

Community Organisations Forum

Building stronger communities
in Tower Hamlets

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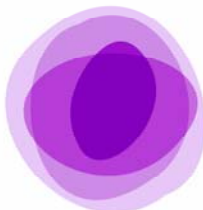
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TOWER HAMLETS SOMALI POPULATION: RESEARCH INTO SUBSTANCE USE / MIS-USE

RESEARCH REPORT

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Promoting volunteering with
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Tower Hamlets Somali Population: Research Into Substance Use/misuse

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1. EXECUTIVE SUMMARY

- **Khat has a widespread use in the Somali community, mostly by men**
- **Khat is seen as a social drug**
- **More education is required on the serious health implications of khat use**
- **Very few people have sought help to manage use/misuse of khat**
- **Afternoon sessions (close to home) is best time to provide drug help services**

2. BACKGROUND TO RESEARCH

Anecdotally, both Drug and Alcohol Service for London (DASL) and St Botolph's Project (SBP) had been hearing for some time that there is a range of needs within the Somali population arising from substance misuse. Some Somalis are sleeping rough, in abandoned buildings or in overcrowded conditions on friends' floors, etc. Others are drinking on the streets and there is a concern from workers on the Aberfeldy and Teviot estates that alcohol usage and self-harm has grown, especially amongst young Somali men. However, DASL and other agencies involved in tackling these issues only see a tiny percentage of Somali clients and it appears that access to housing and other drug, alcohol and counselling services from this community is very limited.

Working in partnership, DASL and SBP decided to undertake a piece of systematic research within the Somali community to establish the level of their housing and health needs. They envisaged a researcher, working with representatives from the Somali community carrying out a range of research interventions, including questionnaires, face-to-face interviews and focus groups. In this way, they hoped detailed knowledge of the Somali community's needs would be established, leading to recommendations and the development of plans for appropriate services.

Expected benefits from the research

- The Somali community will gain advocacy, which will enhance their access to services across the borough.
- A detailed report will be written which will influence local statutory and voluntary provision via commissioning intentions.

Both DASL and SBP will have the information needed to enable increased access to existing services and access to New Opportunities Fund (NOF) funding and other members of the Healthy Living Network (HLN) to establish new services as appropriate.

2.1 Agencies in partnership

DASL and SBP initiated this project and received funding from the NOF through Tower Hamlets HLN. Tower Hamlets HLN is a recently established network of local organisations whose aim is to increase access to health for disadvantaged communities across the borough. After securing the funding both agencies approached the Community Organisations Forum (COF), an umbrella agency, to conduct this piece of research on their behalf as COF employs a Somali worker who had been facilitating the voluntary sector's Health and Social Care Forum for some time. Unfortunately, SBP was closed during the early stages of the research from February to December 2004.

DASL and SBP have been working throughout the East End for many years, helping homeless people and those affected by alcohol and drug misuse. SBP has been working with single homeless people in the City and East End of London for 45 years. They have worked with people who were traditionally hard to reach, including long-term rough sleepers, people with mental health needs and those with drug or alcohol addiction. DASL works to promote the relief of persons suffering from problems caused by alcohol and substance misuse and of their families and related individuals by the provision of advice, support and treatment.

This research was initially designed to examine the issues of homelessness and substance misuse in the Somali community in Tower Hamlets. However, the focus was redefined to explore only the misuse of substances (khat, alcohol, cocaine, heroine, crack, etc.) as SBP was no longer actively involved in the project. The enormity of the task of researching all these issues at one time was also acknowledged.

In light of these developments, the research management group (DASL and COF) decided to focus on substance misuse. That is not to diminish the importance of homelessness in the borough or in the Somali community. Indeed, it should be emphasised that housing need in the borough remains very high, with homelessness running at three times the average of England and Wales. It is hoped that the issue of homelessness within the Somali community will be researched at length in the near future. A meeting with Tower Hamlets Homeless Persons Unit was arranged and we were told that there are 170 Somali households in temporary accommodation. Subsequently the idea of including homelessness in the research was dropped, as SBP was no longer involved in the research.

2.2 Tower Hamlets context

Tower Hamlets is one of the most deprived boroughs in the country. It is an ethnically diverse borough of which Black Africans, including Somalis, make up 3.2% of the total population. There is a high unemployment rate (12.1%) and high rates of health deprivation; an estimated 18.1% of people have a significant psychiatric illness; an estimated 3.1% have a drug dependency and an estimated 5.4% have an alcohol dependency. All of these are higher than the inner London averages. Housing need in the borough is very high, with homelessness running at three times the average of England and Wales. Overcrowding in Tower Hamlets is the worst in the country, running at 13%, double the rate for London. This is compounded by a chronic shortage of larger properties.

2.3 Khat

Within the Somali community it is hard to talk about substance misuse and not mention khat. Khat is the main social drug widely known to Somalis and currently has a social and cultural role across all Somali communities in the Horn of Africa and in the Diaspora. Khat is a shrub leaf which has stimulant effects and is chewed at social gatherings. It is mostly chewed in the Somali, Yemeni, Ethiopian and other East African communities in the UK. Air transport has facilitated the almost daily import of tons of khat leaves into the UK. In the Somali community it is predominantly men who chew khat, although evidence suggests there is an increasing number of women who chew it. Many members of the Somali community have long been concerned about the social and health implications of khat chewing in their community.

Drugscope is currently carrying out wide ranging research on the international trade of khat chewing and is studying its production, distribution system, pricing, etc.. MIND in Tower Hamlets has also recently initiated research on khat misuse, funded by the Home Office. Ideally these two pieces of work will highlight issues related to the khat trade and how it is affecting consumers in Europe. While it is assumed that alcohol is used in the Somali community, other drugs, as many people believe, are increasingly taken by Somali youth in the Diaspora.

3. PROJECT METHODOLOGY

3.1 Aims and objectives

The project aimed to contribute to the well-being of the Somali community in Tower Hamlets by carrying out research, exploring strategies to improve the health of the local Somali community, facilitating access to local services and engaging stakeholders in future developments. In particular, the research aimed to target those in the Somali community who may have khat, drug, and/or alcohol issues. Exploring the barriers and problems people face and the types and extent of impact that

homelessness and substance misuse are having on both individuals and the Somali community as a whole was the main motive for the research.

There are several studies on drugs and homelessness and drugs and BME communities but very few on drugs, alcohol, homelessness and BME communities. Initially, that made this proposal very unique, as it was attempting to focus on the Somali community in Tower Hamlets, homelessness and substance misuse. Ultimately, the research focused on substance misuse and the Somali community in Tower Hamlets.

Objectives:

1. Establish the level of alcohol, drug and/or khat use/misuse in the community and how these issues relate to each other.
2. Establish what impact the above issues are having on individuals as well as the community concerned (i.e. the Somali community in Tower Hamlets).
3. Identify the barriers facing Somalis when using public services.
4. Identify appropriate and effective ways to help these groups.
5. Learn about the social dynamics and perceptions of the target group, problems and solutions.
6. Recommend appropriate actions for stakeholders.

3.2 Principles of the research

During the research, those involved were strongly advised to oversee and adhere to the following principles:

1. Comply with the data protection act.
2. Respect diversity and peoples cultures, individuality and attitudes.
3. Not to influence by any means, knowingly, the process of the research.
4. Protect strictly the confidentiality of respondents.
5. Treat individuals with respect.
6. Involve all stakeholders and inform them of the findings of the research.

No respondent was asked his/her name or address. However, interviews took place in community settings in Tower Hamlets.

3.3 Steering group

The project planned to carry out secondary research that has been done in the Somali community. Several studies have been completed but none have focused on substance misuse. The most recent research was done by Regeneration and Research Consultants on behalf of East London Somali Youth & Welfare Centre and funded by East London Connexions. The Ethnic Unit of Central Lancashire University has also compiled information on minority and ethnic communities in relation to substance misuse.

A steering group was set up by the project to oversee the research and consisted of a variety of stakeholders, including Somali community groups and other voluntary groups. Steering group meetings proved difficult to convene and had poor turnout, however. Tower Hamlets Community Drug Team engaged very well with the research since its inception.

Terms of reference were drafted for the steering group and circulated among its members. The steering group discussed the terms at its first meeting. Fifteen steering group members were recruited although participation in meetings was low over the lifetime of the project. It proved difficult to recruit additional members as well as to adhere to the timetable of the research. The research methodology was drafted and distributed to steering group members as well as to DASL and SBP for comment. The lack of full involvement by steering group members in the design of the methodology is a further limitation to the research. The questionnaire was finalised in the final steering group meeting on 3rd August 2004. The project then moved on to volunteer recruitment and logistics.

3.4 Sampling

The goal of the project was to survey a representative sample that would reflect the Somali population in Tower Hamlets. Ideally the project would have used the register from the Homeless Persons Unit of London Borough of Tower Hamlets and the last national census data however this was not possible due to changes in project focus and limited resources available to the project in terms of funding and time. It is acknowledged that research results herein may not be fully representative of the Somali community in Tower Hamlets and further research is needed.

The total number of completed and returned questionnaires was 74. Gender and age demographics of respondents are shown below in figures 1-2. 'N' represents the total number of valid responses per question, as not everyone answered each question. Unless otherwise noted, n= 74. NA stands for the total number of respondents who did not answer the question.

