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BUILDING A SAFE, JUST AND TOLERANT SOCIETY

Khat use among Somalis in four English cities

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Home Office Online Report 47/05

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Background

Khat (also known or spelt as 'qat', 'jaad', 'qaat' or 'chat') is a plant most commonly grown in Eastern African or Middle Eastern countries. Its leaves are chewed for their stimulant effect mostly by people from these regions. Khat itself is legal in the UK, however the two main active ingredients (cathine and cathinone) are Class C controlled substances, under the Misuse of Drugs Act (1971).

The use of khat has a long-standing history within the Somali culture in particular. Before the civil war, khat chewing was a traditional social activity in Somalia and would bring people together for relaxation and to stimulate conversation (Ismail and Home, 2005). Khat use would normally be restricted to particular times of the day and session length. Some people also chewed khat in order to remain alert for studying or work reasons. Attitudes towards khat use vary but it is generally perceived as a legitimate activity, by substantial proportions of the communities who use it and not censured in the way that those communities censure alcohol and illicit drug use.

There have, however, been some concerns about the effects of khat. Research on a Somali population in London in the 1990s (Griffiths, 1998), reported health effects of khat use including sleeping difficulties, paranoia and mood swings. Other research indicates that frequent khat use can have physical health implications, such as oral infections or problems with digestion (Ali *et al.,* 2004; Rassool and Abou-Saleh, 2000). There is also concern that people who do not wash khat before consuming it will ingest pesticides (Date *et al.,* 2004).

Aims

This study sought to examine the level and nature of the use of khat by Somali people in four cities in England (Birmingham, Bristol, London and Sheffield). In addition, the study focused on:

- the perceived health and social effects of using khat;
- whether khat use was associated with alcohol or illicit substance use or offending; and
- attitudes to khat use.

It also aimed to examine how UK khat users obtain their supplies of khat and to seek the views of a smaller number of people from other khat chewing communities, such as Ethiopians, Kenyans and Yemenis.

Method

The current study updates and expands on the earlier work of Griffiths, using the same methodology but including data from a larger number of Somali people from communities in four cities. In the main, this research was informed by data from 602 questionnaire-based interviews with Somali respondents in London, Birmingham, Bristol and Sheffield. The sampling method was a purposive one, aiming to include both women and men with a wide range of ages. It was a challenging task to engage people from this population in a research study, due to potential language and cultural barriers and the sensitivity of the topic. For this reason, it was not possible to obtain a random sample and this limits the extent to which the interviewees can be considered representative of the Somali population in the UK. However, the size of the interview sample was substantial for a study of this type.

The interviews were carried out by trained Somali Privileged Access Interviewers (PAIs). The rationale for using a PAI approach is that engaging researchers from a similar (or the same) social and cultural background as the target population maximises the ability to reach 'hard-to

-access' groups (Winter and Noom, 2003; Elliott *et al.,* 2002 and Nacro, 2004) This was a methodology found to be effective by previous research of the same nature (Griffiths, 1998).

Questionnaire data were supplemented by in-depth, qualitative interviews with six Somali community workers. Focus group discussions were also carried out with PAIs at the beginning and end of the fieldwork.

In addition, qualitative interviews or focus groups were carried out with 14 Yemeni people, four Ethiopian community workers and one Kenyan community worker[1]. These communities represent those settled in England who originate from areas where khat is grown and/or chewed. As small numbers of respondents from these backgrounds were interviewed, it limited the extent to which conclusions could be drawn about those comunities' levels of khat use. The different methodology used in gauging the views of respondents from other backgrounds also meant it was not possible to make comparisons with the Somali sample. However, the views of respondents from these communities are included throughout the main report in order to enhance the understanding of khat use in this country.

Profile of the Somali sample

Just over half of those interviewed (54%) were male; ages ranged between 17 and 74 years (with a mean age of 35 years), and one-fifth were aged 25 or under. In terms of differences between the samples interviewed within the four research sites, London had a high proportion of male respondents (73%), and Birmingham had a relatively high proportion of young respondents (32% aged 25 or under).

Khat use within the Somali sample

Thirty-eight per cent of the overall sample of Somalis had ever used khat in their lifetime and 34 per cent of the overall sample had used khat in the month prior to interview. Khat users were, on average, older than non-khat users and a higher proportion of khat users were men: 58 per cent of the men reported having ever used khat (51% in the last month) but only 16 per cent of the women reported using khat in their lifetime (14% in the last month). Analyses of patterns of khat use revealed that almost half of khat users first tried it before they were 19 years old.

The average frequency of current khat use in England was three days a week, although ten per cent of those who had used khat in the past month were using it on a daily basis at the time of interview. Out of those who had ever used khat, 47 per cent said they had used it daily, at some time, for a period of at least a month. Respondents reported an average quantity of 2.5 'bundles' being used in a typical session (range: one to six bundles[2]). Khat chewing sessions were described as lasting an average of six hours but could last from one to twenty hours.

Sessions typically took place within a single sex group which had an average size of ten individuals (range: two to 30 people). However, out of the 40 women who reported using khat in the last month, 32 per cent said they had used khat in mixed sex groups. More of the women (44% of women, compared with 19% of men) said that they chewed khat in groups of fewer than six people and a higher proportion of the female khat users reported using khat alone.

Where applicable, respondents were asked whether they thought that they used khat more in England or in Somalia. Approximately a third of respondents said that they used more in Somalia, a third said they used more in England and a third reported no difference.

[1] These interviews and focus groups were carried out by the lead researcher.
[2] It is important to note that 'bundles' are not a precise unit of measurement, but the weight of a 'bundle' or bunch of khat usually varies between around 200g and 250g).

Perceived health effects

Respondents who reported using khat in the last month were asked whether they had experienced a range of symptoms after khat use. Seventy-five per cent reported experiencing some kind of health problem after using khat but most symptoms were generally reported as being mild as opposed to moderate or severe. Only three health problems were reported by more than 40 per cent of respondents who had used khat in the last month and these were also the only three symptoms to be described as moderate or severe by more than 15 per cent of the group. Sleeping problems were reported by 65 per cent (8% severe, 23% moderate), 51 per cent reported loss of appetite (2% severe, 18% moderate), and 44 per cent reported feeling the urge to chew more khat (11% severe, 11% moderate).

Perceived social effects

Respondents also commented on the social problems they had experienced and which they attributed to their own or someone else's khat use. The most commonly cited social problems associated with khat use concerned the family unit and/or the marital relationship, for example, spending some of the family income on khat (a bundle of khat usually costs around £4 to £6), spending long periods away from home to chew khat, and in six cases becoming violent towards family members. Alcohol use and illicit drug use were each reported by one per cent of respondents and offending was reported by fewer than one per cent.

Attitudes to khat

Respondents were given a set of statements about khat (for example, "Chewing khat is alright if it is done in moderation") and were asked to indicate the extent to which they agreed or disagreed with (or had no opinion on) each statement. Opinion was divided on most of the statements, and higher proportions of recent khat users (compared with those who had never used khat or not used it in the last month) agreed with the positive statements about khat. The interviews indicated that khat use was viewed more positively than the use of cigarettes or alcohol and this was true to the greatest extent among recent khat users. For example, 61 per cent of recent khat users but only 36 per cent of non-khat users agreed with the statement "I would rather my children chewed khat than smoked cigarettes" while 83 per cent of recent khat users and 44 per cent of non-khat users agreed with "I would rather my children chewed khat than drank alcohol". Only 14 per cent agreed with the statement "It is alright for women to chew khat". Women tended to be more negative than men in their opinions towards khat use.

Respondents were also asked about their attitudes towards approaches to the prohibition of khat in the UK; 49 per cent were in favour of making khat illegal, 35 per cent were against this action, eight per cent were indifferent (and 8% did not respond to the question). Opinions on prohibition were related to recent personal khat use: a quarter of recent khat users were in favour of banning khat, compared with around three-quarters of those who had never used khat or not used it in the last month. Some respondents suggested introducing more limited controls such as a licence to sell khat and/or age restrictions on purchasing it.

Conclusions

The overall picture was that most of the interviewees who were using khat were using it in a moderate way, in terms of amount used and the frequency and length of chewing sessions and that it was usually a social activity. However, there were a small number of people who said they were using khat every day or for very long periods and some felt that their use of khat was out of control. These groups of people may need some help and support in moderating their khat use.

Opinions of Somali interviewees were fairly evenly divided on khat and on whether it should be prohibited. The focus groups with members of other khat chewing communities and those with PAIs also revealed mixed feelings about the control of khat. There was no evidence from

this research that restricting khat use would have any effect on drug or alcohol use or on offending.

The research identified a need for greater awareness among khat-chewing communities, and also among health care professionals, of the health problems associated with khat use. There were suggestions of simple measures which people could take to reduce the risks to their health. These included washing khat to remove pesticides before chewing, eating a good meal before using khat (because it is likely to reduce the appetite), and improving ventilation in khat-chewing venues. Reducing the frequency and length of khat-chewing sessions was also suggested as a way that people could reduce their risk of health problems although, as already mentioned, some may need help to do this.

1 Introduction

Khat (Latin name *Catha edulis Forsskal,* sometimes spelt in other literature as 'qat') is a green-leafed shrub grown mostly in Ethiopia, Kenya and the Yemen. Its leaves and stems are chewed and the juice swallowed for its stimulant effect[3] - described as anything between caffeine and amphetamine (Patel, 2004). The main stimulant components of khat are cathine and cathinone – both of which are controlled substances under Class C of the Misuse of Drugs Act (1971). Khat itself is legal in the UK and, despite not being an indigenous plant, it is imported so frequently that it is available in many cities to buy almost every day. It can be purchased, for example, from Somali cafes and khat-chewing venues, known as the 'marfrish'.

The substance is referred to by many different names, depending on dialect or the nationality of the chewer.[4] In Ismail and Home (2005 : 8) the various names are listed as 'African salad', 'Abyssinian tea', 'Tea of the Arabs', 'Bushman's tea', the 'Flower of Paradise' (Griffiths, 1998 : 7), 'chat' or 'herari' in Ethiopia, 'mirra' in Kenya, 'qaat' or 'jaad' in Somalia and 'qat' in Yemen. During the fieldwork for this project it was also heard being referred to as 'gaat' by some Somalis.

There are two main types of khat available in the UK; that which is grown in Kenya – called 'mirra' – and that which is grown in Ethiopia, called 'herari.' PAIs involved in this study described the Kenyan khat as having the stronger effect, and sometimes the stems are chewed as well in order to enhance its potency. The Ethiopian khat is thought to have a milder effect and typically only the leaves would be chewed. Khat is usually sold wrapped in banana leaves in order to preserve freshness. The potency of khat degrades within approximately 36 hours of being picked and for this reason people prefer to chew it while it is still fresh.

The historical use of khat is detailed in a number of reports and its function through history has been varied. It was used to treat medical ailments (Beekhuis, 1997), it was (and still is) an aspect of social/recreational activity (Fountain *et al.*, 2005), and it was even associated with the learning of religious literature within the Somali and Ethiopian cultures[5] (Gatiso and Jembere, 2001; Whittingdon and Abdi, undated). Most literature indicates the use of khat in Somalia in the pre-civil war period as a 'socially regulated' activity (Kujog, 2001), in that consumption was traditionally limited to a certain time of day, for certain hours and done mostly by men who were considered to be 'of age'[6]. This was to ensure that men would be able to stop chewing activity in good time to rest, be with their families, or go to work afterwards. Community attitudes towards khat are variable, but, in the main, khat is perceived as a legitimate substance. Its use is not censured in the same way that the use of alcohol or illicit substances are.

The research study

In 2004, the Home Office commissioned Nacro to conduct a review of khat use among Somalis living in four English cities. The research took place over a period of 13 months.

The research reported here follows an earlier Home Office study by Paul Griffiths (1998) which sought to investigate patterns in the use of khat within a sample of 207 Somalis living in London. The Griffiths study used a 'Privileged Access Interviewer' methodology, whereby members of the Somali community in London were recruited, trained and equipped with the appropriate material in order to survey their contemporaries. They used a questionnaire to

[3] Khat can also be used in tea or made into a chewable paste (Source: www.drugscope.org.uk).
[4] The substance is sometimes spelt as 'qat' in other literature. In this report, the authors will use the spelling 'khat', unless they are quoting from another source.
[5] During the course of this present study, a Somali community worker commented that historically religious scholars, called 'ulamers', would chew khat in order to stay awake and read or memorise the Koran.
[6] Anecdotal information provided by PAIs suggest that this age would be approximately 20 years and above.

scope the extent and nature of khat use. At the time, findings suggested that 67 per cent had used the substance in the week prior to interview and that around three-quarters were using more khat in London than they had in Somalia.

The main aims of the new study were to investigate, within a wider sample of Somalis:

- the level and nature of khat use;
- the perceived health effects of using khat;
- whether khat use was associated with alcohol or illicit substance misuse, or offending; and
- attitudes to khat use.

It also aimed to examine how UK khat users obtain their supplies of khat and to seek the views of a smaller number of people from other khat-chewing communities, such as, Ethiopians, Kenyans and Yemenis.

This research study drew on the same methodology as Griffiths's study, and Privileged Access Interviewers carried out a total of 602 questionnaire-based interviews in four sites across England. The sites were chosen to represent some of the key areas of settlement for Somali people in the country.

The four research sites were:

- Birmingham;
- Bristol;
- London;
- Sheffield.

The majority of the fieldwork conducted by PAIs was concluded in November 2004. Qualitative interviews were conducted with Somali community workers across the sites to supplement the other data collected in the study. Interviews were also carried out with community leaders, workers or members from Ethiopian, Kenyan and Yemeni backgrounds. Finally, focus groups were conducted with PAIs on two occasions to scope their opinions on the extent, nature and implications of khat use in the Somali community.

2 Literature review

Interest in khat use

Both before the Griffiths research (reviewed below), and in subsequent years, there has been much interest in the subject of khat use. This has come from a variety of sources: within the Somali community itself (Ahmed, 1994; Ahmed, 1995); local health or substance misuse services (Isse, 2002; Patel, 2004); the media (*The Guardian*, 2002; *The Voice*, 2002; BBC London News, 2002); and academics (Ahmed and Salib, 1998; Griffiths et *al.*, 1997; Griffiths 1998; Nabuzoka and Badhadhe, 2000). Most of the literature tends to highlight changing patterns of khat consumption amongst Somalis following settlement in the UK as well as the social causes and impacts associated with it.

Griffiths's research: khat use in London

Between 1994 and 1995, a sample of 207 Somalis living in London (152 men and 55 women) were interviewed by PAIs using a structured questionnaire and the Severity of Dependence Scale. The mean age at interview was 36 years, participants had lived in London an average of four years and there was a high rate of unemployment within the sample (83%). Some of the main findings from the study are listed below and, to an extent, reflect the focus of this present study.

- Seventy-eight per cent of the overall sample had used khat at some point in their lives.
- Eighty-six per cent of khat users (67% of the overall sample) reported using khat in the week prior to interview.
- Six per cent reported using khat on a daily basis – on average use took place three times a week, but 27 per cent had used khat daily at some point in their lives.
- Ninety-six per cent used between one and three bundles of khat per day[7] and seven people used more (the maximum being 15).
- Sixty-four per cent reported using more khat at the time of interview than one year ago.
- Seventy-six per cent reported using more khat in the UK than in Somalia. Proposed reasons for the increase in use included high unemployment, increased availability of khat, decreased cost in 'real terms', lack of cultural constraints or a desire to affirm cultural identity by chewing at social gatherings.
- The average time for chewing was 6.8 hours.
- Generally respondents did not self-report serious problems caused by khat chewing. However, 90 per cent said they had trouble sleeping after using the substance (74% felt paranoid, 72% experienced mood swings and 15% reported having hallucinations). In the majority of cases the symptoms were reported as being mild or moderate, rather than severe.
- Six per cent said they had *ever* used cannabis, four per cent said they had *ever* used heroin and three per cent said they had *ever* used cocaine or crack-cocaine– although three per cent had used cannabis, 0.5 per cent had used heroin and none had used cocaine or crack-cocaine in the year prior to interview (see Appendix 2).
- Participants did not want khat to become a prohibited substance in the UK and the majority believed that if it did become illegal, Somalis would continue to use it.

