to be unemployed than in full-time employment.

HOUSING (Figure 7) – Most respondents were either council tenants or renting with private landlords. A surprisingly high proportion of the sample (20%) was living in short-term accommodation. Note that 'living with friends/family' is also likely to include a number of 'hidden homeless'.

MARITAL STATUS – The proportion of single respondents would have been significantly lower had there been fewer respondents aged 16-20.

Marital Status	% of Respondents
Single	33
Married	40
Widowed	5
Separated	5
Divorced	17

LEGAL STATUS (Figure 8) – The majority of respondents had residency rights within the UK. Nearly 40% had been granted leave to remain as refugees – slightly less than the proportion of British citizens. Some respondents citing 'Other' will have been granted some sort of residency in other EU states; others will have no legal rights to reside in the UK. A significant proportion chose not to answer this question.

4.5 PATTERNS OF KHAT USE

PREFERRED PLACE OF KHAT USE (Figure 9) – Most users chewed khat either with friends at home or in *marfeshes*. Women did not generally use *marfeshes*, although there is apparently a women-only *marfesh* in Lambeth. A small number of users chewed khat in their vehicles – suggesting they worked as drivers of some variety.

AMOUNT CHEWED PER SESSION – Most male users (40%) chewed 4-5 bundles of khat in each khat 'session' (n=272); women generally chewed less than men. Roughly the same proportion of male to female users chewed more than 5 bundles per session (14% of the using sample as an aggregate). There was a also a clear linkage between age and amount chewed per session. Those aged 30-45 used the most on a sessional basis, although the 16-20 age group also showed quite high levels (roughly 40% of these chewed 4-5 bundles per session).

AVERAGE WEEKLY EXPENDITURE ON KHAT (Figures 10-11) – Male users spent more on average than female users, as might be expected from the amounts used show above. The highest levels of expenditure were among the young and middle-aged. There was a clear correlation between expenditure and employment status; those who spent the most were the unemployed. As might have been expected, this group also spent the most sessions chewing khat each week.

FIGURE 8: LEGAL STATUS

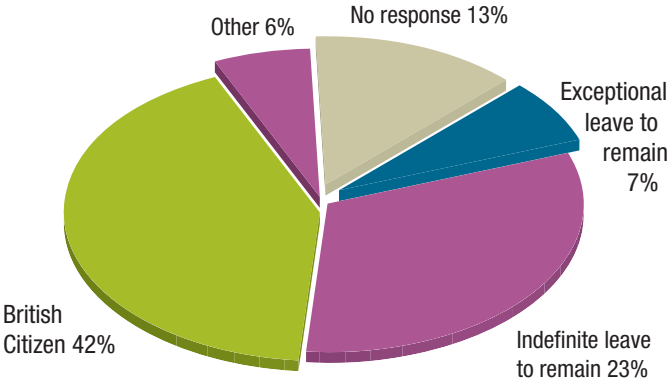


FIGURE 9: PREFERRED PLACE OF KHAT USE

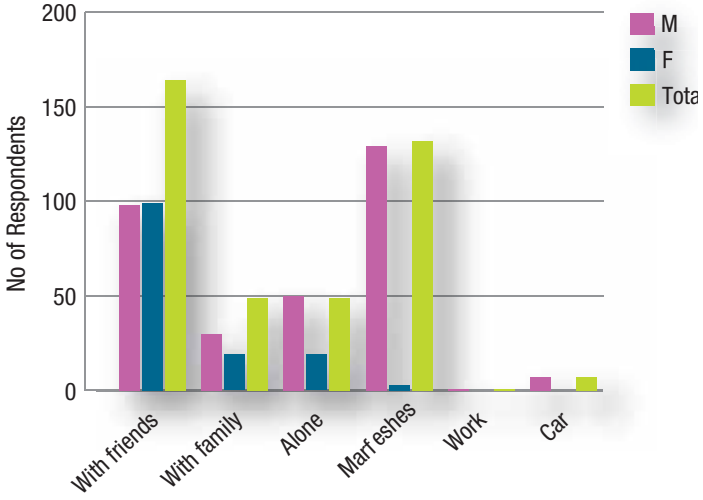


FIGURE 10: AVERAGE WEEKLY EXPENDITURE

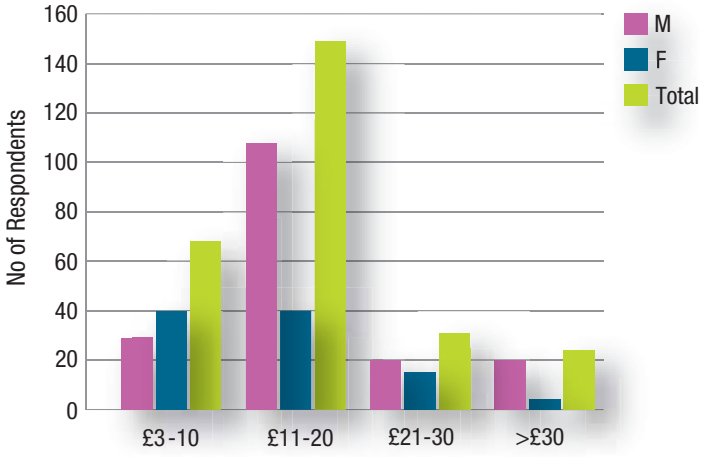


FIGURE 11: AVERAGE WEEKLY EXPENDITURE BY EMPLOYMENT

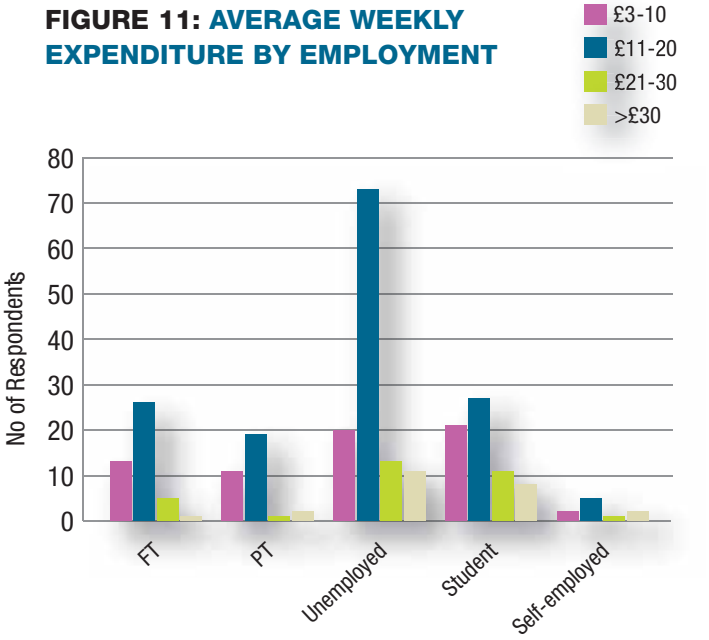


FIGURE 12: AVERAGE LENGTH OF SESSION

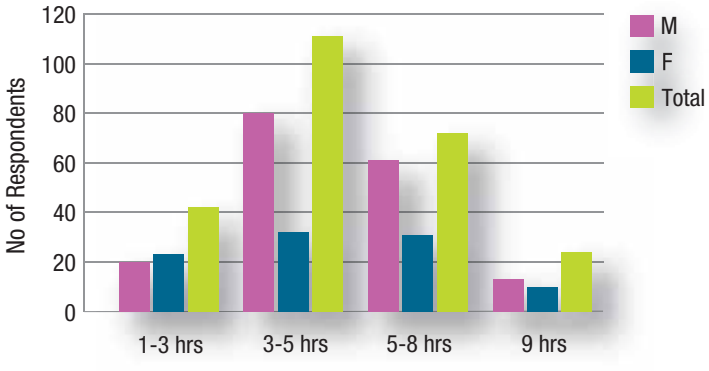
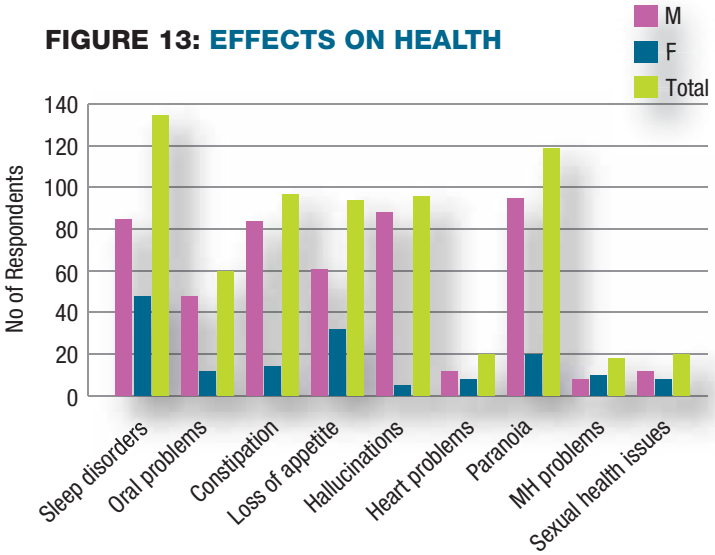


FIGURE 13: EFFECTS ON HEALTH



AVERAGE LENGTH OF SESSIONS

(Figure 12) – Session length varied according to age, gender, and employment. Female users spent less than half the amount of time on each session than males. The longest sessions were among the young, the unemployed, and those aged 30-45.

STARTING TO CHEW – Most users (just under 45%) started using khat before the age of 20, and many were under 16. Users were most often introduced to khat by friends; users were roughly as likely to start of their own accord as to be introduced by family members

4.6 HEALTH AND OTHER IMPACTS OF KHAT USE

Figure 13 – Users cited a wide range of effects on health from using khat. Most common were sleep disorders and paranoia, followed by constipation, loss of appetite, and hallucinations. Note the relatively low levels of reporting for mental health and sexual health issues. This is in line with stigmas attached to both types of issue. However, it should be noted that sleep disorders, paranoia, and hallucinations can all be considered as symptoms of mental ill-health.