Figure 1:

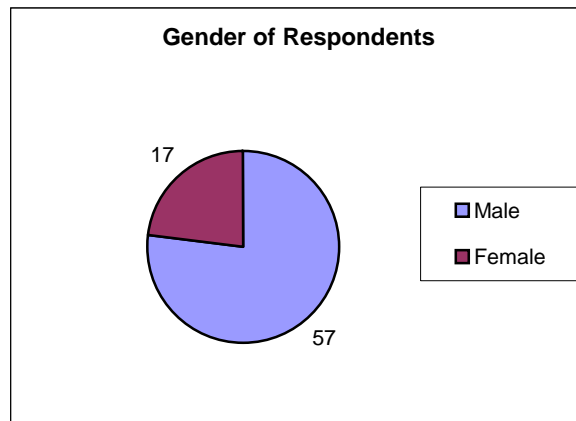
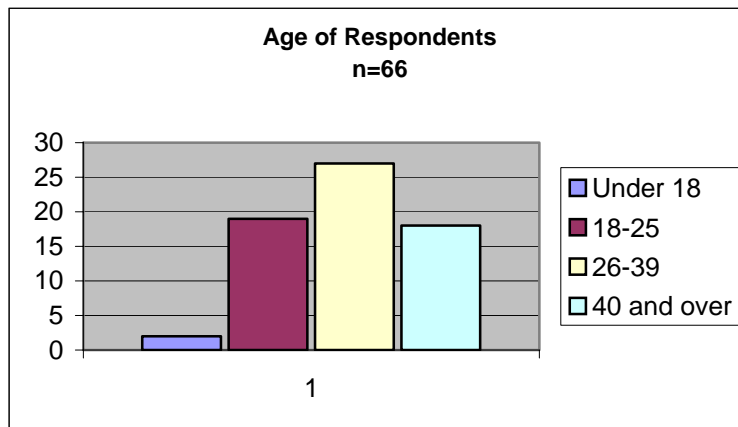


Figure 2:



Nearly half of the sample identified themselves as single, about a fourth of the sample were couples with children; nine were single parents, and ten of the sample did not answer that question. Nearly half of the sample had lived in the UK for more than ten years; a fourth of them have lived here for 5-8 years; about one in ten lived here for 1-5 years, and very few of them were born in the UK (3). Most were British citizens; nearly one in seven were on indefinite leave to remain; one in eight had full refugee status and only two people were asylum seekers. A majority of the respondents (44) live in permanent social housing and nearly a third live in temporary accommodation, mostly flats and houses.

3.5 Questionnaire

Two questionnaires were initially planned, however, that was not feasible as the focus shifted solely to substance misuse. One questionnaire was designed for individual interviews which was mainly quantitative with some open-ended questions for clarification.

An opportunity was given to Somali community workers and members of the steering group to comment on the draft questionnaire. It was then piloted and changes were made as a result of feedback. Copies of the questionnaire were distributed widely among Somali community workers. They were asked to help clients/users of their services complete the questionnaire. This proved a difficult task due to time and resource constraints. While the researcher visited many community groups to convince them of the benefits that this work may bring to the community, there was still a low return rate. These difficulties highlight the limited resources available to the research project and the hectic schedule of community workers.

Initially, the project goal was to distribute 300 and receive 200 returned questionnaires. However, due to the challenges inherent with this type of research, 82 questionnaires were returned, of which 74 were valid and complete.

3.6 Analysing results

A database was designed to record and conduct quantitative analysis of the results of the questionnaires. The limitations of the research include a majority of male respondents (77%). There were also difficulties with the database, which have been corrected accordingly.

Results from focus group discussions have been examined separately using thematic qualitative analysis and identifying emerging issues.

3.7 Focus groups

General guidelines for discussions within the focus groups were established in order to create a consistent approach for analysis. Four focus group discussions were conducted; a men's group, a women's group, Alhuda Somali Mosque group and a Somali community workers group; with a total of 20 participants. Participants in group discussions were mainly men and it became clear that a paid female assistant researcher/interviewer would have been an advantage although not possible due to limited resources. One in-depth interview on khat chewing and mental health was conducted in partnership with MIND in Tower Hamlets: Somali Mental Health Project.

Although the research aimed to tape-record interviews and produce transcripts, consent from participants was not granted, therefore notes were taken of group discussions. This created a challenge and limitation for the facilitators.

4. RESULTS

4.1 Quantitative results

4.1.1 Levels of substance use

This question was posed in third person, as it is a culturally sensitive topic. Respondents were asked the number of people they know who take substances. The intention was to enable the research to detect the prevalence of substance use in the community. Findings are shown below in figure 3.

It is evident from the above findings that **khat has a widespread use** in the community and people chew khat often or on a regular basis; however, the research found **higher levels of alcohol use** in the community than expected from the research. The main question raised by these responses is the connection between the two. It is important to bear in mind that the sample is not necessarily representative of the community as whole.

4.1.2 Frequency

The frequency of substance use is important in order to establish the pattern of substance use. Responses varied according to type of substance, as shown in figure 4.

Figure 3:

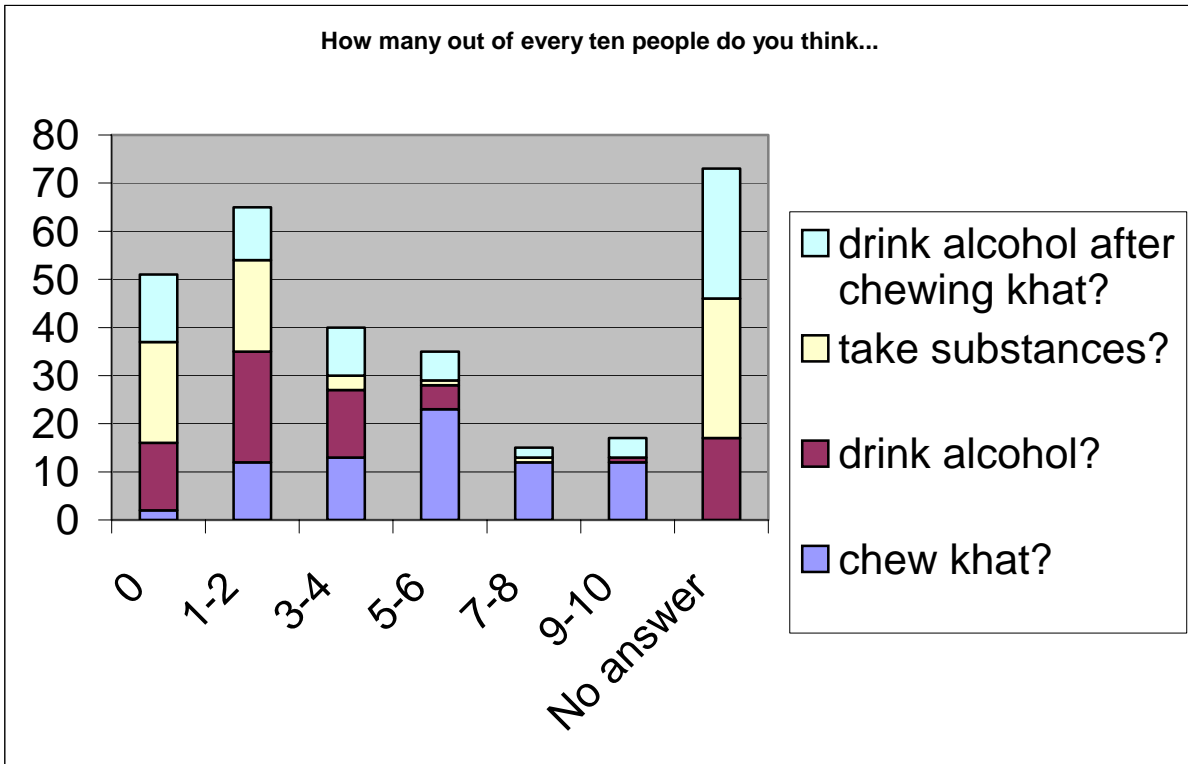
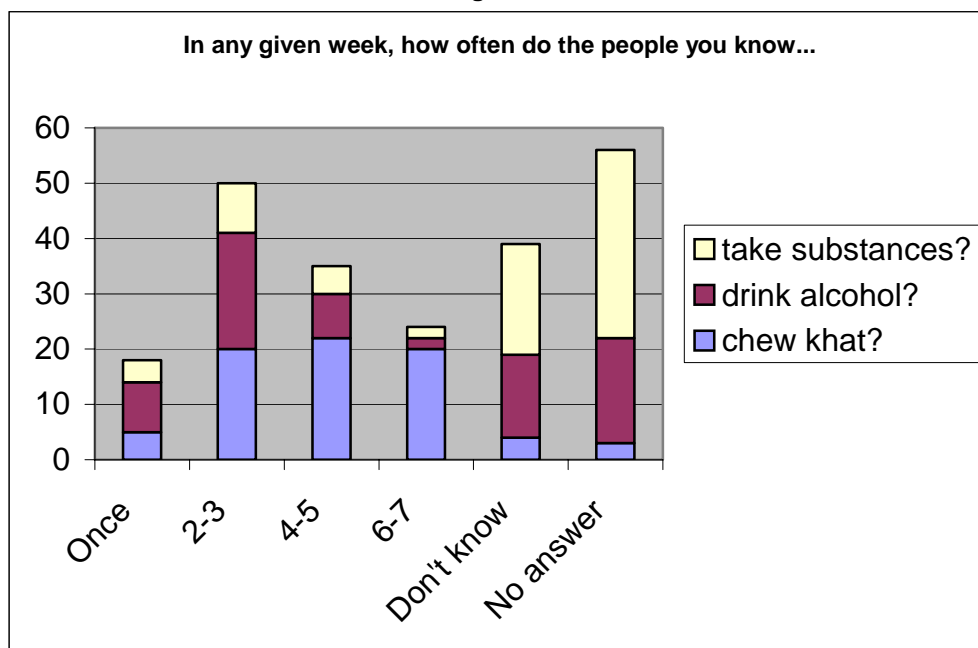


Figure 4:

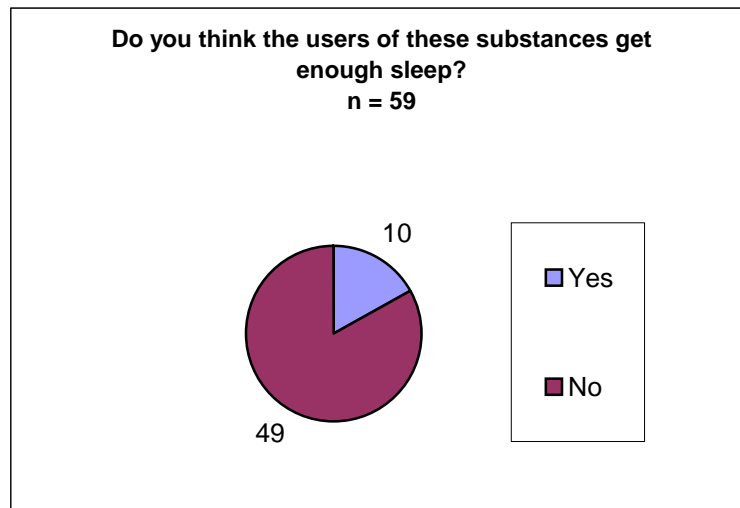


As shown above, **khat is the most frequently** used substance according to respondents, trailed by alcohol then **illegal substances** in the Somali community in Tower Hamlets.