Griffiths emphasised that the sample in this study was not a random one, which limited the extent to which the findings could be generalised to the population *en masse*. However, as

[7] This is not a clear measure of usage because there can be inconsistencies in the amount sold, purity value and over- or under-reporting.

discussed in Appendix 1, random sampling of the Somali population would prove very difficult to do.

Overview of khat use: other UK research

Although it is difficult to quantify the overall extent of khat use, there are studies on small populations of Somalis that can provide some insight into the issue. It should be noted that the Home Office also commissioned a study by Turning Point to explore treatment issues related to khat use and to make good practice recommendations.

In Sheffield, Nabuzoka and Badhadhe (2000) researched khat use among young Somalis, and nearly half of the 97 participants indicated chewing khat between two to three times a week, with 32 per cent doing so on a daily basis. Fifty-nine per cent chewed one bundle, and 34 per cent chewed two bundles. A quarter said they currently used illegal drugs – although it is not known whether khat was used in conjunction with any of these. Similarly, it is not reported whether the use of khat formed a 'gateway' to other substance use – or *vice versa* – or if certain substances were used to temper the 'come down' of others. The authors described limited employment prospects for young Somalis, and attributed the use of khat and other substances to frustration and 'lack of a sense of purpose' (p. 8).

Ahmed and Salib (1998) compared 27 male khat users living in Liverpool to 25 non-khat users, using interviews and General Health Questionnaire data. Just over half of the khat users expressed the belief that khat is harmless, compared to eight per cent of non-users. There were no other major differences between the two groups.

Bashford *et al.,* (2003) reported the findings of drugs misuse needs assessments carried out by 51 community groups across England. Ethiopian, Kenyan, Somali and Yemeni participants were included in the study, along with a number of other communities. Within an overall sample of 11,579 respondents, 287 people reported using khat; 194 were Black African, 75 were Middle Eastern and 14 were South Asian (a further four were Unspecified).

In Patel (2004) the reasons for khat use were explored within a small sample of Somalis in London. For some, using khat – and going to the khat-chewing venue, in particular – provided male users with a social pastime and a 'refuge'. Interviewees in this study described an initial sense of euphoria when khat is used, and chewers made plans about what to do with their time in London/England. However, after using, people faced an unpleasant come-down and depression could set in – which in turn, could lead to using khat again.

Khat and physical health[8]

Chewed in small quantities and occasionally, khat is unlikely to cause long-term physical harm (Burnett and Fassil, 2002). However, if it is chewed frequently and in large amounts, it can lead to consequences for the individual's health. This can include oral infection (Ali *et al.*, 2004); problems associated with ingesting khat that has pesticide on it (Date *et al.*, 2004); and khat-induced psychosis (Yousef *et al.*, 1996). In their review of literature on khat, Rassool and Abou-Saleh (2000), stated that it affects the 'cardiovascular, digestive, respiratory, endocrine and genito-urinary systems' (p. 1).

Khat use does not lead to physical dependence *per se*, however it is reported to cause 'moderate' psychological dependence (Ahmed and Salib, 1998). Isse (2002) also described 40 per cent of 210 Somali participants in his survey as having a 'compulsion' to use khat. A study by Mela and McBride[9] showed that out of 61 Somali men interviewed in Cardiff, 13 per cent reported daily use of khat and 19 per cent described themselves as 'dependent.'

[8] This section incorporates UK and international research.
[9] Referenced online by the Royal College of Psychiatrists in 2002.

Khat and mental health

The relationship between khat use and mental ill health is noted in other reports, including Refugee Health Team (2000) and Whittingdon and Abdi (undated). However, it is not clear whether khat use causes mental health problems where they did not exist before, or whether it exacerbates already existing problems. Bhui *et al.,* (2003) found suicidal thinking to be more common among Somalis who were using khat in the UK. Furthermore, khat use – as well as other variables – was a 'risk factor' for psychiatric symptoms.

CVS Consultants (1999) sought information from a Somali community organisation and a mental health service for refugees about problems encountered by newly arrived refugees/asylum seekers. The mental health service had observed higher levels of khat use leading to the exacerbation of existing mental health conditions. The Somali organisation noted high levels of suicide amongst young men linked to khat use.

The social context and impact of khat use

The research on khat use has highlighted the involvement of a number of social variables being somehow associated with khat use, however the precise nature of the relationship remains unclear. It is difficult to distinguish between the social factors being a precursor to khat use, a consequence of khat use, or both. The issue does not appear to be one of straightforward 'cause and effect'.

Patel (2004) found that using khat was blamed for people not accessing education or employment, and familial/marital discord. However, people also turned to khat use when they were unsuccessful in accessing education or employment.

Attitudes towards khat use and khat users

Views on khat can be polarised, with some perceiving its use as legitimate and others associating it with social problems (Fountain *et al.*, 2005). For example, in the Bashford *et al.* (2003) study, respondents had mixed opinions about khat; a number of people did not see it as a drug, but as part of their culture and history.

However, female interviewees in a study by Nahdi (undated) concerning Muslim perceptions of drug use in a north London district, provided very negative views on khat use. They felt that their khat-chewing partners spent a significant amount of their limited finances on the activity and also did not help with domestic or childcare responsibilities.

Traditionally, khat use was predominantly an activity for men over a certain age. However Kujog (2001) notes that there are a growing number of young men using khat, as well as the increase in female khat use reported by Bashford *et al.* (2003). The use of khat by women is still stigmatised within the Somali community and most would rather carry out this activity in private in order to avoid censure. The study also found that women are more likely to chew khat alone as well as report feeling that their use is 'out of control'.

3 Research design

There were three main strands of data collection in this research. These were:

- the completion of 602 in-depth interviews with Somali men and women in Birmingham, Bristol, London and Sheffield, using a structured questionnaire;[10]
- focus groups with the PAIs at the beginning and conclusion of fieldwork; and
- qualitative interviews with six Somali community workers, 14 Yemeni people, four Ethiopian community workers and one Kenyan community worker.

Community interviews and the PAI method

The 602 interviews were carried out using the Privileged Access Interviewer (PAI) method, which has been shown to be effective in reaching 'hard to access' groups (Winter and Noom, 2003; Elliott *et al.*, 2002; Nacro, 2004). The PAI method involves choosing people (not usually experienced research interviewers) who share the language, culture and many of the characteristics of the target population to recruit participants and carry out the interviews. Using PAIs from the communities to be interviewed helps to overcome potential barriers to communication and to reduce the suspicions and hostility which might be aroused by 'outsiders' asking detailed questions about sensitive issues such as drug use.

PAI training events were carried out in each site and covered basic research skills, the importance of confidentiality and informed consent, ethical conduct, health and safety and the administration of the research tool.[11] It became clear from the training that, for cultural reasons, female PAIs would mostly interview female participants and, likewise, male PAIs would mostly interview male participants, although on occasion PAIs interviewed participants of the opposite sex. Participants in the current study were recruited through the social networks of the PAIs and through Somali community organisations in the four cities. PAIs were encouraged to seek a variety of participants. That is, where possible, they were asked to seek interviews with:

- khat users and non khat users;
- men and women;
- different age groups (but no one under the age of sixteen[12]);
- first and second generation immigrants to the UK;
- people with various places of birth (in Somalia) and 'clan affiliations'; and
- some people included in the import or selling of khat.[13]

Thus, the approach to sampling was a purposive one. The chosen method of recruitment to the study was the most suitable for the purpose and achieved a substantial number of interviewees from different sections of the population. However, the study sample was not a random sample and this may limit the extent to which the participants can be considered representative of the wider Somali population in England.

The questionnaire used for the interviews was divided into six sections. The first section addressed the respondent's personal information, such as date of birth, date of arrival in the UK and employment status. The second section concerned the use of khat, followed by a section on the health effects of khat use (for those who have used khat). The next two sections covered other substance use and offending. The final parts of the questionnaire

[10] Each respondent received a £10 High Street Gift Voucher as a token of appreciation for their time.
[11] The training pack was based on materials used in previous Nacro research (Nacro, 2004). In this study based in the London Borough of Southwark, young people were trained, supervised and equipped to conduct interviews on their peers.
[12] No one under 16 years of age was interviewed because of the additional responsibility to the PAI of obtaining the consent of the parent/guardian for the young person to take part in the research.
[13] Over the course of the fieldwork, PAIs reported finding it difficult to engage khat sellers, who were suspicious about the nature of the research.

were more qualitative and focused on information about khat import as well as opinions about potential methods of khat control.

Interviews with Ethiopian, Kenyan, Somali and Yemeni community practitioners

An additional aspect to the research was qualitative interviews with individuals (usually community workers) from Ethiopian, Kenyan, Somali and Yemeni backgrounds in each site. This was in order to scope the experiences of the community in that particular research site, such as educational/employment achievement and integration in general, as well as the extent and nature of khat use.

Six Somali community workers were interviewed in Bristol, London and Sheffield. Establishing contact with Somali community workers proved problematic in Birmingham, where there was not an established network of minority ethnic community organisations through which potential interviewees could be traced. In addition, there were four interviews with Ethiopian community workers (London and Sheffield), one with a Kenyan worker (London), two focus groups with Yemeni community members in Birmingham and Sheffield (attended by 13 people in total) and an interview with a Yemeni community worker (London). Similar difficulties to those described above were experienced in contacting members of these communities.

Interviews with community practitioners and people from other khat-chewing groups were based on a qualitative schedule. Firstly, questions were asked about the population in the city, with specific focus on integration. Then respondents were asked about khat use – its historical context, its current context, the profile of users, reasons for use and the impact of using. Questions were also asked about other substance use and offending, and finally, people were asked about their general opinions on khat use and potential methods (and implications) of control.

Data management and analysis

In total, 602 questionnaires were completed by Somali respondents and entered on the research database. Table 3.1 illustrates the number of questionnaires completed per site.

Questionnaire data were entered on to an Access database and imported into a statistical software package (SPSS) for quantitative and thematic analysis. Transcripts from interviews with workers across the various community groups and PAI focus groups were imported into the Nud*ist programme for qualitative analysis.

Table 3.1: Completed questionnaires by research site (whole sample)

Site	Completed questionnaires
Birmingham	148
Bristol	152
London	150
Sheffield	152
TOTAL	**602**

4 Research sites and the sample

This chapter describes the profile of the sites and the sample of 602 Somali research participants in this research study. This incorporates a description of the characteristics of the sample (as well as inter-site comparisons[14]). Specific information on age, gender, employment and length of residence in the UK are provided.

Contextual profile of the research sites

This section provides an overview of the four research sites involved in the present research. Obtaining 'hard' data on Somali population size has not been possible for either Birmingham or Bristol. Furthermore, the figures from Census 2001 are inconsistent with estimates from other studies and may under-report the number of Somalis living in any particular area. Therefore the information detailed below is derived from available documents.

Birmingham

All of the information concerning Somalis in Birmingham is taken from discussions and focus groups with local PAIs. The PAIs themselves were all from districts in the south of the city, such as Small Heath, Balsall Heath and Spark Brook. There are a small number of Somali community associations listed in the area, although these community organisations were not listed with the local authority's Equality and Diversity division at the time of fieldwork. PAIs believed that Somali settlement in Birmingham was relatively recent (from the year 2000 onwards), but Cole and Robinson (2003) reported that Somalis had first settled in the area to work in 'heavy industry' (p.8) in the 1950's. Furthermore, PAIs believed that Somalis arrived in the UK via European countries.

Educational and employment achievement appeared to depend on the age of Somalis; generally, people over the age of 30 did not access either education or the labour market, whilst younger people found this easier to do. The non-transferability of qualifications and skills was a particular issue with respect to finding employment.

Regarding the sense of 'integration' within the city, this depended on age and the ability to speak English. Elderly Somalis tended not to speak the language and could not, therefore, relate to people from other communities. The language barrier also impeded their knowledge of their rights. Younger Somalis were perceived as more able to integrate with other communities as they found it easier to learn English.

Bristol

Settlement of Somalis in the city is thought to date back to between 50 and 100 years. Following the civil war, the Somali population has increased and is estimated as between 7,000 - 10,000 people. Somalis tend to reside in inner city parts of Bristol, such as Barton Hill, Easton and St Paul's.

Early research established a number of difficulties that Somalis faced in the city. These included: unemployment; over-crowded accommodation; social isolation experienced by the elderly; the language barrier impeding application for welfare benefits or other support; and a range of emotional issues related to the civil war (Somali Educational and Cultural Community Association, 1997, cited in Cole and Robinson, 2003). A focus group with PAIs indicated some small changes had taken place with respect to employment. That is, Somalis had been able to access 'casual' employment, but this was less easy for women with childcare considerations. In addition, a community worker said that some Somalis had set up small businesses in the area.

[14] Where possible, the findings have been compared to those from the Griffiths (1998) study and these can be seen in Appendix 2.

London

Census 2001 data show 33,831 Somalis living in London. According to these data, there are particularly high concentrations of Somalis in the boroughs of Brent, Camden, Ealing, Enfield, Haringey, Newham and Waltham Forest. Anecdotal information suggests that high numbers of Somalis live in Hounslow and Tower Hamlets as well.

The population is diverse; there are Somali seamen who settled in the city from the 1940s onwards, migrants (pre-civil war), as well as more recently arrived refugees and asylum seekers. Refugees and asylum seekers from the Somali background tend not to be dispersed to other UK cities due to the extensive network of support in London (from family members and/or community organisations).

A community worker commented on difficulties experienced by first generation Somalis in accessing employment. These seem to have decreased over time and a number of Somalis who were young when they arrived here have been able to gain qualifications and find employment.

When asked about integration, Somali PAIs described the community as preferring not to mix with other cultures due to some instances of young people becoming involved in anti-social behaviour.

Sheffield

Census 2001 data show that 1,306 Somalis live in Sheffield. Estimates of the Somali population size provided by the Information Centre about Asylum and Refugees (ICAR) (based on local studies) range between 3,000 and 6,000 people. There is also an historical Somali settlement dating back to the 1930s, when seamen moved into the steel and mining industries. More Somalis arrived following the outbreak of civil war in Somalia (from 1988 onwards). The main areas Somalis live in are Broomhall, Pitsmoor, Firth Park, Park Hill, Manor, Sharrow and Netherthorpe.

In focus groups, PAIs in Sheffield spoke about the educational and employment situation for Somalis in the city. Men were thought to be more successful at finding employment than women, in occupations such as security guards and factory workers. The PAIs also described a similar situation to other cities where older members of the community tend not to integrate with other groups but younger people find this easier to do.

Profile of the questionnaire research sample[15]

This section describes the profile of the research sample, and details the differences between the four research sites. The main characteristics of the sample are summarised in Table 4.1.

Gender differences

Just over half of the total sample (53.8%, n=324) were male. Generally, similar numbers of men and women were interviewed within each site, however 73 per cent of the interviewees recruited in London were male. Also, whereas there were fairly equal numbers of male and female interviewees in the '40 years and under' age group, just under two-thirds (65%) of the sample aged over 40 years, were male.

[15] *Notes on analysis*: In order to respect cultural sensitivities about certain questions, PAIs were asked not to pursue answers where it was apparent that the interviewee did not wish to answer. Therefore, questionnaire data analysis highlighted that some respondents either did not elaborate or the PAI had omitted certain parts of the answers. As a result, there are some missing responses.