PROBLEMATIC EXPERIENCES OF KHAT USE (Figure 14) – The total sample reported a range of problematic experiences of khat use (their own or that of others). Financial difficulties were the most common, as were negative impacts on health, employment, and education. Respondents citing experience of domestic violence was higher perhaps than expected; note also the disparity between male and female respondents in this area. This is arguably attributable to stigmas surrounding reporting domestic violence by women.

KHAT USE AND SMOKING – More than half of respondents said they regularly smoked cigarettes or other forms of tobacco (e.g. shisha) when they used khat. The proportion of smokers to non-smokers was roughly equivalent between male and female users.

4.7 ATTITUDES TO KHAT USE

Respondents reported almost uniformly negative effects of their khat use across different areas of their lives, with the exception of the contribution to social life which was valued positively. Women were twice as likely to consider the impact of khat use on their social life as a positive thing than men.The majority of respondents considered khat use to be an individual problem (40%) or a problem for family and friends (47%). Only 12% of respondents described it to be a 'drug menace'; surprisingly, fewer still considered khat to be a cultural practice only.

4.8 KNOWLEDGE/ATTITUDES TO OTHER DRUGS; POLYDRUG USE

Broadly speaking, levels of knowledge about different types of drug were relatively low. Cannabis and alcohol were the most well-known (49% and 45% respectively), followed by cocaine (44%). Women were 3 to 4 times less likely than men to claim some knowledge of different drugs.

Fig. 15 – As might have been expected, most polydrug use reported was the use of cannabis and/or alcohol with khat. The 16-20 age set were the most susceptible to polydrug use.

FIGURE 14: PROBLEMS EXPERIENCED BY USERS

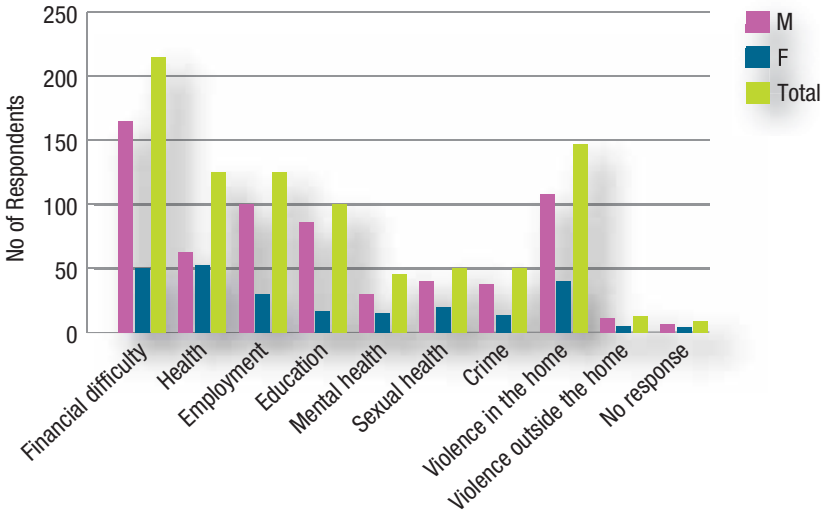


FIGURE 15: POLYDRUG USE

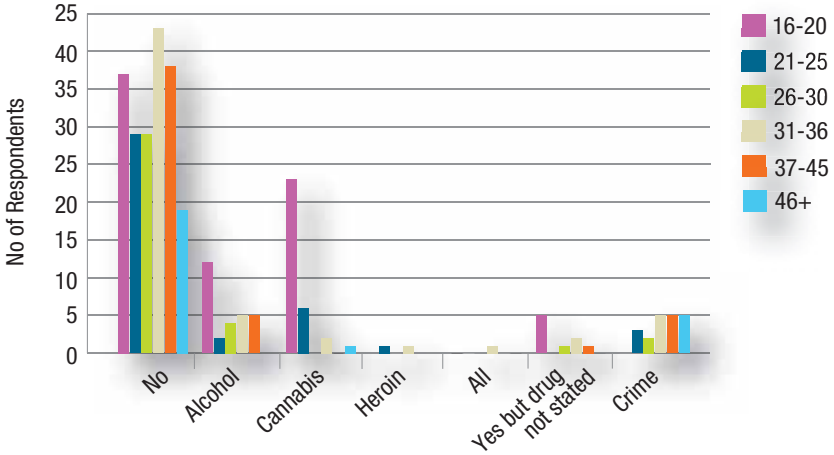


FIGURE 16: PREFERRED SOURCE OF HELP

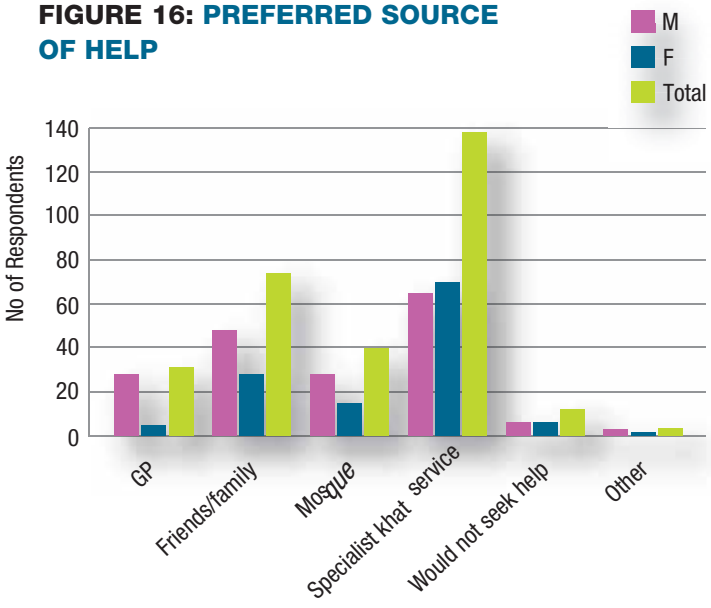
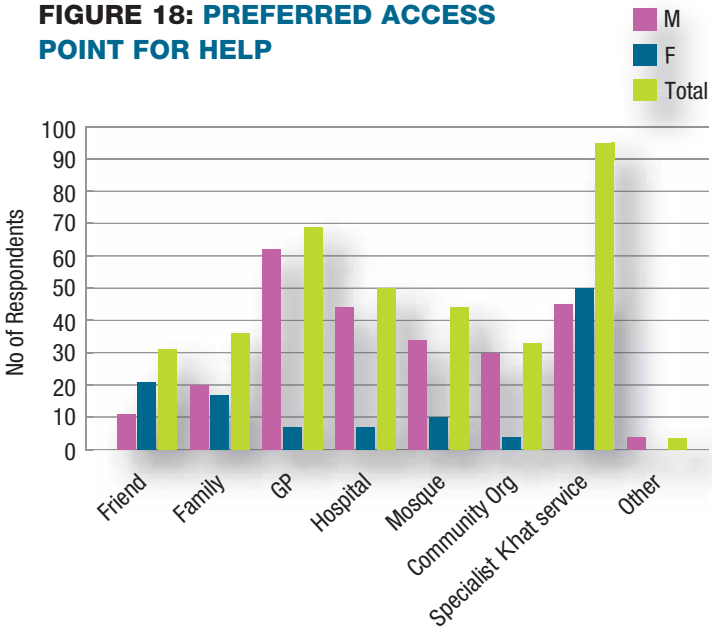


FIGURE 18: PREFERRED ACCESS POINT FOR HELP



4.9 ACCESSING TREATMENT AND OTHER SERVICES

Fig. 16 – There was a clear preference among users for accessing help from a specialist khat service. It is significant that male users were as likely to access help from a mosque for their khat use than from their GP. Women were even less likely to access mainstream services for help with their khat use. Note that khat users are unlikely to approach religious leaders for help or advice around khat use directly; they are more likely to seek help for related concerns

Giving Up Khat – over half of respondents had thought about or tried quitting khat at least once. Slightly fewer had tried more than once than had tried to give up on just one occasion. The highest proportion of users (28%) had never considered giving up.

ACCESSING HELP AND SUPPORT

Fig.18 – Of the total sample, GPs scored highly for accessing help with khat use. However, women were far less likely to seek help from a GP or hospital, and most likely to seek help from a specialist khat service. This suggests that stigma and fears about confidentiality being breached are active barriers to women accessing services for help with khat use, either their own or someone else's.

5 RESULTS FROM QUALITATIVE SAMPLING

5.1 QUALITATIVE DATA

A total of 6 focus groups were carried out by study project workers and volunteers, covering different subsections of the community: male khat users, male non-khat users, female users and non-users; elders; religious leaders, each made up of between 4 and 8 participants. In addition to this 16 semi-structured stakeholder interviews were carried out, including an ex-khat user, a Somali medical doctor, a former *marfesh* owner, a public health professional, a community leader, a mental health worker attached to a community organisation, a psychiatrist working in a mental health hospital, a religious leader, two female users, a female non-user, and 5 young people.

A significant barrier to collecting qualitative data was a widespread reluctance on the part of participants to have their views recorded, despite reassurances about confidentiality. This meant that researchers had to take notes by hand, supplementing these with memory where necessary, and inevitably led to a degree of inconsistency between interviews.

Participants were asked a standard set of questions that covered attitudes to khat use, general concerns within the community, and attitudes to services in Lambeth (see appendices 1 and 2 for samples). Results from focus groups and interviews are here presented thematically.

5.2 GENERAL CONCERNS

"You become cut off from the rest of society. You will only be best friends with your friends at the marfesh but there is no way you can be part of wider society… Our circle of life becomes getting benefits and chewing"

(MALE USER/FORMER *MARFESH* OWNER, 30S)

Khat use was by far the greatest concern across all the different groups, users and non-users, professionals and non-professionals. This concern was articulated in different ways by individuals, with some respondents highlighting its negative impact on employment and education, others stressing the financial drain it imposed on individuals and families, while others still worried about the effects of khat on health and mental health.