4.1.3 Health perceptions

There are anecdotal reports on the effects of khat on physical and mental health. This research was not designed to substantiate or disprove this but instead aims to collate the experiences and opinions within the community. The questions raised are in the context of sleep deprivation and sacrificing essential items in order to purchase substances, particularly khat chewers.

Figure 5:

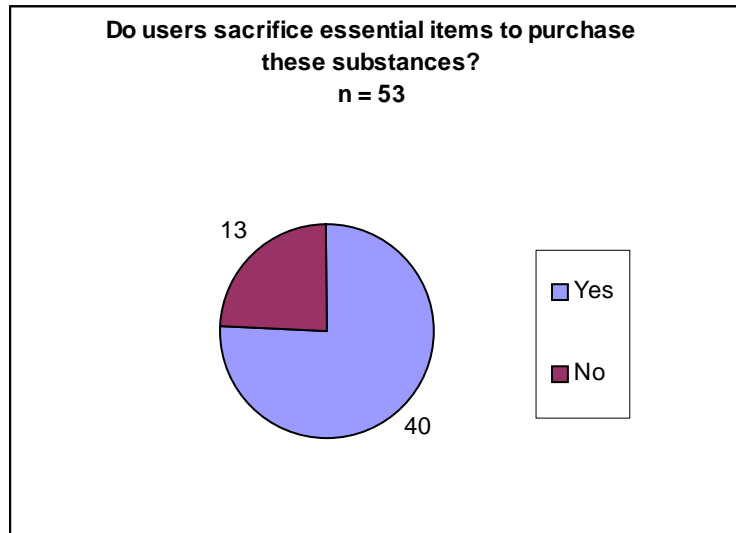


The reasons given why users did not have enough sleep were various:

- Irregular sleep patterns
- It is the nature of khat [as a strong stimulant]
- Improper use of time
- Mixing alcohol and khat
- Illicit drugs cause sleeplessness and developing symptoms of depression and mental health conditions
- Chewing khat late at night causes sleeplessness
- Homelessness
- Drinking a lot of black tea (caffeine)

Asked if users sacrificed essential items (like food) in order to purchase substances, respondent answers are shown in figure 6.

Figure 6:



Respondents attributed this to:

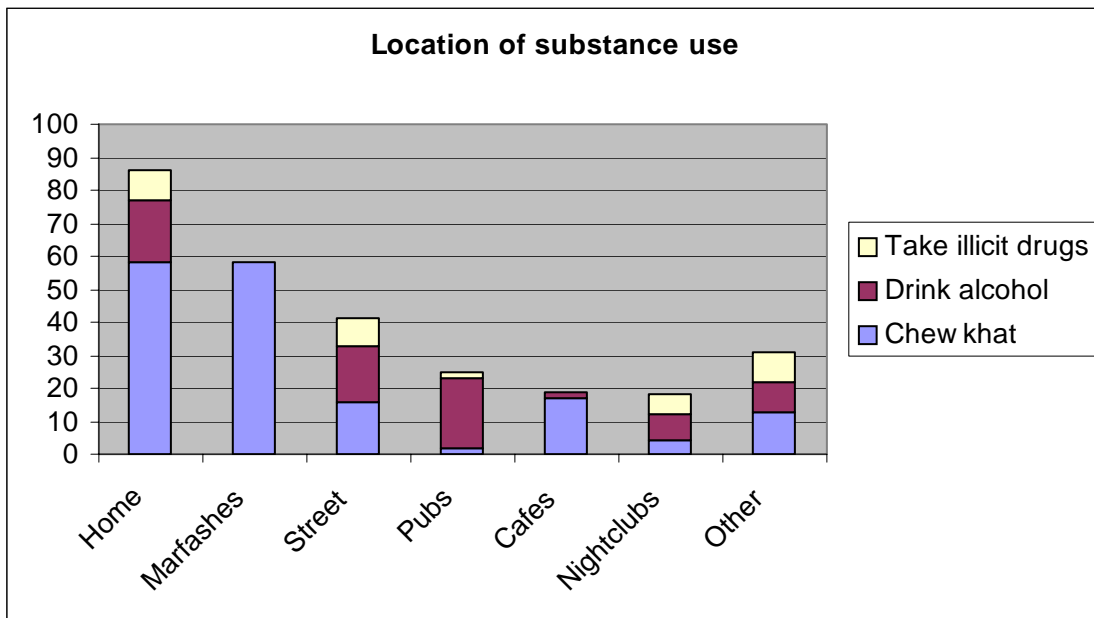
- Addiction
- Excess of substances taken
- May not sacrifice food but clothes
- Using a large proportion of income on substances
- Few resources at their disposal in total
- Taking other items such as cigarettes, alcohol, tea or Coke with it
- Unemployment

It is quite obvious that **increased frequency** of khat chewing for some sections of the community leads to **sleep deprivation and a poorly balanced diet**, as most respondents stated, and may result in **serious health consequences**, both physical and mental. This perception has long been reflected in the views of many community leaders who have expressed concerns about khat chewing and its health effects.

4.1.4 Where use/misuse occurs

The research assumed that the settings in which people take substances might affect health and well-being. Some venues might be 'healthier' than others, for example an area with good ventilation. **Figure 7** shows responses regarding the location of substance use. Please note respondents had the choice of ticking more than one box.

Figure 7:

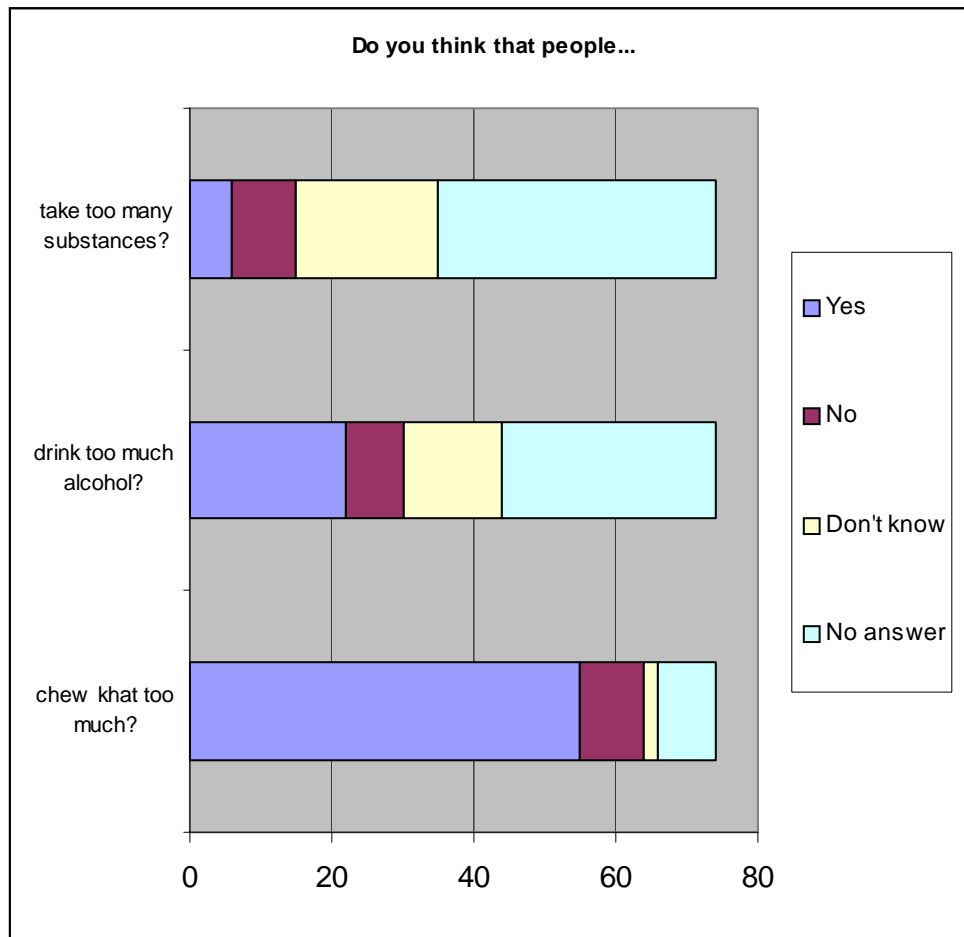


As shown in figure 7, khat chewers are very likely to chew in marfashes, which tend to be **overcrowded, lack good ventilation** and encourage **smoking** while chewing. In terms of drinking, the government is more heavily regulating pubs and nightclubs and new laws will soon be introduced, however, the **hygiene and sanitation** of marfashes **is still a concern** to many members of the community.

4.1.5 Levels of substance use

Frequency alone was inadequate to establish the degree of use/misuse of substances and thus people were asked about the amount of substances taken. Findings are shown **in figure 8**.

Figure 8:



There is no agreed upon limit to the acceptable amount of khat per session; however, the general advice is not to chew more than two bundles in a session (3-4 hours). The above findings suggest that khat is used more than alcohol and other drugs within the Somali community and is taken more often and in large amounts.