Table 4.1: Overview of the whole questionnaire research sample

	Birmingham (n=148)	Bristol (n=152)	London (n=150)	Sheffield (n=152)	Total (n=602)
Gender	43% male	49% male	73% male	50% male	54% male
Age range	17 - 68	19 - 74	17 - 66	17 - 74	17 - 74
Mean age	32 years	34 years	36 years	35 years	35 years
% aged 25 or under	32%	13%	15%	17%	20%
Percentage born in Somalia	74% Somalia + 12% Somaliland	86% Somalia + 7% Somaliland	79% Somalia + 10% Somaliland	52% Somalia + 42 % Somaliland	72% Somalia + 18% Somaliland
Percentage born in UK	2%	1%	7%	4%	4%
Respondents with children under 16 years of age	30%	46%	33%	41%	38%

There were more male than female respondents who were in paid employment at the time of interview: 148 male respondents (46%) were employed compared with only 78 women (28%). This may reflect general employment patterns between men and women, the latter not always being able to enter the labour market because of childcare responsibilities. However, both anecdotal information and research by Harris (2004) highlight the difficulties that Somali women have experienced with seeking employment in the UK. Somali women with domestic responsibilities are often unemployed because they do not have the same opportunities to learn English as Somali men. Those who do find employment tend to take relatively low-skilled positions.

Age distribution

The research sample were aged between 17 and 74 years, with a mean age of 35 years. However, the mean age among Birmingham respondents was lower than for other sites. This relatively young age profile for Birmingham reflected the PAI profile for that site, two of whom were 17 years of age at the time of fieldwork.

Country of birth

Just under three-quarters of the sample (n=435; 73%) reported that they had been born in Somalia. Another 108 respondents gave 'Somaliland' as their country of birth (referring to a region in the north of the country formed after civil war broke out, although it is not recognised as an independent country[16]). Seventeen people specified England as their country of birth (which has been incorporated into 'United Kingdom' in the tables above and below).

Inter-site analysis revealed that a higher proportion of London participants were born in the UK and a higher proportion of Sheffield participants were born in Somaliland. The website for the Information Centre about Asylum and Refugees (ICAR)[17] indicates that an estimated 90 per cent of the Somali population in Sheffield is originally from Somaliland.

The distribution of country of birth is given in Table 4.2.

[16] There is a potential overlap between those who stated Somalia as their country of birth, but who were actually born in what is now known as Somaliland.
[17] http://www.icar.org.uk/res/map/regions/end_n_yh/sheff/over.html, accessed 09/11/2004.

Table 4.2: Country of birth (whole sample)

	Percentage
Somalia	73.0
Somaliland	18.1
United Kingdom	3.5
The Middle East	2.8
Other African countries	2.0
Europe	0.6
TOTAL (n)	***596***

Employment and sources of income

Two hundred and twenty-six respondents (38%) stated that they were in paid work at the time of the interview and 201 of them (33% of the total sample; 89% of those employed) described this as 'formal employment' (i.e. not paid as 'cash in hand'). Eighteen per cent of respondents from Birmingham were in paid work, compared with 29 per cent from Sheffield, 49 per cent from Bristol and 54 per cent from London. Details of the variety of sources of income are shown in Table 4.3. Three hundred and fifty-six respondents (59% of the total sample) described themselves as having another source of income with the result that the percentages in Table 4.3 do not add up to 100.

Table 4.3: Income sources (whole sample)

	Percentage
Benefit	51.3
Paid employment	37.5
Supported by spouse/ partner	4.0
Supported by other family member	3.3
Student loan / university grant	14.6
Pensions	0.7
Self-employed	0.5
Loan	0.2

Accommodation

A high proportion of Somali interview participants (80%) were living in either social housing or vulnerable accommodation and this generally reflects other research findings on the housing situation of Somali people in the UK (Cole and Robinson, 2003). Participants had, on average, lived at the same postcode for just over four years.

Length of residence in the UK

For non-UK birth respondents (n=575), the range for length of time in the UK was between one and 49 years. The mean was ten years.

Self-reported ethnicity of respondents

Table 4.4 gives an indication of how individuals described their ethnic origin, and the degree to which Somali nationals could be distributed within the different ethnic categories of Census data.

Table 4.4: Ethnicity (whole sample)

	Percentage
Black African	82.3
Somali / Somali British[18]	10.2
Black British	7.2
Mixed Race	0.3
TOTAL (n)	***598***

Whilst most Somalis (82%) described their ethnicity as Black African, others categorised themselves as Black British or Mixed Race.

In addition, six interviews were carried out with Somali community workers (five men and one woman) in Bristol, London and Sheffield. Four were carried out with male Ethiopian community workers (in London and Sheffield). One interview took place with a male Kenyan worker (in London), one interview was carried out with a female Yemeni community worker, and two focus groups (13 men in total) were held with Yemeni community workers and members in Birmingham and Sheffield.

Summary of key points

- Six hundred and two Somali respondents were recruited almost equally across the four sites.
- Three hundred and twenty-four respondents were male (54% of the sample), and 278 were female.
- Ages ranged between 17 and 74 years (mean age 36 years).
- Thirty-three per cent of respondents said they were formally employed at the time of interview.
- The majority of Somali respondents lived in social housing

[18] This is not a category within the Census, and these respondents may either choose to identify within one of the other three categories, or may describe themselves as 'Black other'.

5 Patterns of khat use among the sample

This chapter outlines analysis of details provided by Somali respondents to questions about khat use (as well as illicit substance/alcohol use). Where appropriate, the analyses of questionnaire data are supplemented with qualitative findings from Somali community worker interviews and PAI focus groups. The chapter examines the issues listed below and highlights any relevant subgroup variations in responses (such as age and gender) where data are sufficiently strong.

- A general overview of patterns of khat use reported by respondents.
- Comparisons between recent khat users (those who have used khat in the past month), non-recent khat users and those respondents who had never used khat.
- Personal initiation and development of khat use – how did respondents initiate use of khat and why? What patterns developed for those who continued to use khat?
- Patterns of recent use – how much khat did people use, how often did they use khat, when did they use khat, in what context did khat use take place, how much did khat cost and why did people use khat?
- Access to khat and preferences for different types and strengths of khat.
- Geographical or temporal differences in khat use. Effect of country of residence on khat use.

This chapter also examines qualitative responses from interviews with Ethiopian, Kenyan and Yemeni participants with respect to khat use.

Overview of khat use (Somali sample)

Two hundred and thirty-one respondents (38% of the overall sample) identified themselves as having *ever* chewed khat. Most of those who reported ever using khat, had used it fairly recently; 34 per cent of the overall sample said they had chewed khat in the month before the interview.

More men than women said they had ever chewed khat: 58 per cent of the male respondents, compared with 16 per cent of the female respondents.

Those who had ever used khat were, on average, older than those who had not; the mean age of those who had used khat was 38 years and the mean age of those who had never used khat was 33 years.

Respondents who had used khat in the last month (recent users) said that, on average, they used khat on three days per week and consumed an average of 2.5 bundles on each occasion. However, ten per cent reported that they were using khat daily at the time of interview. Out of those who had ever used khat, 47 per cent said they had done so on a daily basis for over a month at some point in their life and 17 per cent reported having used khat daily during the past year. Frequency of khat use among those who said they had ever used khat is summarised in Table 5.1.

Table 5.1: Frequency of khat use among respondents who had ever used

	Total (n=231)
% using khat in the month prior to interview	89
% ever used khat daily	47
% used khat daily during past year	17
Average frequency of khat use	3 days per week
% use of khat alone on >1 occasion	40

Comparisons between recent (in the last month) khat users, non-recent khat users, and respondents who had never used khat

Two hundred and four respondents (34% of those interviewed) were identified as recent khat users, having reported use of khat in the month prior to interview. The characteristics of those interviewed who had recently used khat have been compared with those study participants who had used khat over a month ago (4%), and those who had never used khat (62%). These are reported in Table 5.2.

Table 5.2: Comparisons between respondents who had recently (in the last month) used khat, used it over a month ago, and respondents who had never used khat

	Recent khat user **%**	**Non-recent khat user** **%**	**Non-khat user** **%**	***TOTAL*** **(*n*)**
Mean age	39 years	38 years	34 years	(Mean age of whole sample) 36 years
Gender				
Female	14	2	84	278
Male	51	7	43	324
Country of birth				
Somalia / Somaliland	35	4	61	543
UK	5	14	81	21
Other country	28	0	72	32
TOTAL (n)	***(204)***	**(*25*)**	***(373)***	**(*602*)**

Age

The interviewees who reported using khat tended to be older than those in the group who had not used it. Just over half of respondents in the over-40 age group (51%) had used khat at some point in their life. This compares with 35 per cent of those participants aged between 31 and 40; and 26 per cent of those aged 30 and under.

The ages of interview participants who were recent khat users ranged from 17 to 74 years (the mean average being 39.3 years). Those participants who had not used khat had an average age of 34 years.

Gender

Fourteen per cent of female respondents disclosed using khat recently (16% had 'ever used'), compared with 51 per cent of male interviewees (58% had 'ever used'). This greater prevalence of khat use among male respondents is in accordance with the greater cultural acceptance of men rather than women using it. The mean ages for male and female khat users who participated in the study were 39.6 years and 37.9 years respectively.

Employment

Forty-nine per cent of those respondents who were currently in paid employment had chewed khat at some point in their lives. Sixty-one per cent of the male interviewees and 24 per cent of the female interviewees in paid employment, had ever chewed khat. Of those not in paid employment, 32 per cent of participants had chewed khat at some point in their lives (55% of unemployed male interviewees and 13% of unemployed female interviewees).

In terms of recent khat use, 42 per cent of those interviewees in paid employment had used khat in the last month, compared with 29 per cent of those interviewees not in paid employment.

An interesting finding from this analysis was the relatively high number of unemployed people who did not chew khat (68%), considering the literature that indicates lack of employment being a key issue in using the substance.

Country of birth

Very small numbers of respondents currently chewing khat were born in countries other than Somalia/Somaliland. A smaller proportion of interviewees who were born in the UK reported currently using khat. However, the subsample of people born in the UK was small and skewed towards the younger age groups, who were less likely than the older interviewees to report that they used khat.

Respondents who had never used khat

The majority of the sample (61%) reported never having used khat. Most non-khat users were female (63% were women and 37% were men). This is not a surprising finding, given the cultural attitude towards women who chew khat. In comparison to khat-users, a higher proportion of the non-khat users had been born in the UK, a higher proportion were unemployed and the non-khat users were, on average, slightly younger.

Initial experiences of khat use

Most respondents first tried khat when they were relatively young: 46 per cent had tried it by the time they were 19 years old, and 92 per cent had tried it before they were 30. The high rate of initial khat use up to the age of 19 years is surprising in light of the approximate acceptable age to begin chewing (traditionally) proposed by PAIs and Somali community workers (that is, 20 years and above).

Table 5.3: Age range of first khat use (among respondents who had ever used khat)

	Percentage
Under 10	1.3
10-19	44.3
20-29	46.1
30-39	7.4
40-49	0.9
TOTAL (n) 230	

Initial access to khat was most commonly through friends (n=115; 49%). A smaller number bought the khat for themselves (n=54); had it provided by a sibling (n=22); by a member of the extended family (n=20); by parents/grandparents (n=12); and by their partner/spouse (n=6).

Among interviewees' reasons for first trying khat, the most commonly cited one was 'for socialising' (n=119; 47%), then 'curiosity' (n=45), and 'enjoyment' or 'fun' (n=38). Other respondents had first used khat to mark their transition into adulthood (n=9), or in response to pressure from others (n=9). There were also small numbers who cited using khat for the first time to alleviate depression (n=6); to overcome tiredness (n=6); as a means of celebration (n=4); to be 'part of Somali culture' (n=4); to have something to do (n=3); and to improve their concentration (n=3).

Patterns of consumption among recent khat users[19]

For those 199 respondents who answered how many days in a typical week they chewed khat, the mean was three days a week (ranging from one to seven). Over a quarter chewed khat once a week, with similar proportions using khat twice a week, and three days a week. Just over ten per cent reported using khat on a daily basis.

Table 5.4: Average frequency of khat use (recent users)

Average number of days use khat / week	Percentage of respondents (recent users)
1	26
2	24
3	23
4	11
5	4
6	2
7	10
TOTAL (n) 199	

Most respondents reported using two (48%) or three bundles (26%) on a typical session/day, ranging from one and six bundles (mean 2.5 bundles).

Table 5.5: Number of khat bundles consumed in a typical day/session (recent users)

	Percentage of respondents (recent users)
1	12
2	48
3	26
4	11
5	3
TOTAL (n) 198	

Somali respondents mostly chewed khat after 12 pm, with the majority doing so between 6 pm and midnight. On average a khat chewing session lasted for six hours (range 1 – 20 hours). The full distribution of responses is shown in Table 5.6.

Table 5.6: Length of time spent chewing khat (recent users)

	Percentage of respondents (recent users)
1-4 hours	17
5 hours	18
6 hours	27
7 hours	10
8 hours	15
Between 9 and 20 hours	13
TOTAL (n) 214	

The analysis also showed that whilst consuming khat, some respondents would drink tea, soft drinks or water. Thirty-one people mentioned smoking cigarettes at the same time, and one person said they smoked 'shisha' (tobacco in a pipe).

Eighty-one recent khat users said they had chewed khat by themselves on more than one occasion and 27 recent khat users said that they thought they had chewed more khat when

[19] Although 214 respondents answered the questions in relation to 'current khat use', this included 22 individuals who had not used khat for over a month (16 of whom had not used it in over a year), and 3 individuals who could not remember when they last used it. These individuals have been excluded from the analysis of 'recent khat users'.

they were alone than they would have done in a group setting while 40 said that they chewed less when they were alone. Out of those interviewed, more of the women than men reported using khat on their own (65% of female recent khat users compared to 34% of male recent khat users).

In terms of the gender composition of groups, traditionally men would chew khat together, and women would be discouraged from doing so at all. Generally, respondents reported chewing khat in same-sex groups. However, a small number of people (n=18) said they chewed khat in mixed groups.

The size of the groups varied from two to 30 individuals, with a mean size of ten people. Fifty-two respondents said the number of people in their group exceeded 14. The two most commonly cited places for where the group of people gathered to chew khat was either a house (115 respondents; 47%), or the *marfrish* (98 respondents: 40%).

Reasons for using khat (recent users)

> *I enjoy it, I like the feeling I get after I chew. [It] takes away all my problems and I dream of what it is like to be at home and all is well with family and friends.*

Reasons given by respondents for their ongoing use of khat included it being a 'fun' activity and part of socialising, although it also had a role in helping users to relax or counteract feelings of stress. Sixteen interviewees said they used it to 'pass the time'. However, 15 people said they used khat because they were addicted to it.

Table 5.7: Respondents' reasons for using khat (recent users)

	Percentage of respondents (recent users)
To socialise	40.3
For enjoyment or fun	16.9
To relax or counter stress	10.9
To be happy	7.3
To pass the time	6.5
Addiction	6.0
Somali cultural tradition	4.4
To overcome tiredness or aid concentration	4.0
Other	3.7
TOTAL (n) *242*	

Access to khat and preferences

Those respondents who identified themselves as recent users of khat were also asked questions about how and when they purchased their khat, the preferred type of khat and reasons for this preference. Differences in khat originating from different countries were also examined.

The most common source from which interviewees reported purchasing khat was an independent dealer. Just over one-third of khat-using interviewees identified this source. Similar proportions of interviewees also reported buying khat from the *marfrish*, or from a shop, café or restaurant. Responses are summarised in Table 5.8.

Thirty-four per cent of the interviewees who were recent khat users stated that there had been changes in the availability of khat since they started to use it in the UK. The majority of these (87% of those responding) stated that availability had increased, with only three per cent reporting that it had decreased. Factors associated with increased availability were identified

as: a larger number of khat sellers; cheaper khat being available now; and an increase in the number of khat houses.