"They learn English here, but not the sort of English that will help them find good jobs."

(MALE ELDER)

Young people were identified as the second greatest issue of concern among respondents. Older community members worried about young people dropping out of school, and getting involved in drug use and gangs. Particular emphasis was placed on their interaction with the education system. Many felt that more support was needed to help bridge the gap between educational experiences outside the UK and the British system. Concern was also shown about educational standards. Of the young people themselves, over half felt threatened living in Lambeth, either from other young people or the police. Islamophobia was cited by several young women as an issue in this regard.

"We have many graduates, but we are not [adequately] represented in the workforce"

(MALE USER, 30S)

"Although we have a large community in Lambeth we do not still have any representation in most services or service providers"

(FEMALE NON-USER, 20S)

The existence of barriers for Somalis in Lambeth – real and perceived – to accessing training and employment opportunities, and to accessing services – was a major issue for respondents. A common observation among participants was that there were no Somalis working for the council, as opposed to other communities. One community worker framed the problem thus: "we encourage people to apply for jobs that they do not get. This feeds the perception that these jobs are 'not for them' and so when there are jobs available they do not apply." Transferability of skills and qualifications was identified as an issue in this regard, as was language skills. Combined with a lack of ESOL provision, this underscored the multiple barriers Somalis in Lambeth face in terms of finding employment.

"Users spend too much time at the marfesh, and this puts severe pressure on families and marriages…it can be like having another person to look after"

(FEMALE ELDER, 50S)

Women and families (and the impact of khat on this) was a significant worry for many respondents, male and female. A common perception was that the traditional family model was under severe pressure; cultural dislocation and isolation was leading to the breakdown of families. Use of khat by women was seen by many as a response to this.

Additionally, the cost of khat use on families was understood in economic and emotional terms – not only was there less money available to spend on family needs, but use of khat by both sexes placed greater emotional pressures on carers and dependents. In the words of one respondent:

"One of my biggest concerns with khat at the moment is, the man loses his role as a father. He will be no good for himself either. Thus the family breaks down. The mother then struggles to bring up her children on top of her other social problems. She may then turn to khat use. She will then be unable to cope with all her motherly duties. That is how khat is destroying our family and social fabric."

(MALE NON-USER, 40S)

5.3 ATTITUDES TO KHAT USE

"My biggest concern is the Somali single mothers coping with life on their own with the children and mostly cultural and language problems being the usual obstacles. It is easy for them to take up the khat habit"

(MALE NON-USER, 30S)

Respondents were divided over their attitudes to khat use. Users generally felt that it was an important cultural practice that helped reinforce Somali identity and which performed a function not unlike alcohol for other communities: khat was seen as a source of relaxation and release from stress, as well as providing an opportunity for socialising and social bonding. By contrast, non-users felt that khat use was actively holding back the Somali community in Lambeth as it was either responsible for, or reinforced, the problems facing individuals and families.

"I used to chew khat back home and it affects people in different ways. It is more of a problem now than it was in Somalia. Here people almost forget their families once they become addicted to khat, so it affects family life greatly. It puts off some people from going to work or study. It also prevents others from performing their prayers because they are busy in chewing khat."

(MALE USER, 30S)

There was consensus, however, around the fact that the problems attributed to khat were related to changed patterns of use. A number of users and non-users contrasted the way in which khat was 'traditionally' used in the Horn of Africa with current patterns of use in London.[18] A lack of employment or other activities meant that chewing sessions were longer, and more khat was chewed, which exacerbated the problems associated with khat use.

"I use it to socialise with my friends. We cannot go to the pub or clubs. This helps us de-stress after the week."

(FEMALE USER, 20S)

The use of khat by women forms a good example of this process. Female khat use is heavily stigmatised in Somalia (although much khat is sold by women) and is quite rare. In the UK however, increasing numbers of Somali women are taking it up. Respondents explained this change in terms of the changing position women find themselves in here in London. Many women came to the UK alone, or have ended up being single parents due to marriage breakdowns.

Although arguably there are greater opportunities for women in London, feelings of isolation, language barriers, and a shortage of appropriate activities actually limit what Somali women feel they can do. Khat use thus offers an opportunity for social bonding and group support that does not exist elsewhere. Because of the stigma associated with female khat use, women generally do not go to *marfeshes*; they chew with friends at home. Several female respondents spoke of hiding their khat use from the wider community. Moreover, as they are often primary care-givers, khat use by women could potentially have a greater impact on family life than that of men. According to one female user, "one of my [female] friends is a heavy khat user; she is up till four or five in the morning every night, and when she can't get up in the mornings the children don't get taken to school."

The picture regarding use of khat by young people was somewhat contradictory. On the one hand, many of the young people interviewed said that khat was something that only the elder generation did. On the other hand, participants across all groups agreed that the age of starting is usually between the ages of 16-18 but these days was getting lower, citing instances where children as young as eleven had been seen chewing. Those with family history of khat were seen as more likely to chew khat. Some felt that nowadays khat has become a fashion for many young people and this gives them higher status within their peers. Others knew of young people who dropped out of school who started chewing khat or taking drugs lie cannabis out of boredom and frustration. What was clear was the young people were using khat, and that this was perceived as preferable to their using other drugs common amongst their non-Somali peers at school.

All users that took part in focus groups felt that chewing khat was relaxing and a form of release. It was seen as an escape from life's problems, as well as helping users relate to their friends. Participants also saw its role as a social lubricant as important in brokering consensus, citing a saying used when people have a difficult issue to resolve, "let us chew for it". Most felt that khat use discouraged Somalis from drug and alcohol use, which would lead to increased levels of crime and violence within the community. Some considered that it occupied unemployed people's time in a harmless way, preventing their involvement in crime.

5.4
KHAT AND HEALTH

A wide range of physical health effects were cited by focus group participants and interviewees, including lack of appetite, oral health, insomnia. Some felt that despite this many chose to believe that it helped many common illnesses. For example, one user described how he felt it helped his diabetes.

Insomnia was highlighted as the most common effect and one of the most difficult to contend with. Some users would be up so late that they would have to keep themselves awake to attend appointments (e.g. at a GP's surgery or benefits office) the next day, before collapsing asleep afterwards. One user, a van driver, spoke of using khat as a stimulant but that when 'khat-time' (ie early evening) came, he would feel unable to work any longer. The culture of *marfeshes* – which are often open twenty-four hours a day, was seen to reinforce patterns of insomnia, and it was not unknown – if unusual – for users to be awake for twenty-four to forty-eight hour periods.

As an appetite depressant, khat was linked by a few respondents to poor nutrition and weakened immune systems. One user spoke of living on a bowl of pasta and a pint of milk a day. Conversely, several users noted the way in which khat use causes constipation, which could be so severe as to require medical treatment. In the word of one respondent:

"I witnessed a friend whose belly has swollen as nothing was coming out for two weeks because of constipation caused by khat. It was very uncomfortable and distressing for him. We then had to take him to hospital. He had to be given oral and rectal medicine which cleared all his stomach after a few hours"

(MALE USER, 30S)

Participants also drew attention to oral health problems such as cuts and abrasions to gums and cheeks; several suggested users would only visit the doctor or dentist if the condition became severe. Tooth decay was further exacerbated by the prolonged use of sugary drinks like sweet tea and fizzy soft drinks to compensate for the dryness and bitter taste of khat. It was suggested that this was likely to cause problems with diabetes for older users.

Two Somali doctors who were interviewed associated khat with hypertension and stress. Both argued that the linkage was complex because khat use was in many ways a response to, and a coping mechanism for, stress; yet at the same time using a stimulant like khat increased stress levels. One likened this to nicotine for smokers, who think it is reducing their stress levels when it is actually having the opposite effect.

Both users and health professionals referred to the role of tobacco in khat use. Even those who did not normally smoke would often smoke cigarettes as part of a chewing session, often in poorly ventilated areas. Of particular concern to health professionals interviewed was the potential under such conditions for spreading tuberculosis. Although no users themselves admitted to suffering (or having suffered) from tuberculosis, it was pointed out by several that rates of the illness are highest in the UK among newly arrived, predominantly African, groups.

5.5 KHAT AND SEXUAL HEALTH

Participants agreed that a common perception within the community was that it has a Viagra-like effect, but that this was a myth. Some reported greater sensitivity and feeling but agreed that this did not translate into an ability to 'perform' sexually. One estimated that three-quarters of users he knew had low libidos. Another commented:

"In my view khat misuse damages the chewer's sex life whether they are married or not. I use khat myself and I know for a fact that is true of 80% of men chewers. Some people say that it increases the sexual drive but I think that is just a false drive"

(MALE USER, 40S)

Similar attitudes were also found among some women, who blamed this aspect of khat use as a factor in marriage breakdowns, although one female respondent said that she found using khat actually improved her sex life.

5.6 KHAT AND MENTAL HEALTH

"Don't cry for dead men, cry for the mentally ill"

(SOMALI SAYING)

The links between khat use and mental health was one of the most contentious areas for different respondents. Several noted how in Somali culture, mental health problems were seen as incurable except by the will of God. Some users had experienced no or little impact on their mental health, and scoffed at the idea that khat could do so. As with sexual health, respondents were reluctant to speak of their own personal experiences of mental ill-health, and when they did so, it was usually in terms of feelings of paranoia or panic rather than specific conditions. None of the female participants reported suffering from mental ill-health. Nevertheless, many men and women referred to the effects of khat on mental health of those they knew. Some users reported seeing khat causing disorientation and aggression:

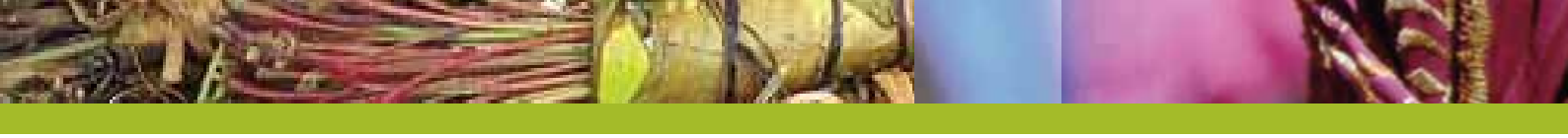
"Khat over-use makes you disorientated and even aggressive. I have witnessed people fighting after chewing khat for long periods. You see it makes you disoriented, someone might go to a place they did not intend to go without any plan."