4.1.6 Percentage population using

Respondents were asked about the percentage of men and women who take substances:

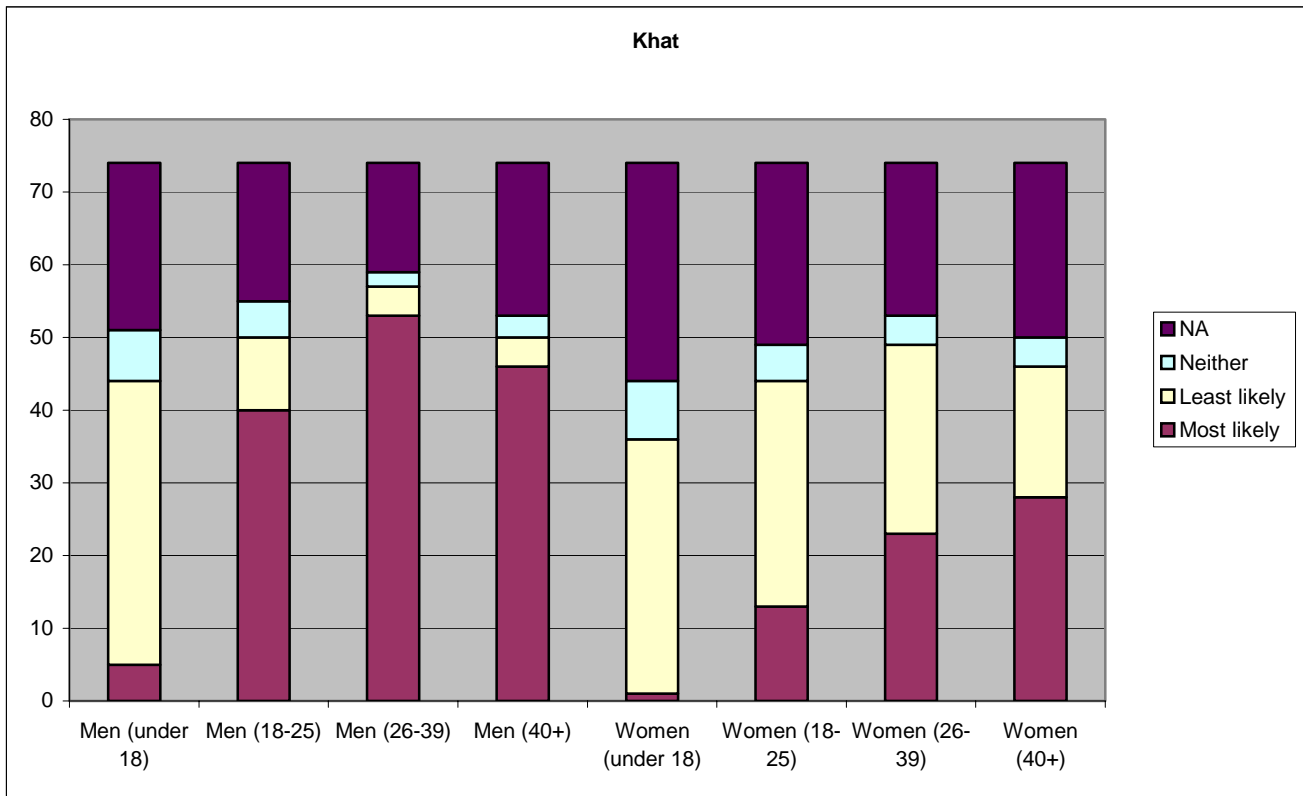
- 25 of the respondents thought that almost all men (95%) chewed khat, 9 thought 10-15% of women chewed it, 5 thought 20-25% of women did the same, others had a varying opinion on the percentage of women that chewed khat. However, there was a consensus that a maximum of 30% of women did so. 8 respondents did not answer that question.
- In relation to alcohol, 12 respondents thought up to 30% of men drank alcohol, others had a varying opinion; though 28 respondents did not answer the corresponding question. However there was a consensus that very few women (3-5%) drank alcohol.
- In regard to illicit substances, 25 respondents thought up to 30% of men took illicit substances, 7 thought 15% of women took them. Significantly 39 did not answer the question.

Respondents felt that **a majority of Somali men chew khat**, casually or regularly, and **increasing numbers of women** do so. However, it is clear that more research is needed regarding the proportion of Somali's who drink alcohol and/or take illicit drugs. Please note that the percentages mentioned above are based solely on the perceptions of the respondents and further research is needed in order to understand the problem.

4.1.7 Social groups

The likelihood of social groups taking substances (according to gender and age) was assessed and responses are shown in figures 9-11.

Figure 9:



Figures 9-11 indicate that **men are more likely** to use substances than women. **Young men (18-25)** are **more likely** to use illicit substances than older men. However **young women (18-25)** have the **same chance** as young men of a similar age of taking illicit drugs. This warrants **special attention** to be given to men irrespective of their age and **raising awareness** about drugs among young women is also to be given a big consideration.

4.2 Effects of substances

Asked how different substances affected the community, figure 12 shows how respondents ranked these substances.

4.2.1 Increase/decrease

Asked if they thought the use of these substances was increasing or decreasing, figure 13 shows respondent attitudes to levels of use in the community.

- As can be seen from figure 9, most respondents felt that khat use is on the increase
- The reason that khat use is increasing was attributed to its availability and social acceptance and to it being legal.
- See figure 14 for responses to whether or not substances have affected the lives of respondents directly.

Figure 10:

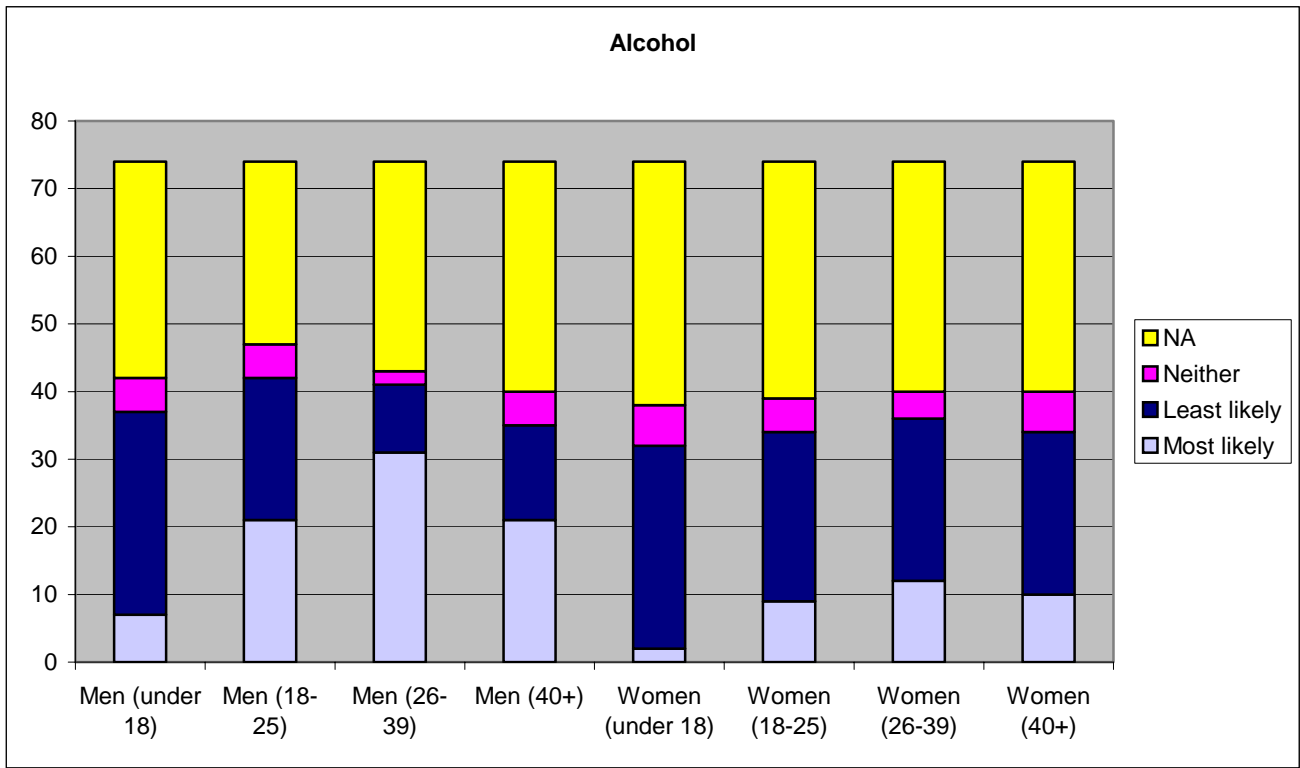
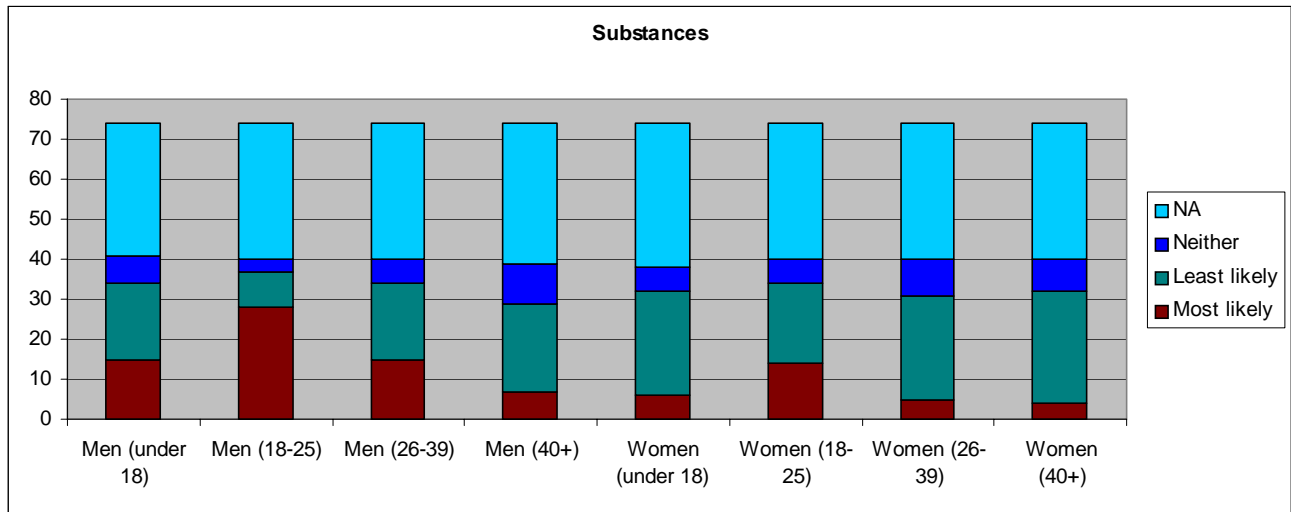


Figure 11:



The implications from the above findings suggest that khat use has been **alarmingly on the increase** and **affects** the lives of a **majority in the Somali community** and that illicit substances **affects the community least**. On the other hand, 17 out 76 people (Muslims) said **alcohol directly affected their lives**, a point which must not be underestimated and should be taken very seriously.