On the whole, Kenyan khat was reported to be the most easily accessible form of khat (60%), although almost one-third of respondents stated that there was no difference (32%).

Table 5.8: Places where khat is purchased (as identified by respondents)

	Percentage of respondents (multiple responses possible)
Independent seller	35
Marfrish / khat house	30
Shop / café / restaurant	29
Multiple sources	7
No comment	3
Friends	2
TOTAL (n) 204	

Respondents were asked whether they typically chewed Ethiopian, Kenyan or Yemeni khat. The majority (48%) stated that they chewed Kenyan khat, ten per cent said they typically chewed Ethiopian khat, and five per cent said Yemeni khat. However, 19 per cent said that they chewed 'whatever is available'. In terms of the type of khat they preferred, most people cited Kenyan khat (59%), followed by Ethiopian khat (18%).

Kenyan khat was reported to be the strongest form of khat by 35 per cent of khat users and it was also identified as being 'preferable' by another ten per cent. Reasons for this preference were: because it was stronger and cheaper, with faster effects; because it had a longer shelf-life; because it tasted better; and because it was tender/easier to chew. However, some interviewees disagreed, and reported either no difference between the various types of khat, or preferring khat that had originated from either Ethiopia or the Yemen.

The majority of responses were that strong khat was preferable to weak khat. Stronger khat was preferred because it was relatively cheaper to get a stronger effect from it and also because users became more talkative and experienced a 'high', making them happier and relaxed. However, ten per cent of current khat users in the study reported having no preference about the relative strength of khat, whilst seven per cent preferred weaker khat. Weaker khat was preferred because it caused fewer side effects and in particular did not cause sleep problems. Weaker khat was also reported to allow more sociable interaction, because chewers did not get 'too high' to talk to each other coherently.

The overwhelming response to the question about factors associated with the strength of khat was that it was stronger when it was fresh, with 60 per cent of the 204 current khat users giving this response. However, users also reported that Kenyan khat was the strongest.

Generally khat was reported to be of no different strength in the UK than it had been in Somalia. However, there was some disagreement on this issue with a quarter of recent khat users reporting that khat had been stronger in Somalia and a similar proportion of interviewees reporting that it was stronger in the UK.

Table 5.9: Relative strength of khat in UK compared to Somalia

	Percentage
No difference	45
Stronger in Somalia	28
Stronger in UK	27
TOTAL (n) *196*	

Twenty per cent of recent khat users reported that there had been changes in the quality of khat. The most common response was that khat was now of poorer quality than it had been (n=22). Linked to this were reports of fresh khat being less accessible now, worse side effects being experienced from it, and variability in its quality.

When asked if they had ever experienced difficulty in affording khat (one bundle usually costs around £4), 48 respondents (24% of recent khat users) answered that they had. This difficulty in affording khat was typically attributed to 'low income' (n=38).

When asked what they did if they could not afford to buy khat, most respondents said they would 'go without'. The most common responses are shown in Table 5.10. In addition, a small number of people said they would try and get some khat from elsewhere or smoke cigarettes.

Table 5.10: Respondents' actions if unable to afford khat (recent users)

	Percentage of total comments (multiple responses possible)
Go without it	36.8
Ask friends/family to buy it	19.6
Do other things	13.4
Borrow money	11.0
Get credit from seller	7.2
Share other people's khat	4.8
Other	7.2
TOTAL (n) 204	

Furthermore, respondents were asked what they would do if they were unable to find khat (for example, if none was available for sale). A small number of respondents said they would use leftovers, drink coffee, that the khat seller keeps some khat aside or they would buy enough for a week. The most common responses are summarised in Table 5.11.

Table 5.11: Respondents' actions if unable to find khat (recent users)

	Percentage of total comments (multiple responses possible)
Go without	44.3
Do other things	39.5
Keep looking for it	5.2
Drink alcohol or use other drugs	4.3
Other	6.7
TOTAL (n) 204	

Women and khat use

The issue of Somali women using khat is not easy to research and is a very sensitive topic. There is a social stigma surrounding the use of khat by Somali women (Ismail and Home, 2005) and they are generally reluctant to openly consume the substance, much less discuss it with strangers. It is therefore a credit to the tenacity of the PAIs that they managed to interview women and, where applicable, elicit information about their khat use.

Overall, there were 44 women (16% of women in the sample) who reported ever using khat in their lifetime. This is considerably lower than the 58 per cent of male interviewees who had ever used khat.

Forty female respondents were recent khat users (14% of all women interviewed) and their mean age was 38 years. There was little difference between women and men in the study in terms of frequency of khat use (two days a week for women, three days a week for men); the average number of bundles used (2.4 for women, and 2.5 for men); the time of day when khat was used; or the average length of the chewing session.

More of the female respondents than the male respondents said they had first used khat outside of Somalia (57% of female recent khat-users, compared with 31% of male recent khat -users); and a larger proportion of the women reported using khat in groups of less than six people (44% women, compared with 19% of men). It is of interest that five women said they chewed khat in a group of 14 people or more, which could imply doing this in a khat-chewing venue. Furthermore, 11 out of 34 female recent khat users reported chewing khat in mixed-sex groups.

Men and women gave similar reasons for using khat, as Table 5.12 illustrates:

Table 5.12: Gender comparisons in reasons for using khat (recent users)

	Women	**Men**	**TOTAL % (n)**
Enjoyment/socialising	62%	65%	65% (160)
Positive psychoactive effects	25%	13%	16% (39)
Cultural tradition	2%	6%	5% (13)
Habitual activity	4%	9%	8% (20)
To pass the time	8%	6%	7% (16)
TOTAL number of responses (some respondents gave more than one reason)	***53***	***195***	***248***

A lower percentage of female than male respondents reported that people within their family knew about their khat use. Twenty women (50% of female recent users) reported older family members being aware of their khat use, compared with 123 men (75% of male recent users). Twenty-four women (60% of female recent users) reported that other family members, such as their partner, children and siblings knew of their khat use, compared with 142 men (87% of male recent users).

Fifteen (38%) of the female recent khat users reported sometimes having difficulty in affording khat. This contrasts with 33 (20%) of the recent male khat users. The percentage of female recent khat users (85%) and recent male users (95%) who did not think their use was 'out of control' was fairly similar. However, a larger percentage of the women (50%) said they would like to stop using khat, compared with 27 per cent of male recent users.

Geographical and temporal differences in khat use

This section reports on interviewees' experiences of changes in khat use between living in Somalia and living in the UK, examining frequency of khat use in Somalia, and levels of stability or fluctuations in reported use.

Table 5.13: Frequency of respondents' khat use in Somalia compared with that in the UK

			Respondents who used khat in both Somalia and the UK	
Frequency of khat use (Somalia/UK)	**In Somalia %**	**In the UK %**	**In Somalia %**	**In the UK %**
Daily	24.2	10.6	24.6	14.3
Six times a week	3.9	1.5	4.0	1.6
Five times a week	2.3	4.5	2.4	7.1
Four times a week	8.6	11.1	8.7	10.3
Three times a week	17.2	22.6	17.5	22.2
Twice a week	21.9	24.1	21.4	26.2
Once a week	17.2	25.6	17.5	18.3
Less than weekly	4.7	-	4.0	-
TOTAL (n)	***128***	***199***	***126***	***126***

Twenty-one per cent of those interviewed said they had used khat in Somalia. Their reported frequency of khat use at that time is presented in Table 5.13, and compared to the frequency of khat use among recent khat users when in the UK (n=199). This suggests that among the study participants khat tended to be used less frequently in the UK than it was in Somalia, with only 11 per cent of respondents using khat daily in the UK, compared to 24 per cent of respondents when in Somalia. The last two columns show the frequency of khat use in Somalia and in the UK by respondents who reported using khat in *both* countries.

Respondents were asked to recall how many bundles of khat they consumed in Somalia. For those who provided an answer (n=139) the number of bundles ranged between one and 12, the mean being 2.6 bundles (compared to an average use of 2.5 bundles per session in the UK). As in the UK, most respondents would consume two to four khat bundles per session, in Somalia. Thus, little appeared to have changed in terms of the amount of khat consumed. However, caution is advised in using 'bundles' as an index of quantity, because this is not a consistent unit of measurement in terms of both size and potency. Bundles usually vary between around 200g and 250g although they are not usually weighed before sale. In particular, potency is mainly affected by the freshness of khat, and so it is reasonable to expect that khat available in the UK is not as strong as that available in Somalia (although mixed opinions on potency were reported earlier in this chapter).

On being asked how they perceived their khat use in the UK compared to Somalia, almost equal proportions of respondents reported that their use in the UK was less, more or the same. The percentage of people making each response is shown in Table 5.14.

Table 5.14: Comparisons between respondents' khat use in the UK and Somalia (recent users)

	Percentage
Less now	34.3
More now	34.9
No difference	30.7

For those who felt there had been an increase in their khat use since living in the UK, their reasons are represented in Table 5.15. The most common reasons were based on a desire to cope with negative emotions or the impact of a variety of socio-economic factors. In addition, a few people cited reasons such as longer khat-chewing patterns in the UK, poor khat quality, more leisure time, women being more liberated and for enjoyment.

Table 5.15: Reasons given by respondents for their own increased khat use in the UK compared to Somalia (recent users)

	Number of individuals giving each reason (multiple responses possible)
Changes in family life	11
Depression or feeling stressed in the UK	10
Alienation from the culture	10
Unemployment	8
Having more money in the UK	7
Insecurity of refugee status	6
Lack of other activities	6
Social circle	4
TOTAL	**62**

One respondent explained his motivation for using khat as follows:

> *The reason I am chewing more khat is when I lived in Somalia I was with my family and I was not feeling…alone, but here I am on my own and I feel so lonely I try to make myself busy.*

For those who said they used less khat in the UK, the most commonly cited reasons included there being less time to chew khat and khat being expensive. A few people said it was due to

lack of income, having used home-grown or cheap khat in Somalia, feeling depressed when chewing, following other peoples' patterns of use, feeling happier at present and therefore chewing less and having no close friends to chew with.

The following respondent described his concerns over the different motivating factors for using khat between England and Somalia, which were linked to the reduction in his own levels of consumption:

> *Because in Somalia chewing was more for pleasure, especially done with close friends, but here the khat culture has changed. Most of my friends are not here. People chew here to waste time and that is not good.*

Interviews with members of other khat-chewing communities

Khat use is not restricted to the Somali community exclusively; it is also used by other people from other East African and also Arabic countries[20] (Ismail and Home, 2005). Based on this premise, this present study incorporated qualitative interviews with members of the Ethiopian, Kenyan and Yemeni communities across the research sites (where possible[21]). It should be noted that there was a very small sample of respondents from Ethiopian, Kenyan and Yemeni backgrounds and this limits the extent to which firm conclusions can be drawn from these data.

A report by Gatiso and Jembere (2001) indicated that khat use was a significant issue for the Ethiopian community in a south London borough. Khat was the most commonly used substance: 73 per cent of 250 Ethiopian people interviewed stated that they used it. Older members of the community did not perceive khat use as drug use, but as a legitimate, cultural pastime.

In the present study, there were four qualitative interviews with Ethiopian community workers (from London and Sheffield) and analysis of these showed that, overall, khat use was not perceived to be a particular issue affecting the community in an adverse way. Ethiopian people use the substance on a recreational basis and a small minority do so daily. None of the workers shared the negative views that were expressed by some Somali people.

Only one Kenyan contact was made over the course of the study and, for different reasons to the Ethiopian respondents, he did not think khat use affected his community. He said there was a common misconception that, because khat was grown in parts of Kenya, the indigenous population also uses it. His belief was that khat is consumed only by the people living in the coastal area where it is cultivated, and by Somalis living in Kenya.

Interviews with Yemeni people revealed a pattern of khat use similar to the Somali one in some ways. In interviews with a group of elderly Yemeni men, the consensus was that khat is consumed by a high number of men (and a smaller number of women[22]). This group believed that khat is used to such an extent that limited amounts of money are "wasted" on it and that those who chew khat are damaging their health.

On a separate occasion, a group of six Yemeni men of mixed ages was interviewed. It emerged from this group that, for most working Yemenis, khat is used on the weekends. However, those who are unemployed use it on more days during the week. There were more mixed opinions about khat within this group. Some acknowledged that it helped Yemenis socialise with their contemporaries in a society within which they feel largely isolated, but others said that khat is used to excess, affecting the individual, the family and the wider community.

[20] Khat consumption is banned in Saudi Arabia.
[21] Enquiries were made within each research site and there were some cities that did not have significant settlements of one (or all) of these community groups. This meant qualitative interviews were limited to Birmingham, London and Sheffield.
[22] Anecdotal information suggested this was not as taboo for Yemeni women in the way it is for Somali women.

Summary of key points

- Two hundred and thirty-one Somali respondents (38%) reported having ever used khat at some point in their lives. This group represented 58 per cent of male respondents and 16 per cent of female respondents. The mean age was 38 years. Almost a half of khat users in the study had tried it before they were 19 years old.

- Eighty-nine per cent of those who had ever used khat, reported having used it in the month prior to interview (34% of the total sample).

- More of the khat users in the study were male, older (than non-users), were born outside the UK, and were in paid employment, when compared to the non-khat users.

- The average frequency of current khat use among participants was three days a week although ten per cent said they were currently using khat on a daily basis.

- An average quantity of 2.5 bundles was used in a typical session (range: 1-6 bundles). Khat-chewing sessions could last from between 1 and 20 hours (mean: 6 hours), and were used within a group which had an average size of 10 individuals (range: 2 to 30 people).

- Thirty-four per cent of the recent khat users stated that there had been changes in the availability of khat since they started to use it in the UK. The majority of these (87% of those responding) stated that availability had increased, with only three per cent reporting that it had decreased.

- Comparisons between reported khat use in Somalia among the interviewees, and patterns of khat use disclosed in the UK suggest that khat was used less frequently in the UK, although the average quantity of bundles used per session was very similar. Twenty-four per cent of the respondents who had recently used khat said they chewed khat daily in Somalia compared with ten per cent saying they chewed daily in the UK.

- On being asked how they perceived their khat use in the UK compared to Somalia, almost equal proportions (of respondents who had recently used khat) said their use in the UK was more, less or the same.

- Ethiopian respondents did not identify any problems within their community as a result of using khat. An interview with a Kenyan person suggested that khat is not used extensively within his community. Yemenis reported some excessive use within their communities.

6 Problems associated with khat use

This section examines the types of problems that Somali (and Yemeni) respondents and community members associated with khat use. It includes perceived health and social problems, offending behaviour and other substance use. In places, these data suggested an association between khat use and perceived health (or other) problems. However, they do not establish a cause and effect relationship, whereby, for example, khat is proven to cause certain problems (or used to overcome them). Thus, caution is advised in drawing such conclusions.

Health effects

Respondents were asked whether they experienced specific health or emotional symptoms the morning or day after chewing khat (based on Griffiths, 1998).[23] Seventy-five per cent of recent khat users reported experiencing a health problem after use. These were mostly reported as being mild but sometimes moderate or severe. Examples of the health symptoms which respondents experienced included: sleeping difficulties; depression; mood swings and hallucinations.

The most common symptoms that respondents associated with khat use were: sleeping difficulties; loss of appetite; and an urge to chew more khat. Sixty-five per cent of recent khat users experienced sleeping problems (which 34% of respondents described as mild, 23% moderate and 8% severe) compared to 35 per cent who said they had not experienced that symptom. Loss of appetite was reported by 51 per cent of respondents (31% mild, 18% moderate and 2% severe) and 49 per cent said they had not experienced that symptom. The urge to chew more khat was reported by 44 per cent of interviewees, with 56 per cent stating that they had never experienced it. Details of the responses are shown in Figure 6.1.

When asked if they felt tired and depressed upon waking the morning after using khat, 53 per cent of recent khat users said this occurred always, often or sometimes, compared to 47 per cent who said this happened rarely or not at all.