(MALE USER, 30S)

Others saw the effects of khat on mental health as compounding the difficulties faced by the young, and even interacting with *marfesh* culture. According to one user,

"So many young people have developed psychological problems as a result of khat over-use. It also must be emphasized that those who have developed mental illnesses then tend to regularly visit the marfesh and chew the most. I think that is because it is a place they will be more accepted than if they went to the cafés."

A community worker who provides support on a voluntary basis to Somali patients on inpatient wards in Lambeth reported that all the Somali patients he had seen were heavy khat users. Most were under 30 years old, and some combined khat use with cannabis, and were suffering from some form of psychotic breakdown. He took up the theme of how differing concepts of mental health prevented Somalis from seeking treatment:



"Somalis don't trust Western medication, especially for mental health conditions. Most commonly I have to try and persuade clients just to take the medication prescribed for them by their psychiatrist. There is also the stigma attached to mental health issues in our culture. People would rather send afflicted family members to see a sheikh (religious scholar) in East London and pay several hundred pounds for an exorcism than see a psychiatrist…there is one sheikh in Hargeisa (Somaliland) who sees five hundred clients a month, from the East and the West"

Another community leader closely involved with Somali mental health patients said that these differing concepts of mental ill-health, combined with the stigma, prevented clients from accessing help until their condition became critical: "by the time they do end up in treatment, their condition is much worse than if interventions could have been made earlier". Moreover, when patients are released into the community, there is no support around helping them stay off khat. A Lambeth psychiatrist noted that:

"khat use is very common among clients from the Somali community. I have witnessed clients who were reasonably alright who we gave leave to. After consuming a certain amount of khat, some come back in a completely different state while others even decide not to come back, until they are found by the police in the streets. Their situation is much worse by then."

This was echoed by a director of a community organisation, who stated:

"Another thing is there is no follow-up for people who are discharged from hospital, and so it becomes a vicious circle – patients are treated, released, start using khat, which can interfere with their medication, and then their condition deteriorates rapidly. There needs to be much stronger case-working around this"

A Somali doctor stressed the link between hypertension, post-traumatic stress disorder (PTSD), and khat use, saying:

"Many in the Somali community are suffering from PTSD and hypertension and either do not know or do not want to admit it. You could say they are self-medicating by chewing khat in the marfeshes, except that khat does not always have a positive effect on their condition. And when they do receive treatment for mental ill-health, issues of dual diagnosis are often not addressed"

One final important point about mental health problems going unseen by GPs and hospital staff was made by another health professional from the Somali community, who noted:

"There are about 25 terms for mental health issues in Somali – all of which stigmatise mental health issues. One effect of this is that Somalis often tend to somatize mental-ill health and may present for treatment of a physical health problem which is just a manifestation of an underlying mental health problem"

5.7 KHAT AND POLYDRUG USE

As with the questionnaires, there was a general reluctance on the part of focus group participants and interviewees to be open about their own use of other drugs, with or without khat. A few mentioned using sleeping pills to help counteract the insomnia provoked by khat use; this was reported infrequently and couched in terms of "people do this but it does not help them".

Amongst younger participants there was somewhat more openness about drug use. About half of the young women sampled, and a quite a few of the young men, admitted to using alcohol, cannabis, and speed, sometimes with khat,

although no-one would speak expansively about their experiences in this regard. Alcohol and cannabis were the most common drugs used other than khat.

Somali health professionals were concerned about polydrug use by young Somalis in particular, and young people growing up in a sub-culture that is familiar with different drugs.

No respondents reported using class A drugs in the focus groups or interviews.

5.8 KHAT AND RELIGION

Religious leaders who took part in a focus group spent much time debating what the was the status of khat within Islam – did it count as an intoxicant? Although a majority felt quite clearly that it was against Islamic principles, it was acknowledged that some religious scholars, notably in the Yemen and Ethiopia, had defended the use of khat by Muslims.[19] Faith was seen as a protective factor generally against drug and alcohol use amongst Somalis. This was felt to be all the more important when young people were at such risk of getting involved with drugs.

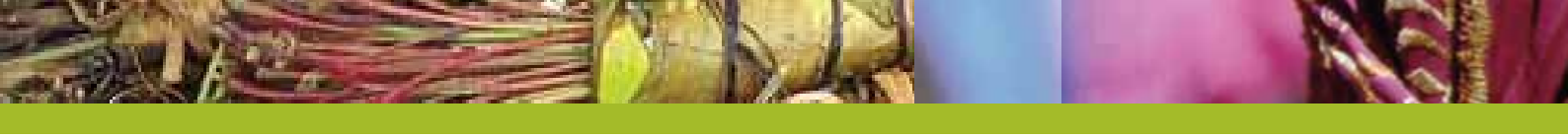
Many of those who disagreed with khat use did so on religious grounds, or articulated their disapproval in religious terms. However, opinion was not unanimous on the issue, with some arguing that khat had formerly been used as part of religious rituals. On the whole though, khat, like other drugs, was seen as *haraam* or 'forbidden' under Islamic law, and some noted that khat use meant people neglected their religious and other duties. One religious leader related an anecdote about a man who asked him to remarry him with his wife. When the Sheikh enquired as to why this was necessary, the man replied that he had been stoned on khat the day before and had divorced his wife without realising. While this should perhaps be taken at no more than face value it illustrates perceptions of khat use – and khat users – among the devout.

5.9 TRYING TO QUIT

Users agreed unanimously that it was difficult to stop using khat completely. Some felt that what made it difficult was that ex-users were cut off from their social circle. One participant spoke of having quit for four months, but he started using again due to loneliness.

All felt that the lack of activities and community venues available to them in the borough was a huge barrier preventing them from quitting. The lack of employment opportunities was in particular seen as a major reason for khat use– and a major barrier to stopping. Several felt that agencies were not doing anything to help them – and young Somalis in particular – get into jobs or trainee schemes.

Attention was also drawn to the way how *marfesh* customers – and indeed staff – are 'locked in' to a cycle of using because of their immigration status. Those who are not entitled to benefits and who cannot work may end up being employed by *marfeshes* illegally, while those receiving state support will often be able to receive credit from dealers on the strength of their benefits.



5.10 ACCESSING TREATMENT SERVICES

"For other drugs there's lots of support available – agencies, helplines, doctors. For khat, there is nothing"

(FEMALE USER, 20S)

Almost all respondents felt that they could not access support from existing services. Reasons for this varied. For many, language and cultural barriers were one of the main barriers to accessing treatment from mainstream providers:

"There is a poor information or translation available in the language that the majority of the community read (Somali), so that is a big barrier for us to start with"

(MALE USER, 30S)

The notion that khat was not a drug, or at least not like other drugs, reinforced the view that treatment providers would not understand their problems or be able to help. This, combined with the stigma attached to accessing drug treatment agencies, was a major barrier to receiving help and support. As one respondent put it:

There's no way I'd go into _____ (drug treatment service based in Lambeth). Firstly, they wouldn't understand me, my problems, my culture. Secondly, they'd do what – stick me in with a load of crack users? Thirdly, if anyone saw me going there, they'd think that I used [other] drugs, not just khat."

(MALE USER, 20S)

These barriers to accessing treatment were higher for women than for men. In part this was attributable to language issues, but equally important was the sense of stigma attached to women using khat. Some questioned the effect disclosing they had a problem with khat use would have on their families – would their relatives be told? What would happen to their children? Indeed, when asked where they would go for help specifically with khat use, most respondents (male and female) said they would turn to a friend, or someone they felt they could trust:

"I would turn to my close friend, or maybe a Somali I can trust who works in the health service"

(FEMALE USER, 20S)

One issue that was raised by a Somali health professional living in Lambeth was that of people, especially young people, being sent back to Somalia to tackle problems they have with substance misuse. Sometimes individuals were even duped into going back:

"One person I know was promised that he was going for a holiday in Dubai. It wasn't till he got on the plane that he found out he was being taken to Mogadishu…he was kept there for several months until he had been 'reconditioned'"

5.11 ACCESSING OTHER SERVICES

It is worth perhaps stressing that these barriers were not unique to treatment services. Even where language was not an issue, there was a widespread perception that services would not be able to meet their specific needs:

"Generally speaking the services in Lambeth are not appropriate for our community. They usually ignore that we are a new migrant community, that we have multiple needs such as a very high rate of homelessness, very high unemployment, as well as cultural barriers"

(MALE USER, 40S)

A number of respondents reported receiving poor or even rude service in other providers, such as housing and education. One woman noted:

"It can be really hard getting basic information. I am often ignored at my children's school because of my lack of English"

(FEMALE NON-USER, 30S)

Another issue for women was accessing culturally appropriate services:

"I have been here 13 years and I have never seen any support for Somali women. We need mother-tongue classes and women-only gym sessions that Muslim ladies can go to, like other communities have. I know I can demand to see a female doctor, but not all women in the community know this"

(FEMALE NON-USER, 40S)

The lack of services and diversionary activities aimed at Somali young people also was a concern for respondents:

"Somali youth do not get enough support in education or employment – that is why you can see them around Streatham high road smoking hashish or chewing khat"

(MALE USER, 20S)

Criticism was not only reserved for statutory providers in Lambeth, but also for the community sector, who it was felt were not as effective as they could be in responding to the needs of the community:

"We have so many organisations but unfortunately we still do not have any voice in the borough."