Figure 12:

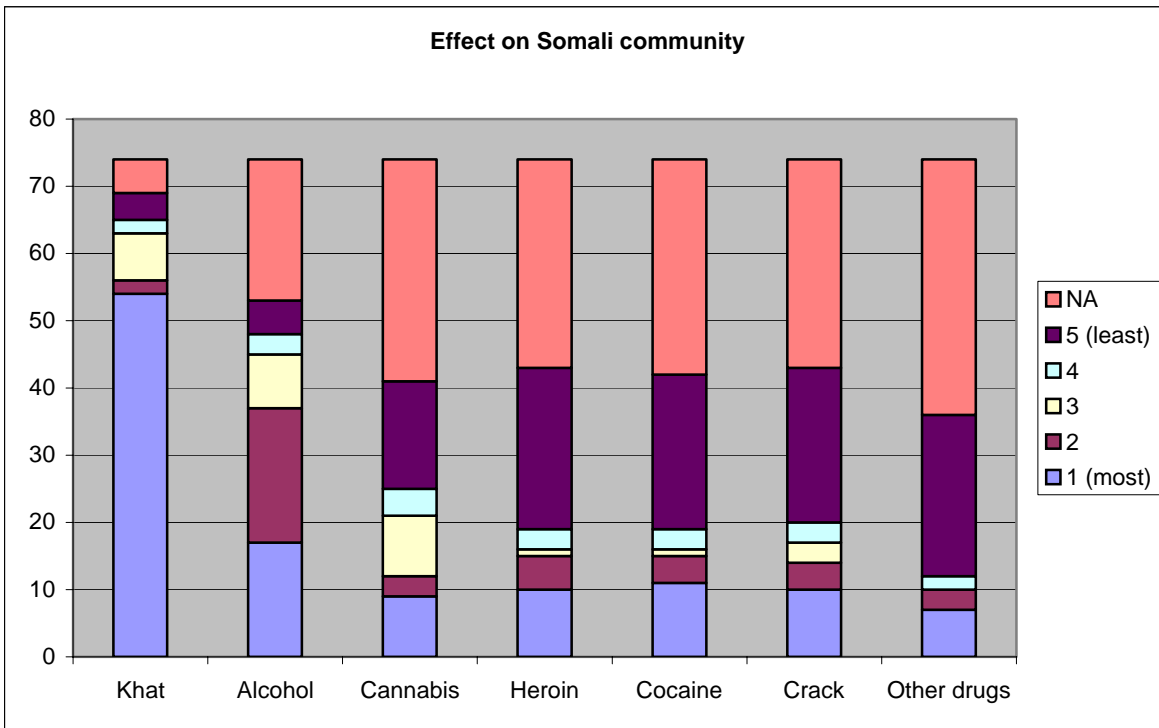


Figure 13:

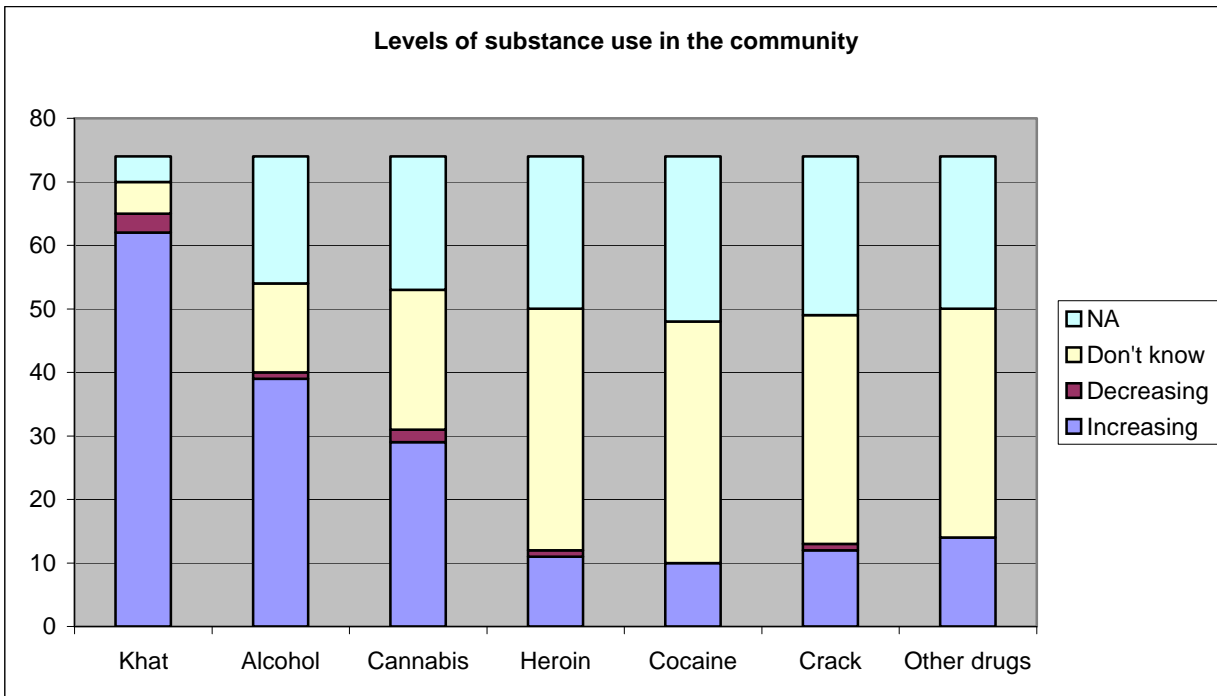
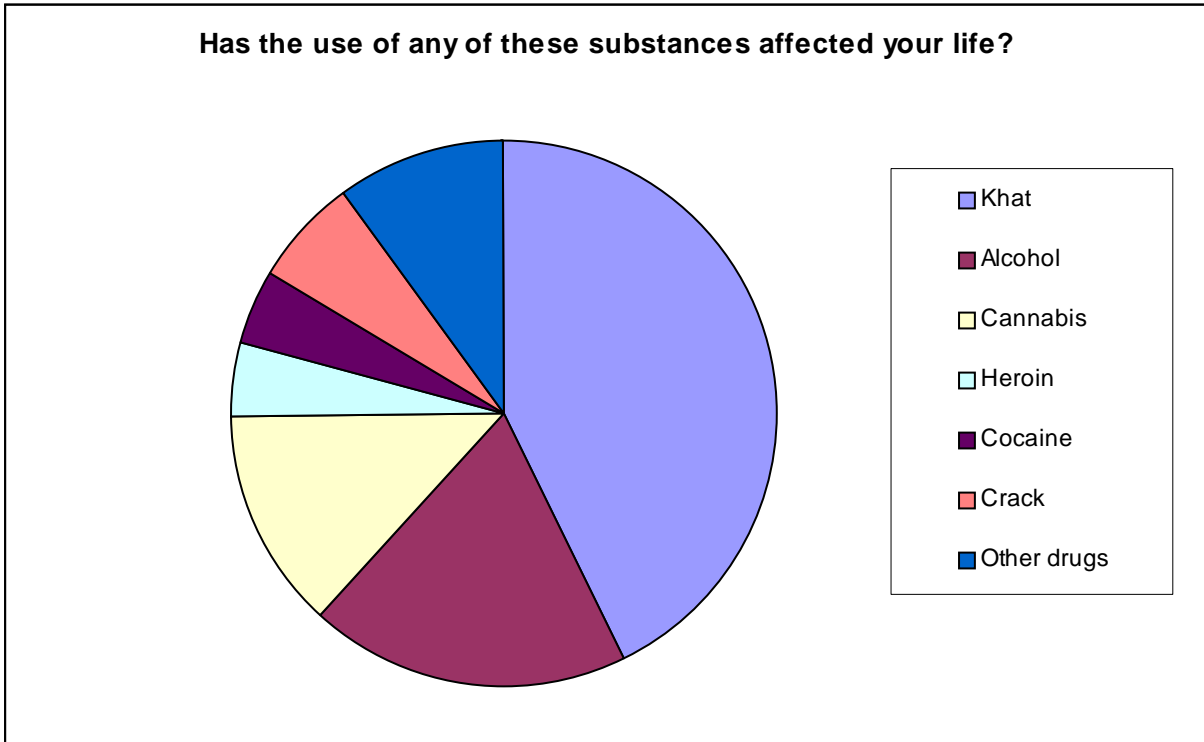


Figure 14:



4.2.2 Banning khat

This is the most debated question in the community whenever khat is mentioned. Asked whether banning khat would have positive or negative impact:

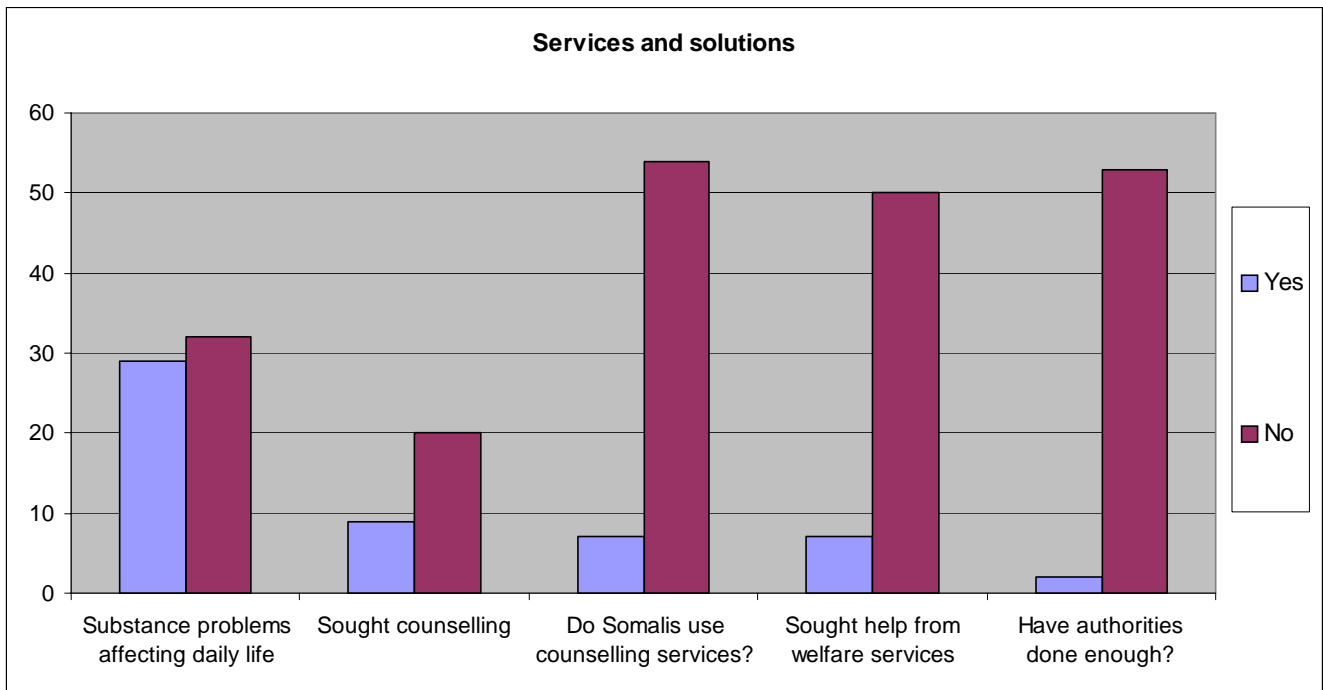
- 48 said it would have a positive impact, 9 said it would have a negative impact and 17 did not answer the question or did not know.
- The reasons given for not banning khat were various: half of all users might turn to class A and B drugs; khat might become a contraband commodity; alcohol use might increase; it is a better drug than other drugs; etc.
- For those who support a ban, respondents noted that there might be fewer financial problems; behaviour might improve: more men would be looking for jobs, more men might enter college; there might be less depression; etc.

Whatever the consequences of banning khat, there is no doubt that the **majority of the Somali community**, and especially women, believe banning khat is **for the good of the community**. The main question is whether or not a majority would vote for a ban given the choice. On the other hand, banning khat might **criminalise** and **stigmatise** people as drug users. Khat is undoubtedly a burden on the community and the challenge of creating a 'win-win' solution is before us.

4.2.3 Responding to problems

The remaining section of the questionnaire covered whether respondents had self-perceived problems with substance use, sought help related to misuse and the likelihood of using counselling services. The findings are as follows:

Figure 15:



- The reasons given by those who did not seek support include: *not having the will power, counselling does not work, do not know about it, no Somali speaker in the support services, no one listens, not good for me.*
- The main reasons why people do not use counselling services include: *do not know, people are ashamed to reveal secrets, cultural and language issues, lack of understanding of services, there were no counselling services in Somalia, counselling services were not promoted in the community, people think it is lowering their status, it is waste of time.*
- Respondents thought the ways that people with substance problems could be helped are: provision of advice and advocacy services, counselling services, employment opportunities, banning khat, becoming religious, raising awareness of problems with khat and other drugs, raising awareness on substance misuse, taking preventative measures and more education on substance issues.
- In regard to the help the Somali community received from local authorities and central government agencies, most of the sample (54) replied that not enough assistance is available
- Suggestions on how to help the community use support services were: more partnership work between service providers, more outreach workers, more jobs and education/training, more information on these services, Somali trained advisors, services tailored to their needs, inform people on how to use services and special Somali support services.
- Responses on the help that could be given to people to avoid substance misuse overlapped with the question about the ways to help people with substance problems. Understandably, there is no clear line between substance use and misuse. However, some of the unique responses given include: they need more religious enlightenment and the guide of true faith, more support for young people, more jobs, more education, give accommodation, more youth workers, employ people with good experience of substance misuse and giving appropriate advice before misuse occurs.

The conclusions are that **very few Somalis** sought help for **problems related to substance use** and the main reasons were **lack of knowledge** of these services and **culturally inappropriate** counselling services. The respondents also pointed to the causes of the substance misuse: **being uprooted, unemployed, not having qualifications and lack of appropriate support** and housing problems.

4.3 Focus group results

Results from each focus group are discussed in the following sections. Quotes from focus group participants are indicated below in shaded boxes.

4.3.1 Somali men's group

Why people do not seek assistance in regard to substance misuse?

Having asked why Somali men did not seek assistance, respondents identified **language difficulties**, as a barrier facing them when using services. They also pointed to the **cultural gap** that existed between Somalis and service providers. They added that feeling shame about having a problem with substances was another considerable barrier. **Many agreed that self-denial** is a strong reason preventing people seeking help in regard to substance misuse problems.

Stiff the upper lip, while having a problem, is also another reason of not seeking help. Another added, we kill time with khat chewing as many of us are not employed or not in education or training. In other words khat itself is a kind of a therapy

Is there any connection between khat and alcohol?

Most were adamantly positive about the connection between khat and alcohol. They explained that some people find it difficult to get sleep after they have chewed khat. The group believed that alcohol helped people sleep after a chewing session.

Some khat chewers got a big problem as they combine khat and alcohol which is not healthy to do and they are more likely not to tell to others. As a result they not only got health problems but they do not seek help. As a Muslim person they feel shame of admitting having alcohol problems.

Who can help people with substance misuse problems?

In regard to who can best help people with substance misuse they said **family members** are best suited to do so. Asked why people do not seek help from public services they mentioned **confidentiality** as the main obstacle. Most of the group felt that this fear applied more to refugees than other groups, who were concerned that any agency that was contacted may disclose their problems with the Home office

People fear that their problems will be in public as soon as you contact services.

The group concluded that peers might advise those who had problems with substance misuse and they strongly agreed among themselves that most Somali organisations were not suitable to work with people with substance misuse problems. Some participants attributed that attitude to the prevailing **mistrust** some people might have about Somali groups. Other participants thought their **staff might not be trained** for that purpose.

What about other drugs/illicit drugs?

The group pointed out that **young people** (mainly those in their late teens and early 20's) were **more likely to take illicit drugs**, which had already landed some of them into jail. They said that few Somali youth chew khat on regular basis.

With which are more problems associated: khat, alcohol or other substances?

The group believed that **khat causes more problems** in the Somali community, followed by illicit drugs and alcohol. That is understandable as the assumption is that more people chew khat, it is mainly youths who take drugs and few people drink alcohol.

Having asked about the connection of the three, one simply replied, **khat leads to alcohol but not necessarily to other drugs/other substances**. They shared with us their observation that those who came from Somalia as adults tend to chew khat while those who grow up here tend to take drugs.

Who are those people who take substances?

It was obvious to respondents that more men chew khat than women. One participant estimated that 40% of women chew khat while others guessed 10%. However, it could be an indication of the trend that **more women are picking up the habit of khat** chewing.

According to the group, girls (late teens and early 20's) tend to smoke hashish. (It seemed to the researcher that any illicit substance smoked was termed 'hashish'). The group guessed that 40% of girls tend to smoke and 50% of boys smoke hashish. One participant said that some of his relatives (young people) took hashish in front of his eyes while they were his guests. It also supports the view that **youth tends to take illicit drugs**.

What are the health effects of substances misuse?

The question turned into a discussion of which substance damages health more than others. Some expressed the ideas that **illicit substances** damage health more than other substances, followed by **alcohol and then khat**. While other participants put it in a different order: **first illicit drugs, then khat, followed by alcohol**.

What are the implications of substance misuse on employment?

The group acknowledged that it depended **on the kind of the job** the person was doing, however, some people might keep their jobs while taking these substances and some might not. Having asked to rank the substances that may risk job loss, one participant put illicit drugs as the one most likely to make people lose their jobs and khat the least likely. The other three put illicit drugs the least likely to do so and **khat the most likely** substance that might cause people to lose their jobs. Alcohol was put in the middle as a substance that might affect the retention of a job. It was interesting to hear khat chewers talking about khat in a negative context.

Since khat has become part of Somali culture, what can be done?

The group suggested **raising awareness** on the health implications of khat chewing in community settings such as community centres, cafés and across Tower Hamlets. They thought it was urgent to educate the community as a whole on khat and health. They also recommended giving people **opportunities on training and employment** and strongly believed as the key in tackling the problems of khat misuse.

Though khat became part of the culture, it is worse in the UK than elsewhere.

To those who want to help people they advised them to go to **community gathering places** such as cafes and khat chewing houses. They explained how some khat chewers might not see other people

except those with whom they chew. Basically it implies people had time to go out and do something.
Time is the issue.

Within a day I saw many people I have not seen for years simply because khat did not come to London that day as the British Airways and other airlines had not brought it that day.

How khat chewing in the UK is different from that in Somalia?

The group observed that the pattern (duration of chewing, quantity chewed) of khat chewing was different in the UK than the one in the Horn of Africa. The **Pattern of chewing** should be looked at closely.

In the UK khat is the companion, work and family of the person feeling isolated. We need something to replace it.

What are the effective ways to tackle the problem?