Table 6.1: Respondents reporting "feeling tired or depressed the morning after using khat" (recent khat users)

	Percentage
Always	14
Often	23
Sometimes	16
Rarely	22
Never	25
TOTAL (n) 184	

Further analysis indicated that among recent khat users, rates of reporting certain health-related problems were associated with two additional factors.

1. The average frequency of khat use.

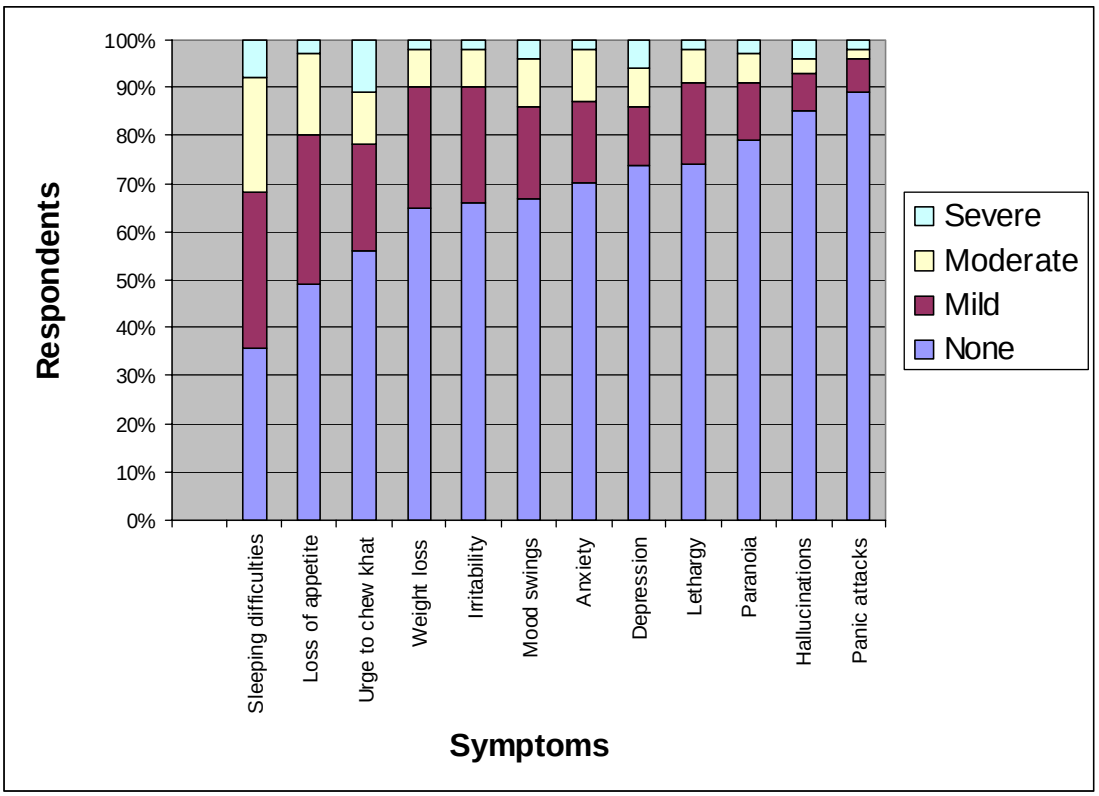
Those who disclosed experiencing weight loss used khat on average 3.7 days a week, compared to an average frequency of use of 2.5 days a week among those who did not report the problem. Those who disclosed experiencing depression chewed khat on an average of 3.8 days a week, compared to 2.8 days a week for those who did not report it. Finally, those who reported experiencing hallucinations used khat on average 4.1 days a week compared to those who did not report it who used khat on average 2.7 days a week.

[23] In order to maximise the accuracy of respondent recall, this health section focuses on recent khat users only.

2. The gender of the khat user.

Irritability was reported by 51 per cent of women, compared to 30 per cent of men. The urge to chew khat was reported by 62 per cent of women, compared to 40 per cent of men.

Figure 6.1: Reported health symptoms among recent khat users



Qualitative information on tiredness or sleeping problems as side effects associated with khat use is provided below. Despite 36 per cent of respondents in this study reporting no sleeping problems associated with their khat use, PAIs across the research sites and Somali community workers indicated that this was an issue. Furthermore, once the individual does fall asleep he/she might do so for an extended period of time, and/or feel very lethargic upon waking.

> *It's affecting you because when you chew all night you cannot wake up in the morning. Very difficult. You get to sleep in the early hours of the morning and you cannot wake up for your job. You cannot be regular…You cannot go out.*

Recent khat users were asked if they experienced any physical problems associated with khat (other than those listed in Figure 6.1). Eight respondents said this was the case and indicated additional problems including headaches and tiredness, nightmares, memory loss and dental problems. These factors suggest potential additional health symptoms to those identified by other studies (referred to in the literature review), although the reporting rate for each problem was very low.

When asked whether they had used khat to counteract any health symptoms, seven per cent of recent khat users said they had. These symptoms were: the urge to chew khat again, anxiety, lethargy, depression and trouble sleeping. This indicated that a cycle of use exists for some recent khat users, in that they would experience a particular health problem, use khat to reduce the effect(s), and so on.

Although not reported by any respondents, PAIs and community workers drew attention to other problems caused by using khat. These included poor nutrition and mental health issues (or exacerbating existing mental health difficulties).

> *You can tell if somebody chews a lot of khat, especially from their teeth and that can lead to other problems. If you mess up your teeth, you're not going to last very long.*

> *I've seen one or two individuals that … are mentally unstable. And they chew khat, but I don't know whether that is purely related to khat or the khat exacerbates it. So once again I can't really say.*

One particular concern about these health effects was that both PAIs and community workers thought there was a general reluctance to seek help about problems from a doctor or any other service. Thus, the health problems tend to go untreated.

> *I don't think they think it's a problem in the first place … It's not like alcohol or cocaine or anything like that. He thinks he is in control and can stop whenever he wants.*

However, other PAIs pointed out that even if Somalis approached a doctor or another service about khat-related problems, there is a lack of awareness about the issue among professionals who do not come from Somali or other khat-using communities.

PAIs and community workers all agreed that usually, people do not wash khat before consumption, due to the belief that this could diminish the potency of the substance. Pesticides are often used in cultivating the plant and consuming khat that has been treated with chemicals can have serious health implications (Date *et al.*, 2004).

Another issue that was discussed at PAI focus groups and by community workers was the health impact of conditions of khat-chewing venues – 'marfishyo' (plural of *marfrish* cited in Ismail and Home, 2005). Isse (2002) noted that venues are often small, poorly ventilated spaces and such environments were conducive to developing health problems, such as passive smoking and the spread of respiratory diseases, such as tuberculosis (TB). Although a community worker in one research site recalled coming across a well-maintained venue in which smoking was prohibited, the interviews in this present study generally reflected the concern that standards in *marfishyo* needed urgent review.

Social consequences of khat use

The questionnaires sought information about whether respondents felt that they were personally affected by another person's khat use. Seventy-five people (13% of the overall sample) said they thought they were affected, including 11 recent khat users. Respondents were asked for specific examples of how they were affected, and analysis showed that "family difficulties or breakdown" was mentioned by 23 of the 92 respondents who answered this question. The example of their partner's use of khat affecting their children, was mentioned by 11 people.

Ten people said they had experienced their partner's mood swings or temper as a result of him/her using khat, and ten people also said the use of khat had a negative impact within the extended family. Six people reported being affected by their partner spending too much money on khat, another six people reported experiencing domestic violence, and five people mentioned that their khat-using partners did not help in the domestic setting.

The theme of khat use being a contributory factor in the breakdown of families emerged in the interviews. Specifically, the time and money spent on the activity was cited as a source of contention between spouses. Other social implications of using khat included tension between siblings, and observing other peoples' problems with keeping jobs and remaining in education. Respondents were provided with an opportunity to elaborate on how they felt another person's khat use affected them. Some of the quotes are included below.

… my partner is chewing the khat and he never helps us [with] anything about our family, i.e. looking after children, making shopping and also we have financial problems because he is using all the money to buy the khat.

My brother chews heavily and is out of work because of khat. He does not hold on to jobs because he is up all night chewing.

Focus groups and community interviews indicated similar social implications. These participants commented on how khat use can affect the family unit and create tension between spouses.

…like, if the man's unemployed and like they get a benefit to go on the family and he's, like, spending £10, £15 every week to get khat, then there will be problems between the two people, like they start arguing sometimes.

Examining any links between khat use and offending

The respondents were presented with a checklist of offences and asked whether they had ever committed any of them, whether that was in the past 30 days, whether they had been using khat at the time and whether any other substance had been used at the time. Respondents were also given the opportunity to comment on whether they thought khat use had contributed to committing the offence(s).

Analysis showed that there were minimal levels of offending in the overall sample. Two respondents said they had shoplifted since living in the UK and three reported committing a violent offence. Of the two interviewees disclosing having shoplifted, one was a recent khat user who had shoplifted within the month prior to interview. Of the three individuals reporting having committed violence, all were recent khat users, and all three had been violent in the month prior to interview.

Four respondents had committed an offence during the month prior to interview. One of these individuals had shoplifted on four occasions over that period, and reported that they had shoplifted in order to get money to purchase khat.

The other three respondents reported committing a violent offence in the previous month (two had been violent once, and one had been violent on three occasions). Two of these individuals reported that their violent behaviour had coincided with khat use (but no other substance). When asked if they thought the offence was linked to khat use, one respondent stated he/she was under the influence of khat at the time of a physical fight with someone.

Overall, the qualitative interviews and focus groups supported the notion of a very low level of offending among Somalis across the research sites, and little evidence of offending associated with khat use. Khat use was seen as an activity that actually prevented people from offending as it is time-consuming and makes them feel relaxed.

When you take khat you cannot do any of those things. It makes you cool and happy and you cannot do something like that.

Khat is relatively cheap to buy and due to the social nature of the activity, users can usually borrow from other users. Users may also buy khat 'on credit' from sellers.[24] Even though people's financial resources were generally described as low, it was thought unlikely that a person would commit, for example, an acquisitive crime to support khat use.

There is this thing where the community comes together, sharing. Those who work may buy you khat. If you don't have the money for khat, someone will buy it for you…Or even the guy who sells khat will lend you some.

[24] Motivation for providing credit is unknown, however a Somali community worker said that sellers would prefer to do this because khat quality deteriorates rapidly and they would want to avoid supplies going to waste.

Other drug and alcohol use

Within the interview, respondents were given a checklist of substances and asked if they had ever used any of them, whether that was in the past 30 days, how much was used (in quantity and/or price) and whether it was used with khat. Additional questions about how the substance(s) was/were obtained were also asked. Due to cultural and religious factors (which are discussed in more detail below), it was not surprising that the section of the questionnaire that focused on the use of illicit substances and alcohol would elicit a low level of response.

Within the overall sample, there was no reporting of Class A substance use. Whilst one objective of the research was to examine any relationship between khat and crack use among Somali women, there were no women within the sample (indeed, there were no respondents at all) who reported using crack cocaine – either on its own or with khat. It is likely that any Somali women combining crack cocaine and khat use would be a particularly 'hard-to-reach' subgroup which the PAI researchers would find it extremely difficult to gain access to.

Cannabis was used by six respondents overall, and none reported experiencing any problems associated with this. Alcohol was used by seven respondents overall, and none of them reported using it with khat. None of the seven respondents reported experiencing any problems with alcohol use. Four recent khat users reported having ever used cannabis, including one person who said they had used it on 20 of the past 30 days – with khat. Two respondents had used khat before trying cannabis.

Four recent khat users reported having used alcohol at some point in their lives. Two had used it in the month prior to interview; one respondent had used it on two days and the other respondent had used it on three days. One person reported using alcohol because khat was not available, and another person reported using it on a 'special occasion'. Two individuals reported that they used alcohol with khat.

Cultural and religious factors concerning drugs and alcohol

Mainstream Somali culture incorporates Islamic ideology[25] and within this, the use of alcohol or any intoxicant is considered 'haram' (which is loosely translated as 'forbidden').

PAIs described how sometimes asking the question about substance misuse itself caused offence, or respondents would not respond honestly. This could be because respondents did not want to reveal such information to either the Somali PAI or they did not want people outside the community (for example, people who might read this report) to know.

> *PAI 1: Well actually they don't admit drugs…That is the truth.*
> *PAI 2: You know somebody in the community who's used cannabis but they won't tell us because you might tell...[someone else].*

PAIs and community workers were asked about their perceptions of Somalis' use of drugs and alcohol. Regarding alcohol, responses appeared to vary by region. In Bristol, a PAI said the use of alcohol was "very rare", whereas in Birmingham two PAIs said some older Somalis occasionally drank beer and a London PAI had observed more extensive use among younger people on one occasion.

Focus groups and community worker interviews incorporated a question about whether Somali people who used khat would have recourse to other substance use if, for whatever reason, khat was no longer available. PAIs said that alcohol, in particular, would be used if khat was not available – which is of interest given the cultural stigma surrounding this.

> *They say, "[Khat is] part of our culture and it helps us to meet and socialise." And if we don't have this khat, if we don't use khat, if khat's banned, we might go…like, you*

[25] Islam is the predominant religion for people of Somali origin.

know, some of us might go into hard core drugs, some might become alcoholic. And…maybe this [khat] is a less…evil…Provided it is controlled, you know.

Yemeni participants

Two focus groups took place with Yemeni men, one in which all participants were elderly and one with a group of mixed ages. The 'mixed age' group described some problems related to excessive khat use by members of their community. They felt that people who use khat are fatigued the next day and might arrive late at work and have difficulty concentrating. This group also felt that the use of scarce household resources to purchase khat was having a negative impact on the family and marriages. Furthermore, khat chewers only socialising with other chewers may lead to 'self-isolation' – a situation where people do not integrate with others, or access mainstream training or employment opportunities.

Both Yemeni focus groups indicated similar low general levels of drug or alcohol use. Furthermore, neither group associated the use of khat with the use of other substances. When asked if Yemenis would use other substances if khat was not available for any reason, the elderly group seemed fairly dismissive of the notion and a member of the mixed age group said that the culture – which is mostly based on Islamic principles – would prevent this.

It was repeatedly emphasised by the elderly Yemeni interviewees that khat should be made illegal in the UK to bring the country in line with other countries and, more importantly, to prevent people from wasting time and money on the substance and to improve their health and lifestyles. The interviewers suggested that khat might be smuggled into the country, and people could be arrested for being in possession of it. The respondents said they would be in favour of the authorities arresting those who continued to buy or use khat after it was prohibited. Overall, they believed the positive outcomes of the prohibition of khat outweighed the negative ones.

Responses from the mixed age Yemeni group about prohibition were varied, as three people were in favour of prohibiting khat in the UK, whilst others wanted there to be a better support structure for the people who use the substance. This would incorporate counselling or encouraging khat users into more 'meaningful lives'.

I think in a sense there needs to be some organisation about khat… I don't know how we organise it, but alcohol is organised in a sense; there's lots of rules around it… The second thing [is] there's no support mechanisms, there's no support structure for khat. I mean how do we counsel people who've got khat issues? It's like drug use. How do you counsel them…? How do you create better opportunities for them, even though they're chewing? How do you use the chewing sessions as a way of developing and progressing these individuals into meaningful lives you know…All these things are not there for khat, [but] they're there for alcohol, they're there for heroin. They're there for many drug users but they're not there for khat and I've always criticised the system for thinking "Because it affects the Yemenis and Somalis, who cares? They're only small numbers of the community". But as soon as it starts to affect the majority in the community then it's a big problem.

Summary of key points

Somali respondents

- Seventy-five per cent of recent khat users reported some (mostly 'mild') problems associated with khat use.
- Sixty-five per cent of recent khat users experienced sleeping problems (mostly mild or moderate) the morning or day after khat use.
- Fifty-three per cent of recent khat users reported feeling tired or depressed the morning after using khat.