(MALE USER, 30S)

"I would ask the council to force our community organisations to prove that they are really doing their work"

(MALE NON-USER, 30S)

5.12 POLICE AND COMMUNITY SAFETY CONCERNS

Respondents across all groups had mixed views about community safety and cohesion issues. Approximately half felt safe generally living in Lambeth; this dropped among young men and women. The interaction between young Somalis and other groups, as well as between the authorities, was a particular cause for concern:

"Our young men are usually bullied, insulted or harassed by other people. Some of the terms used include "you refugees". This is a cause of a lot of the violence with other youth groups"

(MALE USER, 30S)

A number of respondents raised the issue of large numbers of young Somali inmates at Feltham Young Offenders Institute. It was quite common to hear claims that fifty or even eighty percent of the inmates there were of Somali origin. In actual fact Somalis make up 5.3% of the prison population at Feltham – the largest ethnic group there – but this still demonstrates that young Somalis are significantly over-represented in the criminal justice system.[20]

Gangs and gang-related crime was an issue for some, but there was little evidence of widespread involvement by young Somalis in gangs. One or two young men spoke of belonging to SMS (a South London gang operating in Lambeth) but it was not clear whether this was really the case or if they were merely claiming to do so.

Islamophobia was an issue for some respondents. Women in particular had experiences of being targeted because of their dress:

"People still look at us as Muslims with suspicion"

(FEMALE USER, 20S)

"I know some people who have been physically or verbally attacked, most of them wearing hijab (veil). I do not believe that most of them would report it because of language barrier."

(RELIGIOUS LEADER)

Although no-one alluded to the tensions between communities seen in Streatham a few years ago, inter-communal relations were an issue for some:

"Generally, I have not experienced racism in Lambeth. On the rare occasions that I have, it is from West Indians. My friends have also had similar experiences. Why is this?"

(SOMALI DOCTOR)

Attitudes to the police also varied significantly. Some felt confident that the police would take matters raised by the community seriously:

"I have full confidence in the police, I would report any crime that I witness and I would report if I were a victim."

(MALE NON-USER, 30S)

Others however expressed scepticism and distrust towards the police:

"I've never been stopped, but many others I know have been, especially young men"

(FEMALE USER, 20S)

"A friend who was homeless went to the police station and was arrested instead of helping him find a hostel place"

(MALE USER, 40S)

"If I was a victim of a crime I would still report it but I am not sure if all crimes will be dealt with in the same way. For example if I report that my car was stolen or damaged it will be investigated properly where as if I reported a race hate or Islamophobic crime with my poor English then unfortunately, I do not think there is any much chance that it will be taken seriously."

(MALE NON-USER, 30S)

Some saw community organisations as the key to better relations with the police:

"It would have been better if police worked well with the community organisations to build trust with the community"

(MALE NON-USER, 40S)

Finally, domestic violence (DV) was an issue raised by many respondents, male and female, in relation to khat use. While few suggested that using khat led directly to incidents of domestic violence, several argued the pressures on families could be exacerbated to boiling point by problematic khat use:

"Yes, khat users can be violent. I know, I was married to one."

(FEMALE NON-USER, 50S)

"I've seen it [DV] a lot in families. The husband spends all the time away from the house, and spends too much money on khat. This impacts on the whole family. His wife complains, and he snaps because he's feeling aggressive and lashes out at her"

(MALE USER, 40S)

5.13 RESPONDING TO KHAT (MIS)USE

When asked what would improve the situation with regard to khat, respondents drew attention to different types of response. From some non-users, there was bewilderment that khat was still legal in the UK. As one religious leader put it:

"The British government banned khat in Somalia during the colonial occupation... So why can't the British government ban it here in Britain?"

Others acknowledged that this would not be an appropriate response, and would likely push some Somalis into more mainstream drug and alcohol use.

In terms of accessing help for khat use, most felt that that this would best be achieved through having Somali health workers who spoke the language, could be trusted, and would understand the issues faced by users, enabling them to give useful advice.

Health promotions was another strategy which respondents felt should be pursued more actively:

"As we do not have the option of banning it, the second best option is to educate the community about its dangers, printing in Somali newspapers, Somali radio broadcasts, posters warning people about the dangers of khat"

(MALE EX-USER, 30S)

Diversionary activities, and support finding employment and training, were also seen as important, particularly for the young. Many felt that community groups had an important role to play here, particularly in partnership with the statutory sector:

"We need to have specialist community organisations that specifically support Somali people in different areas such as health, training, employment, education and so on"

(MALE USER, 30S)

"There is no youth club for us as Somali youth. We need a youth centre that is run by young Somalis for young Somalis"

(YOUNG MALE NON-USER)

"There needs to be closer cooperation between [community groups] and Lambeth council, the job centres in Lambeth, training centres, the drug services and the local health service. We should also check if those places can cater for the needs of such people"

(MALE EX-USER, 40S).

Women also cited the need for appropriate activities:

"There is a real need for a special women's support group for Somali women, something that can help them get advice, fulfil their potential and keep occupied. We also need crèche facilities and Muslim study groups for our children – we worry about letting them go out"

(FEMALE USER, 20S)

Finally, several respondents suggested that *marfeshes* should be more tightly regulated, particularly around health and safety and trading standards issues, as well as selling khat to young people. A few even argued khat should be taxed:

"We need to tax the marfeshes like they do for cigarettes and alcohol cigarette, so that Lambeth becomes an example for other areas. However, we should also offer them other chances to escape from these problems"

(MALE EX-USER, 30S)

6 ANALYSIS AND CONCLUSION

6.1 METHODOLOGICAL CONSTRAINTS

The needs assessment was conceived of as a mixed methodology study which comprised quantitative and qualitative elements. This was important if the study was to capture both the modalities of khat use in Lambeth and the extent of use. Researching drug use in 'hard to reach' groups is inherently problematic and mixed methodology studies offer greater potential for assessing a broad range of needs in such groups.[21] A steering group was set up at the start of the project to provide strategic oversight around both the service delivery and needs assessment strands of the project. This was composed of the research team, DAT and Community Safety staff, and representatives from FanonCare, staff from LSDP, EAHC, and other community representatives, the police, and other health providers.

The quantitative element was guided by epidemiological approaches including direct and indirect estimation of prevalence. Obviously any social research methodology has its limitations; in part this was why a mixed-methodology approach was adopted for the study. Sample bias is a particular issue in this regard and is arguably inherent in any sampling method. However, the researchers felt that given the available time and resources, and the difficulties attached to researching hidden and marginalised groups of this sort, the risk of a significant sample bias could be kept to a minimum. Certainly, the use of opportunistic and quasi-random questionnaire sampling helped minimize this risk, particularly the use of these over such a diverse range of sites. Indeed, as the extent of khat use within Lambeth's Somali community became apparent, it became increasingly important – and difficult – for researchers to sample non-users, if only because these were in a minority.

6.2 PREVALENCE ESTIMATION

Estimating prevalence rates of substance use in hidden populations is difficult, even with a legal drug like khat. Even when compared to other sets of drug users, local data sources for the Somali community are almost non-existent. Theoretically, it would be possible to gain better local data if it were possible to gain access to NHS and other service data; however, the fact that Somali ethnicity is not recorded in most cases means there would be little advantage in doing so. Consequently, it is likely that the prevalence estimates are low due to the difficulties in identifying unknown populations, and the lack of adequate surveillance data. Stronger and more representative data recording systems need to be implemented in order to gain a more accurate picture of the current Somali population in Lambeth.

For reasons already discussed, general population surveys are not good for estimating the prevalence of drug use, and using national data may not necessarily be representative of the problem in Lambeth. Limitations of the multiplier method include assumptions that individuals are still using; that all users are recorded; and that the multiplier is realistic. The difficulty in establishing a benchmark further complicates the picture. The mean prevalence rate used (derived from a number of limited local and national studies) is likely to underestimate the prevalence rate.

Capture-recapture estimation methods rely on assumptions that may not be met, such as users having available identifiers and not moving in or out of the sample area.[22] Pre-existing lists of users may not be typical of the study population, for example women and minority ethnic groups are often under-represented. Mutual independence is the probability that users appear in one or more lists and this can be positive

(where it lowers the estimate) or negative (where it raises the estimate).[23]

In the case of this study, the lack of existing and reliable lists actually worked to the researchers' advantage in this regard, by forcing them to rely on data they had collected from a large number of sites across the borough. Although the coding of questionnaires presented no small problems in itself (i.e. ensuring codes carried enough information to distinguish individuals and prevent over-counting), using a simplified version of CRM enabled the team to check the consistency and representativeness of respondents' answers.

6.3 DEMOGRAPHICS

The demographics of Lambeth's Somali community are interesting in terms of disparities both from what might be expected from existing data and also in comparison to other minority groups in the borough.

Clearly, one of the most important findings of this study is that the Somali population is two to three times larger than was previously thought. This should not be surprising: the main data set for Lambeth's population is the 2001 Census and it is clear from school registrations since then that the Somali community has been growing quickly both through growth of the existing community through childbirth and through migration into the borough. In addition to this, and in common with other refugee and asylum-seeker populations in the UK, there is a strong reluctance on the part of many individuals to be 'visible' to the authorities. For example, some will even refuse to register with a GP and prefer to seek treatment in Accident & Emergency wards where they can receive treatment anonymously.

As data from this study and Demie's research into educational attainment show, the Somali community is increasingly a young one. However, while addressing young Somalis needs will be an increasing priority, especially in terms of those vulnerable to drugs or crime, it is important not to forget older members of the community who are less integrated, less capable, and more vulnerable. This is true both in the short-term and especially in the longer term, and will present services across a wide range of sectors with significant challenges if not addressed in some way.

The other striking finding is the inequalities that exist in the Somali community, both in relation to others and between community members. Levels of education are high on average, at least among men; amongst female Somalis there are significant levels of illiteracy. Yet in both cases levels of unemployment are high. In the case of women, this can in part be attributed to a lack of education and/or training and also a cultural attitude amongst some families that women's role is to look after children and the home. Also, many individuals are actually debarred from working due to their legal status. Language barriers were cited again and again by respondents as a barrier, if not the biggest barrier, to greater involvement in the workplace and the broader community.