The group thought a **leaflet on problems**, including where to seek help, associated with substances was a good starting point. They also thought **advice sessions** should be organised for those who had problems with substances. In regard to ways of helping people, they had strong opinions such as:

- Those who have substance/khat misuse problems must be seen between **1pm -4pm**, not in the morning and definitely not late afternoon.
- **Make busy** those who are more likely to misuse substances, particularly khat chewers as not having what to do makes people chew khat long hours.
- They were adamant that **non-Somali professionals** must give counselling sessions to these individuals. They were afraid they might breach the confidentiality.
- **Relationship** between parents and young people needs to be improved.
- Parents with problems should be given **counselling services**/advice sessions.
- Encouraging people to **come out of denial** and seek help if they have problems with substances.

Many of the above points indicate that “**time is the issue**”.

The Somali community must be advised **not to stigmatise** people with substances misuse problems, particularly alcohol. Sometimes they [people with alcohol] are discriminated against.

4.3.2 Somali community workers

Six community workers participated in the group discussion, five male and one female, and most of them were experienced community workers.

What was the difference between khat chewing in Somali and UK?

This group attributed the difference of khat chewing here, in the UK and Somalia being an uprooted community and in a situation where the problems are multifaceted and complex: Problems included **unemployment, racism and lack of the ability to do what you wanted to do**. In Somalia, people

never used to chew until after lunch between 4-6pm. They likened it to just going to a pub after a day's work.

Most of the workers strongly believed that khat was not the problem but a symptom. Here they listed the problems such as: **trauma (of being a refugee/civil war), depression and being uprooted**. People blame khat for all of that, as it became an escape. Other problems identified included: not working, not having counselling services, cultural shock and language barriers. Many people went "through a dark hole", as one put it.

Some of the workers thought khat chewing an inevitable thing to do.

*As a Muslim you should be taking no alcohol and no drugs. Then obviously **khat** is the only social drug allowed. The Somali ways of **socialising** do not fit into this society [host society].*

The group also pointed out that there was little understanding between **parents and children**. As far as young people are concerned, it is about the **relationship** between them and their parents. One person held the view that Somalis were **under-represented** in many public services and in some services there was not a single Somali worker.

Do young people use heroine?

The answer was yes: some young people do use heroine, however, abuse of alcohol, they said, was greater than heroine use, as they [young people] often go to nightclubs. Most agreed that **more boys are drinking alcohol** than girls.

These young Somali males have a lifestyle that many of us cannot imagine.

The discussions came to the conclusion that there was a **conflict at home** between parents and their offspring. According to the group, parents' and British society's **expectations** do not go hand-in-hand. They also warned that if a parent smokes, chews khat and goes to khat-houses, she/he should not delude him/herself that they are **good role models** for children.

Do Somali parents seek help if one of their children has problems with substances?

The group consented that Somali parents **tend not to seek assistance** when a member of the family is experiencing problems with substances. They fear they may **lose their children** i.e. have them taken into care. Parents also feel they cannot discipline their children the way they know best like back home.

The group also consented that Somali parents tend to be single parents/mothers and need help when it comes to tackling teenage problems. In Somalia parents have a support system but here, more often, children know more (about the language and British system) than their parents. The worst scenario depicted was that sometimes **parents rely on their children** when it comes to using public services.

Any shame related to substances misuse as in the Bengali community?

The group identified the difference between Somalis and Bengalis: most of the Somali community are not **economic immigrants** as Bengalis are and hence the two communities might have different aspirations. Somali's are mainly refugees and, therefore, very different from the Bengali community.

Somali seamen and their families can be classified as migrants and they tend to be healthier than many young Somali refugees. The main reason is that they came here on their free will.

In the Somali cultural context, it was acknowledged that **shame** did not apply to men and khat but might apply to **women**. But it did apply to alcohol as well as other drugs. In addition, the group admitted not knowing how to handle misuse of alcohol and other drugs.

Youngsters go outside the area they live as their night out: drinking and taking cannabis. They have their own group and totally divorced from traditional ways known to Somalis [parents, adults]. It looks like a secretive group and they live a double life.

What will happen if it [drug taking] becomes problematic?

There was a big concern for Somali youth taking illicit drugs and the group concluded there was a need to raise awareness about drugs within the community, as many people do not know about drugs, particularly parents. The biggest concern was also that some Somali boys are now joining in the drug dealing business. The group also put bluntly that housing is vital as **homelessness** pushes people into **dangerous** lifestyles. The group warned that **violence** might come with increasing numbers of youth taking cannabis as well as the **secretive lifestyle** that accompanies it.

Some youngsters provide illicit drugs in Somali events. So should we be concentrating on khat? We have to take pro-active measures.

Khat and family problems

Though the group felt that khat is a problem within the family, they rejected it being the root cause of such problems.

*Khat is easily blamed in regard to family problems. Somali men and women have been living separately for a long time [figuratively speaking]. They have had **independent lives** from each other but were **supportive** to each other. I wonder why some people are complaining that men are not available at home.*

What makes young people take drugs?

The group put the blame on the socio-economic conditions in which people find themselves like housing and employment conditions. Among Somali youth there is chronic **unemployment**. That is due to **lack of qualifications** and underachievement in schools and above all lack of suitable training that can accommodate their needs. All these conditions damage motivations. **Post-traumatic** stress may also lead to substances misuse. Suicide numbers were high in the early 1990's.

What are the ideal services to provide to those with substances misuse problems?

The group recommended to:

- Provide **holistic services**: housing, employment, legal advice, advocacy in one place. People would be comfortable with one place, a Somali place, where people can receive holistic services and access to qualified professionals.

- Provide a **hostel** for those with substance misuse problems. People will come, as the information of individuals remains confidential. Trust matters most.
- Project Liban, a Somali drug agency, **visits schools** and tries to reach children with substances misuse problems as no one currently offers help in this area.
- Set up, if agreed viable, **Somali organisation similar to Nafas** that deals with issues of mental health and substance misuse.
- Authorities should give **support to people with khat problems** as they do to those with other substance misuse problems. Those with khat problems do not receive such support, as it is legal in the UK. Sometimes they are evicted from their houses without giving the chances usually given to others with similar conditions.

What about banning khat?

The group were totally adamant not to ban khat as they thought it would stigmatise the community as drug users and would also criminalise the community.

Making Khat a Class 'A' drug [banning it] does not make it dangerous.

4.3.3 Mosque focus group

How the use of khat in the UK is different from its use in Somalia

The group were not in full agreement on this issue; and many felt that khat was a bigger problem here in the UK than in Somalia. They felt that khat is a problem wherever it is chewed.

Describing khat chewing in the UK, they thought people got opportunities that they did not have in Somalia such as a **secure income**, when working, and a Social Security income if not working. Thus some people use that money for khat chewing. Hence people chew it here more than in Somalia. They also thought more people take drugs and alcohol on top of khat chewing and that makes things worse.

The group agreed that khat was worse for employment, education and training and social life in the UK than it was in Somalia.

One participant thought **consumption of khat** increased after the break out of civil war in Somalia and concluded that problems are the same both here and in Somalia. Another participant believed Khat problems are worse here in the UK.

In Somalia Khat was chewed in the day. The consumption is high in the UK as people chew both day and night. This caused lack of nutrition, as people tend not to eat while chewing; and that might lead to depression. Here people use alcohol more than in Somalia as the culture was restricting it then.

What

are the

effective ways to help the community in regard to substance misuse?

This group emphasised **education and raising awareness** in the community. They pointed to the responsibilities expected from khat traders, Somali community workers and community leaders. They asked them to lobby the community on the issue before it gets out of hand. They urged people to **join/go to mosques** and follow the teachings of Islam. They also suggested practical things such as organising community events, entertainment and sports activities to redirect people's energy into **positive deeds**. They also came up with the suggestion of asking the council to be aware of the problems associated with khat chewing and if necessary close khat chewing houses/shops. Other

suggestions included: setting up a **Somali youth centre**, provision of **counselling services** and easy access to language classes.

How to help individuals with substance misuse problems

The group generated the following recommendations:

- Somali community **groups** have a **responsibility** to assist individuals with substance problems before their situation deteriorates.
- Receiving people with substance problems and treating them with dignity.
- Having liaison officers between individuals with problems and service providers.
- Access to **counselling services** is crucial.
- **Leaflets** on substances must be published and widely distributed.
- A Somali **employment agency** is needed i.e. an agency that helps people get a job.
- **Supporting families** who look after someone with substance misuses.

5. ANALYSIS OF RESULTS [exec](#)

5.1 Patterns

Khat **has a widespread use** in the community and is chewed often or on regular basis. The research **also** found **higher levels of alcohol use**, according to respondents. Khat is the substance **used in the Somali community more** than other substances. Khat is the **most frequently** used substance, trailed by alcohol **and illicit substances are used less frequently** in the Somali community in Tower Hamlets. Thus khat is not only the substance **most people** use, but the **most taken amount** in the Somali community. It is obvious that **higher frequency** of khat chewing in some sections of the community would lead to not having **enough sleep or a balanced diet**, as most respondents stated, and may result in **serious health consequences**, both physical and mental. Khat chewers are more likely to chew in marfashes [special places for chewing] and marfashes are understood to be **overcrowded**, tend **not to have good ventilation** and **people smoke** while chewing.

5.2 Likelihood

The respondents felt that **most Somali men chew khat**, casually or regularly, and **increasing numbers of women** do so. The research also found that **youth** (mainly those in their late teens and early twenties) were **more likely** to take **illicit drugs**, which already led some of them into jail. **The majority** of the Somali community, mostly women, believe banning khat is **for the good of** the community. Others feared that banning might not only **criminalise** but also **stigmatise** their community as drug users. Men are **more likely** to use substances than women and **young men** (18-25 years old) are **more likely** to use illicit substances than older men. On the other hand, nearly a third of the respondents said **alcohol directly affected their lives**. This must be taken seriously. There was a belief that **khat leads people to alcohol** but not necessarily to other drugs or substances

5.3 Seeking help

Very few Somalis sought help for **problems related to substances** and the main reasons were **lack of knowledge** of these services and **culturally inappropriate** counselling services due to **language difficulties** and the **cultural gap** that existed between Somalis and service providers. **Self denial** is a strong reason that stops people seeking help. Some respondents believed there were connections between **khat and alcohol**. They explained that some people find it difficult to get sleep after they chew khat and take alcohol to make them sleep. The respondents did not think Somali groups are well suited to help people with substance misuse. Some participants attributed that attitude to the prevailing **mistrust** some people might have about Somali groups. Other participants thought their **staff might not be trained** for that purpose.