- Reporting of emotional health symptoms associated with khat use was generally low, with more people saying they had not experienced them at all.

- Qualitative data suggested that conditions in khat-chewing venues such as poor hygiene and poor ventilation could lead to adverse health effects.

- The most commonly cited social problems associated with khat use concerned the family unit and/or the marital relationship, with tensions arising in response to a family member spending time and money chewing khat rather than spending those resources on their spouse or family.

- The association of khat use with offending was minimal.

- Very low levels of self-reported drug or alcohol use were found in the research sample.

Yemeni respondents

- Interviews indicated that khat is consumed by some people to levels which can affect the individual's health, ability to socialise and access training or employment. Purchasing khat can also be a financial drain.

- Yemeni respondents had varied attitudes concerning the prohibition of khat. There were some who believed it would be positive for their community, whilst others thought that resources should be invested in services for khat users to enable them to move on from harmful patterns of use.

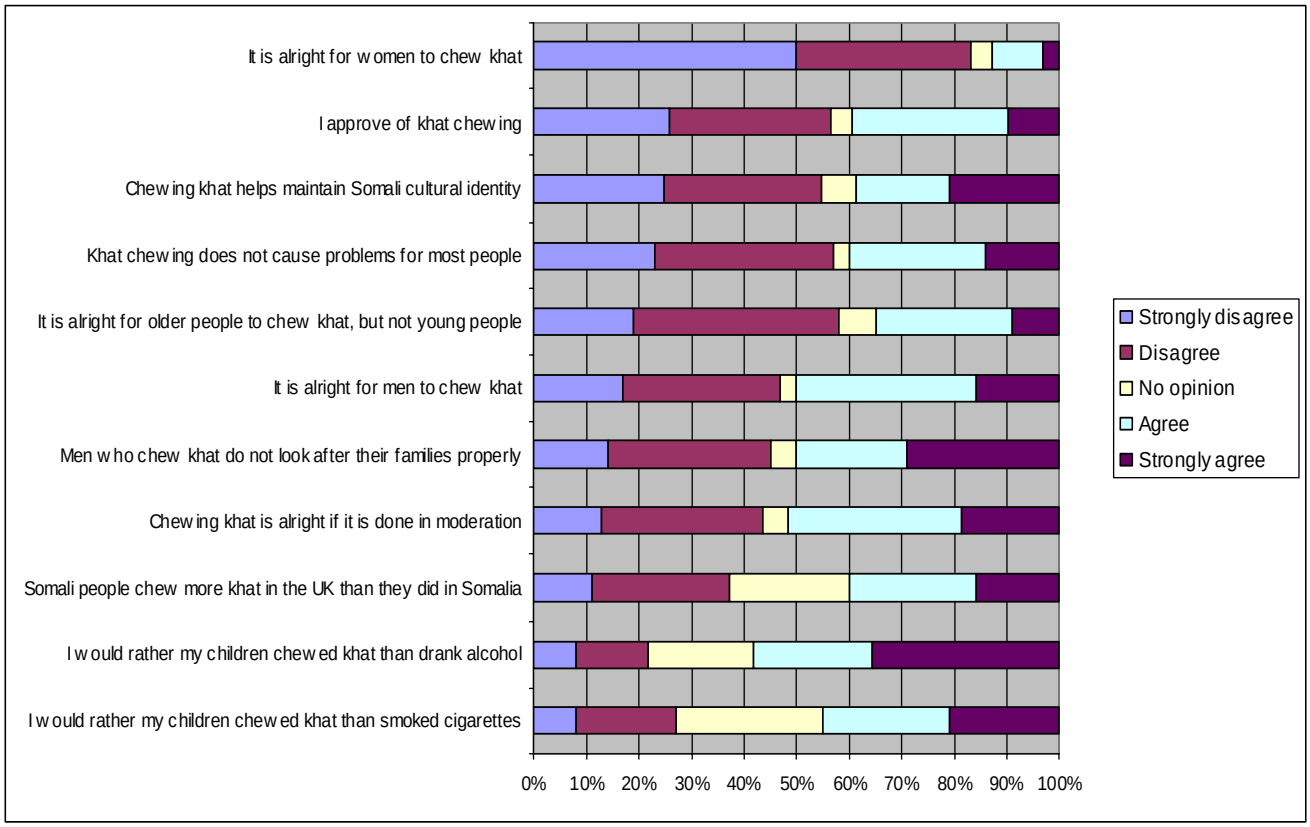
7 Attitudes to khat

This chapter examines respondent attitudes to khat use. This includes: subgroup differences; patterns of control of khat use among recent users; and respondent attitudes towards the potential prohibition of khat.

Attitudes towards khat use

The questionnaire included several statements with which each interviewee was asked to state whether they agreed or disagreed. The results for the whole sample are given in Figure 7.1.

Figure 7.1: Attitudes to khat use (whole sample, n=602)



A substantial number of interviewees agreed and disagreed with most statements. The key exception being the statement that: "*It is alright for women to chew khat*" with which 83 per cent of interviewees disagreed, and only 14 per cent of them agreed. High rates of "no opinion" responses were recorded for three statements in particular:

- *Somali people chew more khat in the UK than they did in Somalia;*
- *I would rather my children chewed khat than drank alcohol;*
- *I would rather my children chewed khat than smoked cigarettes*.

Among respondents who were recent khat users, attitudes towards khat use were still divided, although favourable attitudes towards khat use were more common than for the small sample of non-recent users and the non-khat users. Table 7.1 shows that on the whole, the non-recent khat users tended to exhibit attitudes towards khat that were similar to those expressed by non-users. The exceptions being that more of the non-recent khat users than non-users considered their child's use of khat preferable to the use of alcohol. More of the

non-recent khat users (in comparison to the other two groups) also believed that the Somali population uses khat more in the UK than they did in Somalia.

Table 7.1: Agreement with questionnaire statements by khat user status

Statement agreed with:	Recent khat user (%of respondents who agreed with statement)	Non-recent khat user (%of respondents who agreed with statement)	Non-khat user (%of respondents who agreed with statement)
Khat chewing does not cause problems for most people	67	[24]	27
It is alright for men to chew khat	88	[40]	32
It is alright for women to chew khat	29	[4]	6
I approve of khat chewing	80	[32]	21
Men who chew khat often do not look after their families properly	26	[60]	67
Khat use OK for older people, but not young people	63	[33]	24
Somali people chew more (in the UK) than they did in Somalia	40	[60]	39
I would rather my children chewed khat than drank alcohol	83	[68]	44
I would rather my children chewed khat than smoked cigarettes	61	[40]	36
Chewing khat is alright if it is done in moderation	90	[46]	34
Chewing khat helps maintain Somali cultural identity	62	[29]	30
Total (n)	***204***	***25***	***373***

Subgroup differences in attitudes to khat use

Further analyses of the data from the questionnaires revealed differences in levels of agreement with the attitudinal statements for specific subgroups.

- Men and women.
- Different age groups.
- Individuals who have lived in England less/more than ten years.

Gender differences

On the whole, women tended to be more negative in their opinions towards khat use than men.

More women (57%) than men (42%) agreed with the negative statement that *"Men who chew khat often do not look after their families properly."*

More of the men than the women agreed with the following statements:

- *Khat chewing does not cause problems for most people.*
- *It is alright for men to chew khat.*
- *I approve of khat chewing.*
- *It is alright for older people to chew khat, but not young people.*
- *I would rather my children chewed khat than drank alcohol.*
- *I would rather my children chewed khat than smoked cigarettes.*
- *Chewing khat is alright if it is done in moderation.*

Age differences

With interview respondents divided into three main age groups (up to 30 years; 31- 40 years; and over 41 years), further differences were found in terms of levels of agreement with some of the statements. More of the older respondents agreed with the following positive statements about khat use:

- *It is alright for men to chew khat.*
- *I approve of khat chewing.*
- *It is alright for older people to chew khat, but not young people.*
- *Chewing khat is alright if it is done in moderation.*

More of the older respondents also disagreed with the negative statement that *"Men who chew khat often do not look after their families properly".*

The group of younger interviewees had different attitudes from the two groups of older respondents in relation to only one statement: *"I would rather my children chewed khat than smoked cigarettes"*. More of the younger respondents than the older ones agreed with the statement. This may reflect higher levels of cigarette smoking among younger age groups, or lower incidence of parenthood, leaving younger respondents more ambivalent.

Differences according to length of time respondent has lived in the UK

Those who had lived in the UK for over ten years tended to have more positive attitudes towards khat use than those who had lived in the UK for a shorter time. A higher proportion of those who had lived in the UK for more than ten years agreed with the following positive statements about khat use:

- *Khat chewing does not cause problems for most people.*
- *It is alright for men to chew khat.*
- *It is alright for older people to chew khat, but not young people.*
- *I would rather my children chewed khat than drank alcohol.*
- *I would rather my children chewed khat than smoked cigarettes.*
- *Chewing khat is alright if it is done in moderation.*
- *Chewing khat helps maintain Somali cultural identity.*

More of those who had lived in the UK for less than ten years agreed with the negative statement about khat use that *"Men who chew khat often do not look after their families properly".*

Thus, the key points from this subgroup analysis of attitudes are that women tended to be more negative about khat use and more of the older people agreed with positive statements about khat use. More of those respondents who had lived in the UK for more than ten years compared to those who had lived in the UK for a shorter time, agreed with positive statements about khat and those who had been in the UK for less than ten years tended to agree with the notion that men who chew khat often did not look after their families properly.

Individual desire to cease or control khat use (recent users)

Seventy-three interviewees stated that they would like to stop using khat. They included 8 people who had not used khat in the previous month as well as 65 (32%) of our sample of 204 recent khat users. Only those who had used khat in the last month were included in the group of recent users. The most common reasons given for wanting to stop using khat were that khat use was causing health problems, that it was a waste of money and that it was a waste of time. The least common reasons included: respondents regretting ever starting to chew khat; religious reasons; wanting to discourage children from using it; and their curiosity about khat now being abated.

Table 7.2: Reasons given by respondents for wanting to stop using khat (recent users) – multiple responses possible

	Percentage of all responses
Khat is causing health problems	34
Buying khat is a waste of money	17
Using khat is a waste of time	13
Khat use linked to family breakdown	9
Want to control personal bad habits	7
Feel that khat use is out of control	4
Does not want children to find out	4
Want to stop using khat as gets older	4
Other	8
Total number of responses = 76 N= 65	**100%**

The following quotes provide examples of interviewees' experiences:

> *Because after using khat it makes me tired, gives me headaches, and generally khat is not good for my health.*

> *Because I feel horrible after chewing. I also feel that khat is stopping me from doing a lot of things.*

However, 68 per cent of recent khat users did not wish to stop using khat, and Table 7.3 shows the reasons for this.

The most common benefit that respondents derived from their khat use was its use as part of socialising and personal enjoyment.

> *It is part of our culture, and we use it for socialisation, whilst listening to BBC Somali[a], and seeking information or news from home.*

> *It is the only social interaction or activity that keeps the fractured Somali community together.*

> *I don't consume excessive [amounts of] khat, and khat chewing helps me remain in contact with my friends and the Somali community.*

As the above quote indicates, the positive aspects of the social use of khat was often linked to perceived personal control over khat use, and the lack of any problems being linked to its consumption. Khat use was seen as preferable to alcohol or other substance use:

> *I don't see it as harmful substance like drugs or cigarettes etc. so I don't think of stopping it.*

Table 7.3: Reasons given by respondents for wanting to continue using khat (recent users)

	Percentage of all responses
It is part of socialising activity	28
Personal enjoyment of khat	23
Personal khat use causes no problems	16
It is a cultural/traditional activity	8
Experience positive psychoactive effects	7
Have chewed khat for a long time	4
Khat use relaxes them/relieves stress	3
Family and friends use khat	3
No alternative activity to do	3
Feel addicted to khat	3
Fear substituting khat with other substances	2
TOTAL responses =150 N=139	**100%**

Other interviewees reported positive psychoactive effects of their khat use, which reinforced their decisions to carry on using:

> *I am not planning to stop as it gives me courage to do things.*

Fifteen recent khat users said that they felt their khat use was out of control. The reasons they gave for feeling it was out of control included those related to increased frequency, quantity or length of use (n=6); feeling unable to stop using it (n=4); feeling that khat was damaging their health (n=4); realising that khat use was their only social activity and that they were spending a lot of their money on it (n=3). A few respondents reported that they were "addicted" to khat, and therefore felt unable to cease using it:

> *Because I am addicted to khat chewing, and I am afraid I haven't got the willpower to stop it.*

Those who said they felt their khat use was out of control were asked what they thought would help them to address this lack of control. Their suggestions included becoming more involved in alternative activities such as work and study; prohibition of khat; becoming more religious; and making khat more expensive.

Interviewees were asked what they would do with their time if they no longer used khat. The most common response (shown in Table 7.4) was that no other alternative activity could be imagined, although spending more time with family, staying at home more, and work/study more were frequent responses from other interviewees. Two people said they would use other substance(s).

Other less common answers to this question included: taking part in religious activities, getting frustrated/bored/tired; doing housework; enjoying life; and seeking to start a relationship/family.

Some respondents clearly felt quite distanced from any alternative activities, and had little or no idea how else they could spend their time:

> *I honestly don't know as I am too old to start a career, and I don't know the language well enough. I wouldn't know what to do with my spare time.*

Table 7.4: What the respondents would do with their time if not chewing khat (recent users)

Alternative activity	Percentage of of total responses
No alternatives imagined	19
Spend more time with family	16
Stay at home/watch TV	14
Work/study more	13
Do more sport	9
Sleep more	9
Find other method of socialising	9
Read/listen to radio/go to cinema	6
Other	5
Total responses = 225 N= 204	**100%**

One respondent indicated perhaps mixing more with white friends – although this was the only mention of increasing integration:

> *I [would] go to the gym, or cinema with my white schoolmates.*

Social/familial controls over khat use

As with the use of other substances, the attitudes of family and friends can sometimes exert an influence over whether, and how, individuals consume drugs. Respondents were asked whether certain members of their family were aware of their khat use, and how they had found out about it.

Senior family members

Sixty-five per cent of respondents who reported ever having used khat, stated that senior members of their family knew of their khat use. Among recent khat users, 70 per cent stated that older family members were aware.

Most commonly, respondents had told their older family members about their khat use (n=58), although for 28 people, the family members had seen them using khat. Nineteen respondents stated that someone else had told their family about their khat use and 14 reported that they used khat with their older family members.

Several people described the widespread cultural acceptability of khat use, and so had not even considered whether or how their elder family members knew about their khat use. In addition, 17 individuals reported not having any older/immediate family in the UK, with the result that their family remained unaware of their khat use:

> *Because my parents are not here in UK, nobody knows if I chew khat or not.*

Some women felt it was particularly important to ensure that senior members of the family remained unaware:

> *I don't want them to know because it is not appropriate for women to chew. It is a taboo and I don't want to give a bad name to the family.*

> *They don't know - it doesn't look good if a young female like me is chewing khat. So out of respect I don't want them to know about me and my khat.*

Similarly, a few parents were keen to ensure that their children never found out about their khat use, and so kept it secret from the rest of the family, and strictly controlled their use:

I have two children and I don't want them to know I chew because they're quite young and I myself want to stop chewing. I only chew twice a month.

Other interviewees had stopped using khat, and had never disclosed their use to anyone. Such levels of secrecy would be difficult to maintain over the long term, and may partly explain individuals' decisions to cease using khat. Indeed, a higher proportionof the non-recent khat users kept older family members unaware of their khat use (18 non-recent khat users as opposed to 61 recent users).

Other family members (siblings, partner, children)

Seventy-six per cent of respondents who had ever used khat stated that other members of their family knew of their khat use. Among recent khat users, 81 per cent stated that other family members were aware.