Moreover, the lack of transferability of qualifications and experience prevents many highly-skilled people from working to their full potential. Nevertheless, it is likely that institutional racism and/or islamophobia is a further factor preventing Somalis from finding employment. Whether or not this is the case in any given example is a moot point; but the perception that 'these jobs are not for us' certainly acts as a barrier to Somalis seeking employment. Somalis are not represented in any significant numbers in the council's workforce, for example, despite a desire from some services to recruit Somali staff.

Housing was another area where inequalities were focused. Approximately a fifth of respondents were either no fixed abode (NFA) or living with friends. In some cases this is arguably attributable to the desire of some people to remain 'off-radar', but combined with a high level of family breakdown it suggests that there is a high level of instability in terms of people's housing situations. Not only does this situation have implications in terms of overcrowding for some tenancies, it also indicates that support needs in the broader sense are not being met for a significant number of Somalis.

The data also showed that there were Somalis living in every part of Lambeth. Traditionally, the focus for both the community and the council has been on Streatham and Stockwell. However, as the Somali population spreads into other areas this will doubtless create new social, economic, and cultural challenges and opportunities.

6.4 PATTERNS OF KHAT USE

Perhaps the most striking findings in terms of khat use were both its prevalence generally and more specifically among Somali women. As noted previously, use of khat by women is very unusual in Somalia itself. Other research in London has suggested some female use of the drug but largely on an anecdotal basis and certainly no higher than 10 or 15%.[24] Yet the data showed very clearly that approximately the same proportion of women as men chewed regularly, although women generally chewed less per session and had fewer sessions per week.

Some used khat with their partners or families, but most chewed with (female) friends at home. Certainly, anecdotal evidence suggests the taboo against female use of khat remains strong, which in turn drives the cycle of women's isolation – note how few women would access mainstream treatment services or a mosque for help with their khat use. Use of khat by women is also shaping the khat trade itself. A number of *marfeshes* run a delivery service; one respondent noted that the delivery person would be "treated like a prince" upon arrival at a women's chewing session, with incense being lit for him.[25] Recent information suggests there is now a women-only *marfesh* in Streatham.

Men were the heaviest users of khat in terms of length and frequency of sessions, and in the amounts consumed. The heaviest users fell into two groups: a younger group, aged 17-25 or 30, who were more likely to be employed and therefore have some disposable income; and a older group, in their late thirties or above, who were generally unemployed. The latter group were arguably the most 'problematic' in terms of the effect of their use: some were chewing up to 9 hours a day (or night) every day of the week. Roughly a third of the sample could be described as heavy users (with caveats around setting an benchmark for how different people are affected differently by drugs), suggesting at least 1000 heavy users in the borough as a whole. Aside from the health impact on users themselves, this will impact negatively on family and other carers in a much broader way. Although there is no clear direct causal link between (heavy) khat use and unemployment, some form of interrelationship clearly exists.

Amongst young people sampled there was a clear discrepancy between the focus groups and interviews on the one hand, and on the questionnaires on the other. In the case of the former, respondents tended to claim not to use khat and indeed looked down on it as a negative thing, whether seen as simply 'not cool' or through stronger negative personal experiences. However, the questionnaire data shows not only that levels

of khat use are in fact quite high (albeit significantly lower than other groups in the sample), but also that the age of first use is generally young, around 15 or 16 years old. An implication of this is that education and preventative work with young Somalis around khat use needs to be ongoing.

6.5 POLYDRUG USE

Reported use of other drugs by Somalis of all ages was very low. In part this is a corollary of low levels of awareness within the community regarding street drugs available in London. Most people knew something about alcohol and cannabis (these are drugs well-known historically in N.E. Africa) but little beyond this. For this reason, such polydrug use as was reported was almost (but not quite!) exclusively among young people, male and female. However, there is reason to believe both from anecdotal evidence and from certain aspects of the data set (inconsistency of questionnaire answer, for example) that reporting levels of poly-drug use was low. The taboo against drug use remains strong, even amongst peers, within the Somali community, in common with many Muslim communities, an issue which affected the young volunteer researchers. Further research needs to be done on this area, not least as other studies suggest social exclusion is likely to influence young people in some newly arrived groups to try drugs.[26]

6.6 ATTITUDES TO KHAT USE

As was expected attitudes to khat use were quite sharply divided, both between generations and between genders. Women were more likely to be against khat use than men, and young people were more likely to be anti-khat in their attitudes. However, this is far from clear-cut as the data on patterns of use demonstrates. Many users and non-users felt khat was not a 'drug' like other street drugs or indeed medical drugs, but rather a cultural habit (even if it was a 'bad' habit). Across both focus groups and questionnaires, respondents addressed their attitudes to khat use in religious terms – i.e. in most cases that khat use was intoxicating and therefore haraam, or forbidden in Islam. Yet some argued that khat was not intoxicating or not 'unislamic', especially in relation to other drugs and alcohol.

Those who opposed khat use repeatedly expressed their astonishment that khat was legal in the UK. Many felt that if it were banned the situation for the community would improve significantly. Equally, khat use was not seen as something that one could or should seek help or treatment for. As such, it has not been 'medicalised' or pathologised as much as the use of some other drugs has been. In seeking to address the very real impacts of khat (mis-)use on users and the wider community, health and treatment services, as well as service planners and commissioners, should take care not to over-medicalise the issue, as this will further disengage users.

6.7 HEALTH IMPLICATIONS

As noted above, reporting of negative health impacts associated with khat use was both low and high. Low in terms of numbers of people citing severe or significant ill-health due to khat, but high in terms of the number of respondents citing some effect on their physical or mental health. This can be explained to a certain extent in cultural terms – Somalis will often not seek treatment for health problems unless they

consider it serious. But it also points to a lack of awareness of the effects of khat use, both among health and other professionals, but also amongst users themselves. A user may report feeling a certain health effect, e.g. insomnia or constipation, without considering the effect their khat use is having on their health in a more holistic sense.

Focusing purely on physical health, khat use likely have an effect on their diet and digestive system, as well as their oral and dental health. In addition to this, the 'how' of khat use for the typical user– high levels of smoking, lots of sweet sugary drinks – would increase risk factors further. The economics of khat use also carry a health impact. Some heavy users are likely to be among the poorest community members; as with users of other drugs, they may spend what little money they have on khat rather than food. This can lead to weakened immune systems or even, in extreme cases, malnutrition.

Health providers need to be more aware of khat use, both in terms of its pharmacological effects, and in terms of the impact socio-cultural and economic factors may have on the health of users.

6.8 MENTAL HEALTH IMPLICATIONS

Explicit reporting of mental ill-health was very low, and in part this can be explained by the strong taboos existing against mental ill-health in Somali culture. However, a high proportion of users reported what might be construed as indicators of mental ill-health in some cases – insomnia, paranoia, feeling jittery etc. As noted above the there is substantial debate about the the exact nature of the impact of khat use on ill-health, but it is clear that it does have an impact. The picture is clouded by other, broader factors, such as the general situation of exclusion within the community, high levels of undiagnosed hypertension and post-traumatic stress disorder (PTSD) related to events back home or even the difficult migration journey to the UK.

It is significant, however, that almost all the Somali clients visited by the project workers in Lambeth Mental Health services were khat users and suffered to varying extents from 'dual diagnosis'. As with dual diagnosis amongst users of other drugs, this poses particular challenges to drug treatment and mental health services. In the context of khat use, very few providers in Lambeth have even begun to address the implications for treatment and care of Somali clients.

One significant issue in this regard is a lack of suitably skilled interpreters. Interpreting in complex areas like health and law requires specialist training, not least because the technical vocabulary is large and precise, while in Somali (as in other non-Western languages) there exists not just a different vocabulary but a fundamentally different conception of mental ill-health.

In common with other BME groups, Somalis access mental health services much later than their white peers, and have less successful outcomes.[27] Moreover, the lack of awareness of and common cultural perceptions around, mental ill-health means Somalis are far less likely to access help or even conceptualise their distress as 'mental-ill health'. This is compounded by a distrust of western medicine which makes some clients reluctant to take medication prescribed for them.

A related issue here is the compatibility of western models of mental health care with clients from Somali or other non-western backgrounds. Aside from distrusting medications for mental ill-health, it is unlikely that other forms of treatment, like Cognitive Behavioural Therapy (CBT), will be effective if not adapted to the Somali milieu.

Psychosocial interventions may well prove effective but they need to move away from an individualistic model to one that involves family and even community.[28] There is a strong case for developing more African-centred (or in this case, Somali-centred) approaches to mental health treatment.

6.9 PUBLIC HEALTH IMPLICATIONS

While the data shows a limited impact on public health, there are a number of areas of concern. Firstly, the poor health and safety standards in most *marfeshes*, which are usually smoky and poorly ventilated, will have a negative effect on the health of habitués. Secondly, chewing khat socially in close proximity to others may increase the risk of spreading diseases like TB.

Rates of tuberculosis infection are the highest amongst Somalis of any group in the UK, and without being alarmist some care should be taken to ensure that *marfeshes* do not become a vector for spreading the disease. This needs to be approached sensitively, however: negative and often incorrect media assertions increase suspicion and stigma against and within the community, and anecdotal evidence suggests Somalis often seek treatment for TB at a very late (and therefore more critical) stage in their illness. Care needs to be taken not to further discourage community members who need treatment or are seeking it.

6.10 MAPPING LAMBETH S KHAT MARKET AND MARFESHES

One of the aims of this project was to map Lambeth's *marfeshes* and try to engage better with owners. Counts of *marfeshes* in the borough had to be continually updated as new information came in. On one level, this is indicative of what a dynamic business the khat trade is, with businesses opening and moving premises relatively quickly. At present, it is believed that there are approximately twenty *marfeshes* operating in the borough, including one serving women only. Most are in Streatham and Stockwell, but there are *marfeshes* in all of the five 'town centres' of Brixton, Clapham and Stockwell, Streatham, Norwood, and Kennington.