Those who did not tell their families chose not to either because their families did not use khat and would not approve, or because the respondent was female and would have found it shameful for others to know about her khat use. Some exceptions to this feeling of shame among female khat users were reported, often where female interviewees had lived in the UK for several years:

In Somali culture it's a shame for a woman to chew khat, but my children grew up in Europe and they haven't been raised to follow the Somali culture.

Friends

Ninety per cent of respondents who had disclosed having ever used khat stated that their friends knew about their khat use. Among current khat users, 95 per cent stated that friends were aware.

In the majority of cases, interviewees used khat with their friends, as part of their socialising activity.

We chew and socialise together. We invite each other and share things when there is a shortage of khat.

Several women tried to keep control over who knew of their khat use, due to the negative stereotypes perceived to be attached to women who use khat:

Those [friends who] I chew with know - the rest, I did not tell them. Women who chew are seen as prostitutes in Somali society and I am not, so I keep it quiet.

Again, respondents who had only tried khat for a short period of time were able to keep their friends unaware of this fact:

They don't know because I just tried [khat] for a few months, then I stopped completely because I did not like it.

Although not as pronounced as with family members, there was once again a difference between non-recent and recent khat users in terms of keeping their friends unaware of their khat use. (13 non-recent khat users reported that their friends were unaware of their khat use, compared with 11 recent khat users).

Suggestions on strengthening informal and formal control over khat

Both community workers and PAIs were asked about their opinions on controlling khat, and their responses were as mixed as those of the interviewees. Some people were in favour of prohibiting khat so that improvements could be made in people's health and lifestyles in general. Others believed that prohibiting it would lead to a situation whereby Somalis would be criminalised if they continued to buy or sell khat. Instead, they advocated the introduction of controls on the selling of khat, such as the seller needing a licence.

It was also suggested that the situation should be approached from a holistic point of view. That is, there should be some focus on the reasons for some people's excessive khat use and also how they might reduce that pattern of consumption or cease altogether.

> *You need to look at the reasons for people chewing khat, and develop a policy based on that.*

> *I would say let's take small steps. Let's try to get the individuals to reduce. It's about eliminating poverty and trying to get people into employment … These things need to be redressed in my opinion, prior to any ban*.

Furthermore, some community workers and PAIs discussed the benefits of carrying out some health awareness work concerning khat within the community. Ideas included encouraging khat users to ensure that they eat before chewing khat, washing the khat before chewing it, reducing the amount they chew and reducing the number of hours spent using it. Owners of khat-chewing venues should ensure that good hygiene, and health and safety in general are observed.

> *Not ban it but …like [ensure] the marfrish is clean and everything and they wash the khat and like a few hours chewing not all day or night.*

Attitudes towards the prohibition of khat use

This section reports on interviewee attitudes towards the potential prohibition of khat use within the UK, and their assessments of the likely impact of banning khat. Subgroup differences in attitudes to the banning of khat have also been examined, including: use/non-use of khat; gender; age; and length of time living in England.

Forty-nine per cent of the Somali interviewees were in favour of banning khat, whilst 35 per cent were against its prohibition, eight per cent were indifferent and eight per cent gave no response. Those against prohibition felt that khat use was part of Somali culture (n=35); that it is not a substance that is misused (n=14); that its banning may result in individuals switching to other substances (n=9); that it would cause difficulties for the Somali population (n=8); and that enforcing prohibition would be impossible (n=5). However, 40 individuals felt that tighter controls over the availability and use of khat would be welcomed. This was seven per cent of those interviewees who responded to the question about banning khat and included those who were in favour, indifferent to, and against the prohibition of khat in the UK.

Those who wanted to see it banned generally thought that Somali people would achieve more in British society, working and studying harder than they currently did with khat to distract them. Other reasons were to protect young people specifically from khat use, to prevent harm to both khat users and their families and to encourage Somali people to save money.

> *I believe that the prohibition of khat in the UK will be a good matter. That would be very good for the economical and social life of the users and for their health as well.*

> *[Khat] is waste of money as well as people's health. It causes health problems as well as emotional problems such as depression, anxiety and lack of sleep.*

Most potential benefits of banning khat were thought to relate to greater economic engagement among Somali people:

> *More Somali adults would be learning the language and would have a chance to get a job and mix with people other than Somalians.*

Examining some of the quotes in detail gives a flavour of the perceived (but perhaps unrealistic) links that some interviewees made between khat use and the social problems faced by the Somali community in the UK:

When people chew khat it makes them [get] fired and that's why most Somali people don't have a job. And they don't look after their families and that's why there are so many divorces in the UK.

Khat should be prohibited in this country because family breakdown is increasing and it is due to khat.

Those against banning khat mainly gave reasons related to personal enjoyment of chewing it:

I am against prohibiting khat. I chew to enjoy it, and it does not rule my life.

I don't think it should be prohibited because it is a way of socialising for a lot of people who don't drink and go to pubs and cinemas.

One of the PAIs also described a positive aspect of khat use, in terms of its cultural value:

There's a positive side to Khat when it comes to cultural closeness. Khat was exchanged for births, marriages, celebrations…

Consideration of the availability of illegal drugs which are considered to have much stronger effects than khat also reduced levels of support for banning khat:

I think that [prohibition] would be going too far - other stronger drugs are just as available so why bother with khat?

One interviewee pointed out that it is not the substance khat itself that may cause problems, but rather the decision by some individuals to chew khat rather than deal with their problems:

I don't think it should be prohibited. Khat is not a problem, it is the people who chew them that have problems to solve and they're chewing khat instead of solving their problems.

There was also a substantial group who, whilst rejecting the prohibition of khat, wanted to see its use controlled, and the venues where it is used checked for health and safety standards.

It is a mild stimulant, so I don't think there is a need to be so tough on them. But it should be controlled, and people should be educated about the effects of long-term heavy chewing.

Attitudes towards the potential prohibition of khat were strongly linked to whether an individual used khat or not, as shown in Table 7.5.

Three-quarters of recent users were against banning khat, while only a fifth of non-users and non-recent users were against prohibition. Only a quarter of recent users were in favour of prohibition compared with more than two-thirds of non-users and non-recent users.

There was also a gender difference in attitudes towards prohibiting khat: 50 per cent male respondents were against banning khat, compared to 25 per cent women. However, there was very little difference in attitude between different age groups, or according to the length of time respondents had lived in the UK.

Table 7.5: Attitudes to banning khat, according to respondents' khat-using status

	Recent user	Non-user	Non-recent user	Total N (rows)
Against prohibition	73% (n=140)	19% (n=65)	21% (n=5)	210
For prohibition	26% (n=49)	68% (n=229)	71% (n=17)	295
Indifferent	1% (n= 3)	13% (n=43)	8% (n=2)	48
Total	100% (n=192)	100% (n=337)	100% (n=24)	553

Interviewees were asked to consider what the potential impact of banning khat could be. This was an open question, so that individuals were able to give as many responses as possible, and to examine the potential contradictory effects of such a policy.

Some of those identifying potentially negative consequences of a ban on khat raised the issue of individuals switching to alcohol or other drug use (29%). This was the most frequently mentioned concern, followed by the concern that khat would continue to be imported, but on an illegal basis (10%), and that the use of khat would merely be driven 'underground' because of its illegal status (10%). Other suggested negative consequences included that: problems would worsen for khat users (2%); the cost of khat would increase, causing difficulties for those continuing to use (2%); users would inevitably be drawn into illegal activity (2%); and there would be a loss of socialising (1%).

Conversely, those perceiving positive outcomes from a ban envisaged two main benefits: that those who were stopped from using khat would find employment instead (13%); and that the Somali population as a whole would benefit from having 'a better life' (13%). Other suggested potential benefits included: individuals ceasing to use khat (7%); a reduction in family breakdown (7%); the prevention of young people becoming involved in khat use (2%); and the potential for some individuals to become more religiously engaged (1%).

Understandably, interviewees' attitudes to banning khat were strongly linked to their personal estimation of the potential impact of prohibition. Sixty-three per cent of those who thought that problems related to khat use would be exacerbated by prohibition were against a ban, whilst 91 per cent of those who thought banning would result in beneficial outcomes supported prohibition. However, many interviewees demonstrated that they recognised the complexity of the issue: 13 per cent of those against banning khat nevertheless identified potential positive benefits from banning it and 28 per cent of those who agreed with prohibiting it, recognised that in some cases problems could worsen as a result of a ban.

As with the general attitude towards banning khat, perception of the impact of prohibition was strongly affected by the interviewees' own use of khat. For example, three-quarters of recent users thought a ban would make problems worse and only a quarter thought that a ban would bring potential benefits whereas around a third of non-users and non-recent users thought a ban would make problems worse and around two-thirds of non-users and non-recent users thought that a ban would bring potential benefits.

Table 7.6: Personal use of khat and perception of the impact of prohibition

	Recent user	Non-user	Non-recent user	Total N (rows)
Prohibition would cause problems to worsen	76%	37%	30%	246
Prohibition would bring positive benefits	24%	63%	70%	256
Total	100% n=155	100% n=320	100% n=27	502

Summary of key points

- Opinion was divided on most of the statements reflecting attitudes to khat, with similar numbers saying that they agreed and disagreed. However, only 14 per cent agreed with the statement "It is alright for women to chew khat", fewer than 30 per cent disgreed with the statement "I would rather my children chewed khat than smoked cigarettes" and fewer than 25 per cent disagreed with "I would rather my children chewed khat than drank alcohol".

- Recent khat users reported more favourable attitudes towards khat use, whilst non-recent khat users tended to exhibit similar attitudes to non-users. Other subgroups who tended to report favourable attitudes towards khat were men; older respondents; and those who had lived in the UK for over ten years.

- Among the 204 recent khat users, 68 per cent said they did not wish to cease using khat, whilst 32 per cent did.

- PAIs and community workers had mixed opinions on controlling khat. Some were in favour of prohibiting khat in the belief that this would bring improvements in people's health and lifestyles. Others believed that prohibiting it would lead to further problems. Instead, they advocated the introduction of controls on the selling of khat, such as the seller needing a licence and/or an age restriction on buying it.

- Forty-nine per cent of the interview sample were in favour of banning khat, whilst 35 per cent were against its prohibition, eight per cent were indifferent, and eight per cent gave no response. However, 40 interviewees felt that tighter controls over the availability and use of khat would be welcomed.

- Attitudes towards the prohibition of khat were highly related to personal use of khat: three-quarters of recent users were against banning khat, while only a fifth of non-users and non-recent users were against prohibition. Only a quarter of recent users were in favour of prohibition compared with more than two-thirds of non-users and non-recent users.

- There was also a gender difference in attitudes towards prohibiting khat: 50 per cent of male respondents compared to 25 per cent of female respondents were against banning khat.

- Attitudes towards banning khat were strongly linked to respondents' estimation of the potential impact of prohibition. For example, 91 per cent of those who thought banning khat would result in beneficial outcomes supported prohibition. However, many interviewees showed their recognition of the complexity of the issue: 13 per cent of those against banning khat identified potential benefits of a ban, and 28 per cent of those who were in favour of prohibiting it recognised that some problems could worsen as a result.

- As with the general attitude towards banning khat, perception of the impact of prohibition was strongly linked to the interviewees' own use of khat. Three-quarters of those who recently used khat said that a ban would make problems worse, whereas only a third of non-users or those who had not used khat recently, expressed this view.

8 Conclusions

This chapter will consider the findings in relation to the main areas investigated in the research.

- The level and nature of khat use within the research sample.
- The perceived health effects of khat use.
- Any potential links between khat and illegal drug use, alcohol use and offending.
- Attitudes towards khat use.

The level and nature of khat use within the research sample

Around a third of the interview sample said that they had used khat in the month prior to the interview. There were only a few interviewees (4%) who said that they had previously chewed khat but had not done so in the previous month. This suggests that people who chose to start using khat, tended to continue to do so. More of the male respondents, (around half of the men, compared with 14% of the women) said that they chewed khat and this is consistent with khat cewing being a traditionally male activity. Khat users were, on average, older than non-khat users.

Most people who used khat said that they did so on one to four days a week (an average of three days a week) in sessions lasting around six hours. However, there was considerable variation in the length of khat sessions reported by interviewees, ranging between one and 20 hours. Respondents reported an average quantity of 2.5 'bundles' being used in a typical session but they reported quantities ranging between one and six 'bundles' per session.

Out of those who had ever used khat, almost half said they had used it daily, at some time, for a period of at least a month, and ten per cent were using khat on a daily basis at the time of interview. This suggested that most people had been able to moderate the frequency of their khat use, but around five per cent of men and 15 per cent of women who had recently used khat said that they felt their khat use was "out of control", and larger proportions of recent users (a quarter of the men and half of the women) said they would like to stop using khat.

Khat chewing typically took place in groups of around ten people, usually all male or all female but there were some reports of groups of men and women chewing khat together. Although people said that they tended to use khat in a social group setting, around 40 per cent said that they had used khat alone on more than one occasion. More of the women than the men (44% of women, compared with 19% of men) said that they had used khat alone and more said that they had kept their khat use a secret. Whether someone used khat in a group or alone does not appear to have influenced how much khat they used.

Respondents who had used khat in Somalia and in England were asked whether they thought that they used khat more in one country rather than the other. Approximately a third of respondents said that they used more in Somalia, a third said they used more in England and a third reported no difference.

The overall picture from the people in the interview sample who were using khat was that they used it in a moderate way in terms of amount used and the frequency and length of chewing sessions and that it was a social activity. However, there were a small number of people who said they were using khat every day and/or for very long periods and some felt that their use of khat was out of control. These groups of people may need some help and support in moderating their khat use.

Khat use and health

Generally, most people reported only mild or (less frequently) moderate side effects from their khat use. The most commonly self-reported health implications of khat use included: sleeping problems; feeling tired and/or depressed the morning after a khat-chewing session; loss of appetite; and feeling the urge to chew khat again. However, there were a number of factors that were associated with the occurrence of specific physical or emotional health symptoms. In summary, these were:

- higher frequency of khat use (days per week) appeared to be associated with weight loss, depression and hallucinations;
- a higher percentage of the women than the men reported that their khat use was associated with irritability and the urge to chew more khat; and
- more severe experiences of sleeping difficulties, loss of appetite, paranoia, lethargy, anxiety and irritability were reported by those respondents who had started to use khat over the age of 40.

There was also qualitative information which suggested other issues concerning khat and health, such as: poor nutrition; problems with teeth; risks of ingesting khat that has been treated with chemical pesticides; and the risks associated with passive smoking and developing respiratory diseases in confined, poorly ventilated chewing venues.

The issues mentioned above can provide a basis for health awareness work with the khat chewers in the various communities affected by the practice. Griffiths (1998) noted that medical practitioners need to be made aware of the health problems that can be associated with khat use. It was the PAIs' impression that there is currently a general lack of awareness regarding health effects amongst practitioners and within the community itself. Raising awareness should incorporate the existing networks of Somali (and other community) organisations in order to gain access to people, to khat-chewing venues and to make the message culturally acceptable and appropriate. The same networks could be used to identify and feed back information about the kind of help which would be welcomed by those who were struggling to control their khat use.

There were suggestions of simple measures which people could take to reduce the risks to their health. These included washing khat to remove pesticides before chewing, eating a good meal before using khat (because it is likely to reduce the appetite), and improving ventilation in khat-chewing venues. Moderating the frequency and length of khat-chewing sessions was also suggested as a way that people could reduce the risk of health problems although, as mentioned, some found it difficult to do this.