It is difficult to gauge the size of the khat market in Lambeth. Based on data collected, the average expenditure on khat was £780 per person per year, or £212,160 per year for the sample as a whole. Bearing in mind the fact that respondents will generally under-report their levels of consumption (as with any drug), it is likely that the annual trade in khat in Lambeth is worth approximately £1m. However, it should be noted that London is an international entrepot for khat transit/smuggling. The price of khat in the US is in the region of 10 to 15 times higher than the in the UK. A few individuals the researchers spoke to claimed to know people in Lambeth involved in this illicit trade, and so it is likely that if this is taken into account the total khat trade will be significantly higher.

Engaging with *marfesh* owners was complicated by the community politics and events in the Horn of Africa. In the summer of 2006, the effectively-ruling ICU in Mogadishu banned the sale and consumption of khat. This led to greater instability in the market; paradoxically one effect was a slight drop in the price of khat, and put greater

economic and social pressure on khat dealers. Researchers and partner community organisations tried to engage constructively with owners both in terms of conducting research and also in supporting their businesses develop good practice (e.g. no selling to minors, closing at a set time) and health and safety. However, *marfesh* owners were actively quite hostile to any form of cooperation. Indeed, researchers were told by one khat dealer who supplied a number of *marfeshes* in Lambeth that if any staff in those *marfeshes* spoke to researchers, they would stop supplying those establishments with khat. On another occasion, a khat-dealer physically assaulted a community leader because he claimed that the individual concerned was benefiting from the research.

Despite these difficulties, it is recommended that attempts by the local authority to engage *marfesh* owners continue. However, such engagement work needs to be undertaken with great sensitivity.

6.11 COMMUNITY SAFETY AND POLICING

Unlike in some other parts of London, Somalis in Lambeth are no more likely to be involved in crime or disorderly behaviour than any other groups. While a significant number of arrests by police in Streatham are of (predominantly young) Somalis, the police attribute this to the demographic situation pertaining in that area.

Conversely, in contrast to other parts of London, policing of Somali areas has generally been carried out in a sensitive manner. Police in Streatham have made efforts to engage constructively with the Somali community, for example supporting youth football teams with pitch access as well as funding a mini-tournament of Somali football teams. Significantly, the local Superintendent has expressed his commitment to Somali issues and to be sensitive with regarding policing *marfeshes* and other khat-related issues.

During the course of the research there were complaints from some Streatham residents about groups of Somali youth gathering in one street late at night to take drugs. However, further investigation showed that this group was not exclusively Somali, and the police arranged to make extra patrols in that area. Another issue raised was of young men loitering outside betting shops. Again, this was a phenomenon not restricted to Somali youth. It should be noted in this context that many community members, especially Somali young people, that there is a lack of affordable venues in Streatham such as youth clubs or community centres. Similarly, reports of Somali gangs forming in Lambeth proved to be extremely exaggerated, if not actually baseless.

It is fair to say there has been no repeat of the same tensions between Somalis and others that were seen in the area in 2004. The use of wardens and Somali volunteers, often on joint patrol with local Safer Neighbourhood Police Teams, has gone a long way to preventing the recurrence of such problems. However, with the decision by the council to scrap the wardens scheme (despite the police drafting in a Somali PCSO into the area) the situation will need to be monitored.

On the other hand, many respondents felt at risk of crime or fear of crime in the borough. This was especially true of young people, but not exclusively a youth issue. Islamophobia was also cited as an issue by some respondents. Reporting of crimes as another area for concern – a number of respondents said they either had not, or would not, report an incident even if it affected them

personally. One reason given for this was the perception that police would not take their matter seriously.

Overall, the police have built reasonably good relations with the Somali community in Lambeth but ongoing efforts at engagement need to be intensified.

6.12 ACCESSING TREATMENT AND OTHER SERVICES

Qualitative and quantitative data showed very clearly that there were enormous barriers to respondents accessing treatment and other services for help with khat use. Foremost among these were arguably a generic distrust of mainstream services, coupled with the barriers; in simplistic terms, a feeling that services will not understand 'their' problem. It should be stressed that this is born out of experience as much as perception. Mainstream drug treatment services were in particular not felt to be appropriate for Somali clients, partly because khat was not seen as a drug, partly because of the stigma attached to drug use more generally. At the same time, some respondents did state they would rather approach a service that had no roots with the Somali community as they felt this would be more confidential.

Likewise in terms of accessing more general health providers such as GPs and hospitals, there were some significant disparities. Men seemed more comfortable accessing help from their GPs, but nevertheless were as likely to approach their local mosque for help. Women were far less likely to approach any service at all. Focus group and other data suggested this was attributable to a number of factors, including the taboo against khat use by women, lack of confidence in their English (and concerns about confidentiality using an interpreter), as well as the suggestion that some women did not know they were entitled to see a female doctor.

Varying literacy rates also highlight the care that needs to be taken with using written materials. A referral letter might get thrown in the bin as junk mail by those who cannot read it; leaflets in doctor's surgeries might go unread. Care should therefore be taken not to simply produce lots of literature of local services in Somali (as has happened in some parts of London). More effective are likely to be ways of promoting services that are more in tune with Somali needs and Somali culture. Specialist Somali health intervention workers have proved effective in other boroughs and certainly health promotion sessions organised by research project workers at Fanon with Somali 'experts' on nutrition, mental health etc, have proved very popular. Equally, visual media such as DVD or video could also be used to good effect.

6.13
PROJECT RECOMMENDATIONS

TREATMENT

- Continue resourcing the project at current level with more focused service provision and seek funding to expand the number of workers to two full-time staff
- Work more closely with other statutory health and mental health professionals, as well as those community and voluntary sector groups working in this field, to strengthen referral/signposting pathways, and develop an effective model of care for khat use that combines harm minimisation advice and culturally appropriate psycho-social interventions.
- Extend the existing partnership arrangement with the Fanon Resource Centre to include other stimulant services in the borough where possible and appropriate.
- Greater provision of diversionary activities targeting at risk groups within the community, notably women, carers, the unemployed, and young people.
- Disseminate the findings of this report, as well as a guide to working with Somali clients produced by East African Health Concern, to a wide range of public health providers such as GPs and hospitals.

BROADER RECOMMENDATIONS

- Coordinate more effectively with other agencies and departments within the Safer Lambeth Partnership (SLP) to address a broad range of needs within the Somali community and encourage the formation of a strategic-level group at borough level of SLP and Somali community members.
- Supported Housing and other providers to ensure that Somali tenants at risk are adequately assisted to maintain their tenancies
- Continue efforts to engage constructively with *marfesh* owners, promote good business practice and greater awareness of health and safety issues.
- Intensify efforts to engage young Somalis and develop initiatives to address potential khat and/or other drug use among this group, using innovative approaches– activities, events, etc.
- Support efforts to provide access to suitable community venues
- Promote good relations with the police and the broader community.
- Work more closely with other khat services across London and relevant local authorities. Intensify efforts to establish a cross-borough khat working group.
- Inform and educate local and other media of the issues surrounding khat (mis)use.

ENDNOTES

1 Marfesh or marfesh is a khat-house, a place where khat is chewed. The plural in Somali is marfeshyo

2 There are a number of local variants of the plant's name, such as chat, qat, jaad etc, plus names derived from place of origin e.g. 'Meera' (an area in N. Kenya). However, the most common orthography used in the UK is 'khat'. In this

3 This is the title of a book examining the history of khat use and production in Ethiopia.

4 http://www.dea.gov/slideshow/july2006.htm

5 Al-Hebshi & Skaug 2005:299

6 Alex Kirby, 'Yemen's Khat Habit Soaks Up Water', http://news.bbc.co.uk/1/hi/programmes/from_our_own_correspondent/6530453.stm

7 http://news.bbc.co.uk/1/hi/world/africa/ 6142688.stm

8 http://www.drugs.com/npp/khat.html

9 "Drug classification: making a hash of it?" – HMSO Fifth Report of Session 2005–06

10 UCLAN/GLADA 2004 – Refs and Asylum-seekers

11 Dr. Shamis Hussein, personal communication

12 Luqman 1978; Griffiths et al. 1997; Warfa et al. 2001, 2006

13 Wright 1998

14 NTA 2002

15 The researchers are grateful for the guidance of Mark Asquith, of Wolfson College, University of Oxford, around adapting CRM as far as possible in this way, and checking the statistical analysis of the data

16 Dr. Feyisa Demie, presentation to Somali Educational Conference, Dec. 2006

17 UCLAN Brent 2004

18 It is worth noting that khat use only became widespread in Somalia from the post-war period onwards, with improvements in transport infrastructure in the region. In this sense, it is open to question just how 'traditional' widespread khat use is.

19 A similar point is made by Richard Burton in his 'First Footsteps in East Africa', 3:31fn1

20 Personal communication from Leah Levane, Streatham Town Centre Manager

21 UCLAN/LDA – Refs and Asylum-seekers

22 Hook & Regal 2004:243ff

23 Ibid.

24 C.f. ARMA/UCLAN 2005; REEC/UCLAN 2006, amongst others.

25 Incense is used across a range of contexts in E. African culture, one of which is honouring guests.

26 UCAN/GLA 2004

27 Warfa et al 2006

28 Ibid.; see also Bhui, Bhugra, & Macdonald 2004

APPENDIX 1 SAMPLE QUESTIONNAIRE

LAMBETH KHAT RESEAERCH PROJECT/ LAMBETH COUNCIL KHAT QUESTIONNAIRE

This anonymous questionnaire is being used as part of a research project looking at how the issue of khat is affecting the Somali community in Lambeth.

The answers you give will be used to improve services available to the Somali community in Lambeth.

Any answers you give will be treated in the strictest confidence and will be used by Lambeth Council's Drug and Alcohol Team solely for the purpose of this study. They will not be passed onto to other agencies. You do not have to answer any questions you do not wish to, although we urge you to be as frank as possible.

Please tick the box below to confirm that you have given your consent to take part in this study.

Su aalahaan aan qofna ku magacowneyn (anonymous questionnaire), waa su' aalo loogu tala galay in fikard looga qaato cilmi baaris kooban oo ku saabsan isticmaalka qaadka ee soomaalida degan xaafada Lambeth. Jawaabaha aad ka bixiso waxay naga caawin doonaan sidii loogu diyaarin lahaa caawimaad soomaalida ku dhaqan xaafadan Lambeth.

Jawaabaha aad na siiso waxay noqonayaan kuwa loo isticmaalo cilmi baaristaan oo kaliya iyadoo aan qofna magaciisa la isticmaaleyn (anonymous). Looma gudbin doono urur kale.

Inkastoo cilmi baaris ahaan ay wanaagsan tahay inaad sida ugu daacadsan uga jawaabto su'aalahaan hadana khasab ma aha inaad ka jawaabto su'aal aadan ku faraxsaneyn. Fadlan sax santuuqa hoos ku qoran si loo xaqiijiyo ogolaansahaaga ka qeyb qaadashada cilmi baaristaan.

☐ (tick here/ halkaan sax)

Thank you for your time/ Waad ku mahadsan tahay ka qeyb qaadashadaada.

PLEASE CIRCLE ANSWERS

PART A – PERSONAL INFORMATION

AGE RANGE

16-20 21-25 26-30 31-36 37-45 46 and over

GENDER

Male Female

DO YOU HAVE A DISABILITY

Yes No

If yes please specify: _____

AREA OF RESIDENCE

Streatham Clapham & Stockwell Brixton Norwood Kennington Outside Lambeth

WHICH LANGUAGES DO YOU SPEAK AND/OR WRITE?

English Somali Arabic Italian Other

Spoken (please specify) _____

Written (please specify) _____

EDUCATION

Primary Secondary Higher Education No formal Education

EMPLOYMENT STATUS

Full-time Part-time Unemployed Student Self-employed

HOUSING SITUATION

Living in Hostel Own house Council Tenant Council Tenant

Temporary Accommodation Living with friends/ Relatives No Fixed Abode

MARITAL STATUS

Single Married Divorced Widowed Separated

IMMIGRATION STATUS

Exceptional Leave to Remain Indefinite leave to Remain British citizen

Other (please specify) _____

PART B – KHAT USE

(PLEASE ANSWER QUESTIONS IN THIS SECTION ONLY IF YOU USE KHAT)

WHERE DO YOU USUALLY USE KHAT?

Chew with friends at home Chew with family Chew alone Chew at Marfesh

Other (please specify) _____

AMOUNT CHEWED IN A SESSION

1-3 bundles 3-5 bundles 5 or more bundles

MONEY SPENT PER WEEK

£ 3-10 £11-20 £20-30 £30 or more

LENGTH OF SESSION

1-3 hours 3-5 hours 5-8 hours 9 hours or more

NUMBER OF SESSIONS IN A WEEK

1-2 days 2-3 days 3-5 days 5-7 days

REASONS FOR TAKING KHAT

To relieve stress To socialise As a cultural practice To become more energetic

Positive health effect

Other (please specify) _____

DO YOU FEEL KHAT USE CAUSES ANY OF THE FOLLOWING EFFECTS ON YOUR HEALTH?

Sleep disorders Oral problems Constipation Loss of appetite

Hallucinations Heart problems Paranoia Mental health problems

Sexual health issues

Other problems (please specify) _____

WHEN YOU CHEW KHAT, DO YOU SMOKE CIGARETTES?

Yes No Sometimes

DOES USING KHAT HAVE ANY OTHER EFFECTS ON THE FOLLOWING AREAS OF YOUR LIFE?

MARK WITH + FOR POSITIVE AND – FOR NEGATIVE EFFECTS

Family Social life Finances Employment Education

HOW OLD WERE YOU WHEN YOU FIRST STARTED USING KHAT?

Under 16 16-20 21-25 26-30 31-36 37-45 46+

WHO FIRST OFFERED YOU KHAT?

Friend Wife/ husband Other family member Bought it yourself

Other (please specify) _____

HAVE YOU EVER TRIED TO QUIT?

Never tried to quit Thought about quitting

Tried once Tried more than once Don't need to quit

IF YOU WANTED HELP WITH YOUR KHAT USE, WHO WOULD YOU GO TO?

GP Friends/ Family Mosque Specialist khat service Would not seek help

Other (please specify) _____

DO YOU HAVE KNOWLEDGE OF THE FOLLOWING DRUGS?

Alcohol Cannabis Cocaine Amphetamine Ecstasy Heroin

Other (please specify) _____

HAVE YOU USED ANY OF THESE WITH OR WITHOUT KHAT?

Yes No If yes, which ones? _____

PART C – ATTITUDES TO KHAT

HAVE YOU EVER USED KHAT?

Yes No

IN YOUR OPINION, KHAT IS....

an individual problem friends'/family problem a community problem

not a problem, it is a cultural practice a drug menace

HAVE YOU EVER EXPERIENCED PROBLEMS WITH ANY OF THE FOLLOWING DUE TO KHAT USE, EITHER BY YOURSELF OR BY OTHERS?

Financial difficulties Health Employment Education

Mental Health Sexual Health Crime Violence in the home

Violence outside the home

IF YOU OR SOMEONE YOU KNEW HAD A PROBLEM WITH KHAT USE, WHO OR WHERE WOULD YOU GO FOR HELP?

Friend Family GP Hospital Mosque Community organisation

Specialist Somali khat service

Other (please specify) _____

WHAT DO YOU THINK WOULD HELP REDUCE PROBLEMS CAUSED BY KHAT USE IN THE SOMALI COMMUNITY?

_____

_____

ARE YOU CONCERNED BY KHAT USE BY YOUNG PEOPLE IN THE SOMALI COMMUNITY IN LAMBETH?

Yes No

If yes, why? _____

ARE YOU CONCERNED THAT YOUNG PEOPLE IN THE SOMALI COMMUNITY ARE USING DRUGS OR ALCOHOL?

Yes No

If yes, why? _____

IF YOU WOULD LIKE MORE INFORMATION ON KHAT USE, OR ON OTHER DRUG AND ALCOHOL ISSUES FACING THE COMMUNITY, PLEASE CONTACT:

_____ on _____

or

_____ on _____

or write to them at:

Lambeth DAT/ Fanon Care
105-109 Railton Road
Brixton
London
SE24 0LR

or email: _____

APPENDIX 2 FOCUS GROUP THEMES

1
YP FOCUS GROUP

- What do you think of Khat? Is it something you use/would use, or just something for the older generation?
- What are your experiences of khat use, either by yourselves or by other people? Have these been positive or negative? Do you feel there are effects on health?
- What do you think are the main issues facing Somali youth in Lambeth today?
- How much of an issue is crime for you? When do you feel unsafe in Lambeth? Do you feel you are targeted by the police because you are Somali?
- Do you feel drugs are an issue for Somali youth? Have you, or someone you know, ever used drugs?
- Who would you turn to if you had a problem with a) khat use b) drug or alcohol use? Who would you like to be able to turn to?
- How do you feel about services generally (health, housing, jobcentre etc) in Lambeth? What do you think could be done to make services better for the Somali community?
- Do you have any other concerns?

2
MEN'S FOCUS GROUP

- What do you think of khat? Is it something you use/would use?
- What are your experiences of khat use, either by yourselves or by other people? Have these been positive or negative?
- What do you feel the impact of khat use on health is? And what about work/ family and social life?
- How do you feel about the younger generation using khat? And what about women using khat? What are your concerns about Somali youth?
- How much of an issue is crime for you? Do you feel vulnerable in Lambeth? If so, how?
- Are you concerned about drug use in the Somali community? Is this something you think affects only the younger generation? What can be done to improve the situation?
- Who would you turn to if you, or someone you knew, had a problem with a) khat use b) drug or alcohol use? Who would you like to be able to turn to?
- How do you feel about services generally (health, housing, jobcentre etc) in Lambeth? What do you think could be done to make services better for the Somali community?
- Do you have any other concerns?

3
WOMEN'S FOCUS GROUP

- What do you think of khat use? Is it something you would ever use yourself?
- What are your experiences of khat use, either by yourselves or by other people? Have these been positive or negative?
- What do you feel the impact of khat use on health is? And what about work/ family and social life? Do you feel there is a link between khat use and problems in marriage or family? What about domestic violence?
- How do you feel about the younger generation using khat? And what about women using khat? What are your concerns about Somali youth?
- How much of an issue is crime for you? Do you feel vulnerable in Lambeth? If so, how?
- Are you concerned about drug use in the Somali community? Is this something you think affects only the younger generation? What can be done to improve the situation?
- Who would you turn to if you, or someone you knew, had a problem with a) khat use b) drug or alcohol use? Who would you like to be able to turn to?
- How do you feel about services generally (health, housing, jobcentre etc) in Lambeth? Do you think services meet the needs of women in particular? What do you think could be done to make services better for the Somali community?
- Do you have any other concerns?

4
ELDERS' FOCUS GROUP

- What do you think of khat? Is it something you use/would use?
- What are your experiences of khat use, either by yourselves or by other people? Have these been positive or negative?
- What do you feel the impact of khat use on health is? And what about work/ family and social life?
- How do you feel about the younger generation using khat? And what about women using khat?
- How much of an issue is crime for you? Do you feel vulnerable in Lambeth? If so, how?
- What are your concerns about Somali youth?
- Are you concerned about drug use in the Somali community? Is this something you think affects only the younger generation? What can be done to improve the situation?
- Who would you turn to if you, or someone you knew, had a problem with a) khat use b) drug or alcohol use? Who would you like to be able to turn to for help?
- How do you feel about services generally (health, housing, jobcentre etc) in Lambeth? Are the needs of the older generation being met? What do you think could be done to make services better for the Somali community, and for the older generation in particular?
- Do you have any other concerns?

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