The following quote from an interview with a Somali worker demonstrates the importance of engaging the community:

> *From a community point of view, you've got to be careful about the approach to khat. It is better for it to come from the community. People who consume khat know the cost and benefit of chewing more than anyone and rather than issuing a top-down approach, they should be empowered to do something…You want the community on your side rather than dividing them on this issue.*

Khat use, drugs and alcohol,and offending

There were extremely low self-reported levels of alcohol and illicit drug use among those interviewed in this study.[26] This contrasted with higher levels of self-reported drug use among the Somali interviewees in the Griffiths (1998) study. In the current study there was no Class A substance use, cannabis had been used by six respondents, and six respondents had drunk alcohol at some point in their lives (two people said they used alcohol after khat to

[26] There were cultural reasons why respondents might have under-reported substance use to Somali PAIs, as discussed earlier in this report. Furthermore, PAIs did reflect that there were some people who used alcohol either to come down from the stimulant effect of khat or independently of khat use.

neutralise its stimulant effect). A small number of people suggested that khat users would begin to use alcohol or other substances if khat was not available to them.

There were also very low self-reported levels of offending among the interviewees. Only five respondents disclosed offending: three having committed violence since living in the UK, and two reporting having shoplifted. There were three cases in which respondents reported that they felt their violent behaviour was associated with the psychoactive effects of using khat (as opposed to the cost).

Social aspects of khat use

The social problems which respondents most commonly attributed to khat use concerned discord or breakdown within marital or familial units. In addition, some respondents felt that their children were affected by their partner's khat use, and reported that they had experienced their khat-using partner's mood swings or temper. Khat use could also be a drain on financial resources, and was also blamed for khat users being absent from the family home for extended periods. However, a number of other factors may have also had an impact upon these social tensions, including: the experience of being a minority group within the UK; being isolated from an extended family network; differences in expectations about gender relations within western society; and the experience of socio-economic difficulties. It is not possible within this study to establish where causation lies between all these factors. The suggestion from some previous research, that people use khat more in this country than in Somalia because they are unemployed was not supported by the data from this study. Firstly, there was no evidence that people in this sample were using khat more in England and secondly, a smaller proportion of those who were unemployed compared with those in employment reported using khat.

On the other hand, interviews with khat users revealed another aspect to the social impact of khat use. For the majority of interviewees, chewing khat was important in maintaining a cultural tradition. Also, it was a fun activity that was used as part of socialising, and that also had a role in helping users to relax or counteract feelings of stress. It was described as being an alternative way of socialising for people who do not drink or go to pubs. Khat users were asked what they would do with their time if they no longer used khat, and the most common response was that no other alternative activity could be imagined. Some interviewees said that they would spend more time with their family, stay at home more, and work or study more, so there was the implication that they would use their time more constructively.

Attitudes

In addition to the patterns of khat use and the problems which the interviewees attributed to khat, this research provided a detailed analysis of attitudes towards khat use and towards restricting it.

Interviewees' attitudes to khat were fairly evenly divided with substantial numbers agreeing and disagreeing with most of the statements about khat. However, only 14 per cent of respondents agreed with the statement "It is alright for women to chew khat", indicating that there was little acceptance of women's khat use within the interview sample. Those who had used khat in the month prior to interview tended to have more positive attitudes towards it compared to those who had never used it or had not used it recently. More of the respondents who were male, older and/or had lived in the UK for more than ten years in comparison to those who were female, younger and/or more recently arrived in the UK agreed with positive statements about khat. This highlighted the importance of ensuring that as wide a range of people as possible are involved in any community consultations on khat use.

In terms of attitudes towards the control or prohibition of khat in the UK, just under half of those interviewed (49%) were in favour of making khat illegal, 35 per cent were against it, eight per cent were indifferent and another eight per cent did not respond to the question. Attitudes to prohibition of khat tended to be more positive among those who were not recent khat users. Of those who supported prohibition, 91 per cent believed there would be

beneficial outcomes, and that Somali people would achieve more if they were stopped from chewing khat. However, 63 per cent of those who were opposed to prohibiting khat believed that this course of action would exacerbate the problems associated with khat use and many mentioned the loss of the social aspects already described. There was recognition of the complexity of the issue, in that some people from each side of the debate acknowledged the pros and cons of both prohibition and non-prohibition.

Appendix 1. Methodology and fieldwork

Sampling issues

Attempting to carry out a randomised study of the Somali population across the four research sites would be highly problematic – if not impossible. A key factor in this is inconsistency in methods of ethnicity data categorisation which pose difficulties in constructing a representative sampling frame.

Moreover, there is the issue of gaining *access* to Somali research participants, as exists with any 'hard-to-reach' group. That is, mainstream researchers will often experience difficulty in conducting research with marginalised groups.

Therefore, trust is essential in gaining access, recruiting participants and obtaining good quality data. Establishing trust often means creating a good working relationship with members or leaders of the community being researched, and using these contacts to reach others. It would also demonstrate good practice for this process to be mutually beneficial, for example: building the capacity of individuals or the group to conduct professional research and raise awareness about issues affecting the community.[27]

The PAI Method

As highlighted above, research with hard-to-reach groups is made easier with the input of researchers drawn from the target group itself. Furthermore, it is important that the community researcher shares the language, culture and, to an extent, the experiences of the research participants. Griffiths (1998) proposed that this privileged access approach enhances the ability of research participants to provide accurate answers to questions.

Selection and recruitment of Privileged Access Interviewers (PAIs)

The process of making contacts within the four research sites in order to select and recruit potential PAIs took ten weeks. In London this was achieved via a member of the research steering group committee, and in Birmingham, Bristol and Sheffield queries were made by writing to local Somali community organisations or speaking to staff at health services.

It was decided that there should be at least four PAIs in each site – both men and women – so that the number of interviews that each would carry out would be manageable within the fieldwork period. Specifically, it was planned that four PAIs in each site would carry out 38 interviews each (giving a total of 152 per site and an overall total of 608). Person specification criteria were also drawn up for PAIs, that each should:

- be able to speak, read and write Somali and English;
- have contacts within the Somali community;
- be reliable and available during the fieldwork stage;
- have enthusiasm for the research; and,
- have sufficient educational achievement to carry out interviews.

The PAIs involved in this study represented a number of differences in terms of gender, age and work or research experience. There were a small number of PAIs who themselves chewed khat on a recreational basis.

[27] This capacity building approach has previously been implemented by the Centre for Ethnicity and Health at the University of Central Lancashire (Winters and Patel, 2003; Bashford, Buffin and Patel, 2003).

The characteristics of the PAIs are outlined by research site. Their names have not been included in this section to limit the extent to which respondents can be identified, or identify themselves.

PAI	Gender	Age	Previous experience
Birmingham			
1	Male	46	Community centre co-ordinator
2	Female	17	Student and community volunteer
3	Male	42	Doctor in Somalia
4	Female	17	Student
Bristol			
1	Male	39	Community work
2	Female	31	Volunteer community work
3	Female	39	Volunteer community work
4	Male	54	None[28]
5	Male	20	None
London			
1	M	54	Community work, volunteer with khat service
2	F	26	Volunteer with khat service, student
3	F	25	Student
4	M	30	Community work
Sheffield			
1	F	31	Research, interpreting work
2	F	29	Research, interpreting work
3	M	54	Research, interpreting work
4	M	55	Research, interpreting work, community work

PAI fieldwork

Fieldwork took place between September 2004 and November 2004. Arrangements were made for monthly supervision meetings with PAIs, in order to discuss any fieldwork or general management issues, as well as collecting the completed questionnaires and associated paperwork (signed consent forms and voucher receipts). The research team was also available for telephone advice over the course of the research study. In accordance with Griffiths's (1998) suggestion that close monitoring of the data collection process should be undertaken in order to ensure that the quality of information remains high, observations of PAIs conducting interviews were carried out in Bristol, London and Sheffield.[29]

PAI feedback on the experience of the project

The contribution of the PAIs to the research was invaluable and substantial, and the research team decided that the PAIs should be given an opportunity to express their own opinions on the issue of khat use and of being researchers. Therefore, focus groups were conducted with PAIs from all sites at the beginning (September, 2004) and end (November to December 2004) of fieldwork, in order to record their opinions about the Somali experience in the research sites, as well as perceptions of khat use and its impact.

At the second focus group, PAIs were asked to reflect on the research process and discuss their experiences, focusing particularly on the privileged access method. In general, all the PAIs said that they enjoyed working on the research project and that they had learned some things from the experience. These included learning some new details about how khat is consumed, who consumes it and meeting different people.

[28] Bristol PAI 4 left the research study in October 2004 and was replaced by Bristol PAI 5 soon afterwards. PAI 4 did not discuss his reasons for leaving with the research team.
[29] Interviewees did not turn up to an appointment made in Birmingham and another appointment could not be arranged in time.

It gives you more knowledge about the khat use and the whole society – Somali society…So…I got to know them and…their mentality, the way they think…

They also commented on specific difficulties they encountered during the fieldwork. One example – and, by far, the most cited – was experiencing a great deal of suspicion about the purpose of the research from prospective participants. This situation was exacerbated by the requirement for PAIs to state that the Home Office was funding the research study.[30] The PAIs had been trained in how to respond to this, using their own linguistic/cultural knowledge to convey the message that all data would be held as confidential material and would not be available in its raw format to the Home Office. Nevertheless, a number of people refused to take part.

The perceived 'official' nature of the research study on khat use was interpreted by some Somalis as a *fait accompli* concerning the future of the legal status of the substance. That is, some people believed that the only reason that research was taking place was in order to prohibit khat. Some Somali people were critical of the PAIs for this reason.

…most of them are suspicious about the whole project. [They say] "Why are you doing this?" Some people are very conscious about "Are you trying to stop khat? Why are you doing this? You don't have to take that side, you take our side because we need this khat".

Furthermore, some participants who did agree to take part, were suspicious about giving their names on consent forms or receipts despite assurances that the paperwork would be held in a locked cabinet and inaccessible to anyone outside of the research team.

The impact of PAI khat use upon their individual research samples

During the course of the research, five of the PAIs identified themselves as chewing khat. In order to examine whether this affected the research sample in any way, analysis of khat use among their research sample compared with that of the research sample accessed by non-khat chewing PAIs was undertaken. No differences were found in terms of the examples listed below.

- The samples' lifetime use of khat (37% of the sample interviewed by khat-using PAIs, 39% of the sample interviewed by non-khat using PAIs).
- The average number of bundles used (2.55 bundles among the khat-using PAI interview sample; 2.44 bundles among the interviewees accessed by non-khat using PAIs).
- The distribution of khat use among the two subsamples. This is as follows:

- never khat users (63.3% PAI user sample; 61.4% PAI non-user sample);
- non-recent khat users (3.2% PAI user sample; 4.6% PAI non-user sample), and;
- recent khat users (33.5% PAI user sample; 34.1% PAI non-user sample).

In terms of patterns of khat use only two differences were found.

- The current frequency of khat use was higher among those interviewees who had 'ever used khat' who were accessed by khat-using PAIs (16.9% used daily, compared with 6.7% of the sample achieved by the non-khat using PAIs).
- A higher proportion of the sample interviewed by khat-using PAIs had used khat daily in the past year (10.1% of the sample, compared with 5.1% of the sample accessed by non-khat using PAIs).

[30] Details about the research study, such as who is funding it and why, were detailed on translated information sheets. These were available to all participants so they could make an informed choice about whether or not to take part.

Appendix 2. Comparative analysis with Griffiths's (1998) research

One of the initial aims of this study was to identify whether levels, patterns and types of khat use among Somalis had changed since Griffiths's 1998 study in London. While the interviewees recruited to each study are different and can not therefore be considered as directly comparable over time Table A.2.1 compares key data from the Griffiths sample with findings from the authors' London research, as well as those for the four sites in total.

Table A.2.1: Comparisons between the current research sample and the Griffiths sample[31]

	The Griffiths sample	**Current research sample**	
	London (n=207)	**London (n=150)**	**Total (n=602)**
Gender	73% male	73% male	54% male
Age range	18 – 78	17-66	17 – 74
Mean age	36 years	38 years	36 years
Percentage aged 25 or under	23%	15%	20%
Mean time living in city[1]	4 years	4 years	4 years
Range of time living in city[1]	< 1–22 years	<1–14 years	<1 – 30 years
% living in city for 5 years or less[1]	81%	61%	69%
Percentage born in Somalia	90%	79% Somalia + 10% Somaliland	72% Somalia + 18% Somaliland
Percentage born in UK	1%	7%	4%
Employment rate	17%	54%	38%
Prevalence of khat use (ever)	78%	65%	39%
Prevalence of khat use (ever: males)	79%	76%	58%
Prevalence of khat use (ever: females)	76%	34%	16%

Notes:
[1] For the Griffiths research, the data correspond to 'time in London'. For this study, the data refer to 'time at postcode'.

Comparing the Griffiths sample with the authors' London subsample, the gender split was very similar, and although Griffiths had a higher proportion of young people (aged 25 or under), the overall age profile was similar. Across all four sites, however, this research had a higher proportion of female interviewees, and more of the current sample had lived at their current postcode for over five years compared with the proportion of Griffiths's sample who reported having lived in London for over five years. The recent sample revealed a slightly higher proportion of interviewees having been born in the UK, and a lower prevalence of ever having used khat (although this was not so pronounced in our London subsample). In fact the differences in khat use seemed to arise within the women's self-reported behaviour, with the current research finding lower levels of khat chewing among women than that reported by Griffiths.

Table A.2.2 compares the data on khat use gathered from the Griffiths (1998) London study, with data from the authors' London sample, as well as combined data from all four research sites.

[31] Given the different methods of accessing the two research samples (and the different profiles of the PAI interviewers) caution needs to be applied in any direct comparisons between this study and the Griffiths research. Sampling differences limit the extent to which differences between the samples can be considered to be changes over time in patterns of khat use within London.

A.2.2: Comparisons between the current patterns of khat use and the Griffiths sample

	The Griffiths sample	Current research sample	
	London (n=207)	London (n=150)	Total (n=602)
Mean age of khat users	37 years	38 years	39 years
Mean age of non-khat users	31 years	33 years	
Prevalence of khat use during month prior to interview (among khat users)	75%	85%	89%
Mean khat use month prior to interview	1.9 bundles	2.5 bundles	2.5 bundles
- males	2 bundles	2.5 bundles	2.5 bundles
- females	1.6 bundles	2.5 bundles	2.4 bundles
% chewing khat in past week (total group)	67%	47%	31%
% khat users currently using khat daily	6%	5%	11%
Average frequency of khat use	3 days / week	2 days /week	3 days /week
Ever used khat daily (among khat users)	27%	28%	47%
Percentage using more khat than had used in Somalia (amongst khat users)	76%	28%	34%
Use of alcohol[1]	4%	3%	1%
Use of cannabis (ever)	6%	1%	1%
Use of heroin (ever)	4%	0%	0%
Use of cocaine (ever)	3%	0%	0%

Notes:
1. The current research is not able to match up some of the data exactly to that obtained by Griffiths. For instance, the authors obtained categorical data for the age at first khat use so it is not possible to get a mean age at first use, or to show length of use precisely.

2. Griffiths reports on alcohol use in the previous year, but for this research it relates to 'use of alcohol (ever)'.

3. The mean age among self-identified khat users was similar across the two studies. Although this sample revealed a higher rate of khat use in the month prior to interview than that of Griffiths, the same average frequency of use was reported. The authors' study group also reported a slightly higher average quantity of khat used in a typical day, but a lower prevalence of khat use over the past week among the whole sample than that of Griffiths. However, when focusing on those who disclose ever having used khat, although the two London samples were similar, across the four sites this sample revealed a higher rate of current daily khat use than that reported by the Griffiths interviewees. Similarly, in terms of the prevalence of ever having used khat daily, the rates were similar for the two London studies, but the authors' total sample revealed a comparatively high average rate. Conversely, the authors' sample reported a much lower proportion of interviewees disclosing greater current khat use compared to that undertaken in Somalia. Reports of other substance use were very low among the authors' sample, and whilst this was relatively similar to Griffiths's findings, reported rates among the authors' sample were considerably lower.

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