5.4 Health and social implications

Some respondents believed that **illicit substances** damage health more than other substances, followed by **alcohol and then khat**. Other participants put it in different order: **first illicit drugs, then khat, followed by alcohol**. **Khat** was identified **the most likely** substance that might cause people to **lose their jobs**. Alcohol was put in the middle as a substance that might affect the retention of a job. There is a **conflict at home** between parents and their offspring as in all immigrant communities. There is no detailed scientific study directly tying khat to mental health. Khat is a gender issue in the sense that far fewer women chew than men.

5.5 Summary of analysis

- **Raising awareness** of the health implications of substance use in community settings such as community centres, cafés and across Tower Hamlets.
- Giving people **opportunities for training and employment** are the key in tackling the problems of substances misuse.
- To those who want to help people they were advised to come **where people** are and help in that setting.
- Those who have substance/Khat misuse problems must be seen between **1pm -4pm**.
- **Relationships** between parents and young people need to be improved in the context of parenting and substance use.
- Encouraging people to **come out of denial** and seek help if they have problems with substances.
- Providing housing is vital as **homelessness** pushes people into **dangerous** lifestyles.
- Unemployment and lack of qualifications also push young people into despair. A suitable training that can accommodate their needs is advisable.
- Joining/going to mosques and following the teachings of Islam - spirituality - could be a salvation for many people according to some respondents.
- Access to **counselling services** is thought to be crucial
- **Families** who look after someone with substance use and mental health problems deserve **supporting**.

6.0 OVERVIEW

The findings indicate that khat is the most widespread drug in the Somali community and on the increase. It is a social drug they came with that took a **new social context and meaning** in the Diaspora. There are new social dimensions, as expected, forged in the last 15 years of Diaspora: independent minded youth, powerless parents over their offspring, elders being listened to less than before, assertive women, and religious revival to preserve identity. These dimensions are possibly the results of multiple factors: exposure to British media, experiencing new economic and social settings in the work place, schools, colleges, training venues and using public services or contact with public institutions.

In light of these interactions, new social awareness and views have emerged: **traditional, religious and liberal** (as termed by them). Those who hold **liberal views/attitudes** tend to accept diversity, personal choice and personal circumstances. They also subscribe to the view that every community has its own social drug and so khat is the Somali social drug equivalent to alcohol as it is in the western societies; and they see no problem if [khat] used **safely and sensibly**. Most community workers who took part in the group discussion were more likely to express such views. That is not surprising as British institutions/educational backgrounds inadvertently shaped their views. Their solutions for problems associated with substance-use focus on the support people receive from public services in accordance with their needs and giving them a helping hand to get out of the circumstances they find themselves in.

The second view/attitude (**traditional**) tends to **reject personal choice** if it is hindering an individual's advancement and consequently that of his/her immediate family. For instance, those who held traditional views were likely to express that khat is not good for a person's economic future and likely to reduce a person's chance of taking advantage of opportunities, it should not be a choice available to anyone. This is a view more likely to be held by women who came to the UK as adults than other groups. In this context, solutions focus on banning khat in the UK, which is believed to result in releasing the potential of many Somali men. Some men may agree with this view, except when it comes to khat chewing.

The third view (**religious**) rejects taking any substance essentially **harmful to the individual**, his/her family and wealth; as it is haram (prohibited). It is no surprise then that these substances, including smoking, are considered as haram. They not only subscribe to ban khat in the UK but they see it as a deliberate policy by the British authorities to let down their communities as many European countries already have done so. They say solutions could be found by following the pathways of the faith - praying five times a day, going to the mosque when they get the time and following Islamic teachings - this guides the person not only to live a healthy and fruitful lifestyle but also a self-disciplined one. A good example of this, as anecdotes say, is that Alhuda Somali Mosque since its opening four years ago, helped many people to give up or reduce khat chewing; and religious oriented men run many new, emerging small businesses. No wonder nowadays Somali men are crudely classified into two camps: religious and khat chewers. It seems that this has replaced religious man (wadaad) and man of the spear (warranleh) in the traditional context of Somali pastoral system/rural life [Lewis, 1993].

In support of the above view, the Centre for Ethnicity & Health's - University of Central Lancashire - report in May 2003 reported that many respondents in its research: *Black and Minority Ethnic Drug Misuse Needs*, viewed religion as a protective factor against drug use, usually due to strong religious prohibitions.

To date, academic research done on the Somali community stressed the role of clanship [tradition] as the main basis of social relations amongst Somalis in the Diaspora [El-Solh 1991, 1993], while others pointed out the changes in the role of community elders and shifts in gender relations [Griffiths, 1997]. Griffiths stressed a particular focus on the co-existence of tradition and innovation in relation to the interpretation of clanship and the emergence of new collective and individual identities. In addition to tradition and modernity, what cannot be ignored is the Islamic renaissance in the Somali Diaspora as in many other Muslim communities in Europe. Celia McMichael, who did an ethnographic study of Somali women in Melbourne, said that Islam provided an enduring 'home' for these women that was carried throughout displacement and resettlement. She added that Islam offered a meaningful framework of practice and ideology that sustained women during the hardships of exile [McMichael, 2002]. In the Diaspora there are many focal points for negotiation of identity. Additionally, it is not only the Diaspora that is experiencing these different social dynamics but also people at home in Somalia. Crisis at home also feeds into it.

The above views and attitudes indicate, on the personal level, that a **formulation** of a new British Somali **identity** is underway, with different strands. Somali British youth identity is the most interesting one to pay attention to. Recently East London Somali Youth & Welfare Association carried out research on the needs of this social group.

As can be deduced from the findings of the focus groups and questionnaire, **time is the issue**. All those who misuse substances, as well as others, have to use their time wisely and usefully and not waste it. As, for instance, some may say khat makes people waste many hours of their valuable time; and khat chewers would reply they do not have anything else to do with the time on their hands. So, they kill time with chewing.

As far as **wasting money** and **sacrificing essential items** to khat are concerned, we hope the two researches that are currently underway: international trade of khat by DrugScope and the misuse of khat by Mind in Tower Hamlets will enlighten us more on this issue. However wasting time and money is a double barrier to the economic and social productivity of the Somali community.

6.1 Context of khat use

Khat is a focus for the social life of Somali men. It is a social lubricant as alcohol may be for other cultures. The existing literature on khat concentrates on the shrub's chemical constituents and on its physical and mental effects on users. This study, however, has tried to find out more about the attitudes to khat chewing amongst the Somali community.

The chewing pattern prevalent in the UK is much more likely to lead to a greater waste of time, with chewing taking place all night and sleeping the next day to recover from the previous night. For regular chewers this can reduce educational opportunities and the chances of seeking and securing employment. Such inactivity also implies less productivity in economic terms. The consequences include a worsening socio-economic and health status for the whole community. The pattern in turn feeds into the existing crisis faced by many men as refugees which, in many cases, has already undermined their social position as breadwinners and as heads of their families.

Socially, the abuse/misuse of khat is detrimental to the cohesion and social well-being of the community. Misuse in this sense means chewing increased amounts of khat for longer sessions and more frequently. In other words, **the pattern of chewing** determines the **intensity** of its **negative impact**.

The different chewing patterns in the UK and Somalia are also important in their effects. As has been reported already, with day and night being roughly the same hours throughout the year in Somalia, the typical pattern shows the chewer in Somalia as working from 7am to 2 pm, taking lunch between 2 to 3 pm and then chewing between 3 and 6 pm. After which it is customary to return home. As mentioned above, this allows time for work, eating, socialising and family life. In the UK chewing sessions tend to be longer and take 6-8 hours. This makes men unavailable to their families and may lead to family breakdown. In addition to this, it is generally agreed that a greater amount of khat is chewed in the UK. The type of khat also plays a part -Miiraa, a Kenyan variety- is chewed in the UK. This is stronger than the Ethiopian khat, which is normally used in Somalia.

While the findings of this study may be generally applicable to other khat chewing communities, it is worth remembering that Somalis have a distinct culture of their own and in Britain at least, live in different social, economic and political circumstances to other khat using communities. As a largely refugee population, Somalis face high levels of unemployment and problems in adjusting themselves to a totally alien environment. It is hard to divorce finding solutions to these difficult circumstances and the abuse of khat chewing. On one level, khat abuse expresses the hopelessness of the community as alcohol abuse may in other cultures.

Since health is defined as a state of complete physical, mental and social well-being, there is no doubt that khat chewing has both direct and indirect effects on the health of its users. Physically, it has been reported, khat chewing causes loss of appetite, insomnia, constipation, loss of sexual desire, and in some cases, hypothermia and dental and oral health problems. It can also raise blood pressure and the heart rate. The tannins present in khat leaves are mainly responsible for the effects on the digestive system. It has also been suggested that they may be a factor in the development of periodontal disease. Khat chewing can also cause cardiovascular problems relating to the amount that most chewers smoke combined with the rise in blood pressure associated with the effects of the leaf itself.

The health effects of khat do depend, however, on the amount that is chewed, its freshness (the fresher it is the more cathinone it contains) and the type of khat. In the long term it may result in anorexia, which leads to malnutrition, and thereby increase the susceptibility to infectious disease. A particular threat is TB, as khat sessions often take place in very congested places.

The other major adverse impact of chewing khat is the financial burden it imposes on users and their families. In the Somali community, women are reported to be more opposed to khat than men. This is probably due to the reduction in support they might receive from men when they are frequently chewing as well as the reduction in family income. It was found that substantial proportions of men not only smoke during khat sessions but may also drink alcohol after sessions. This amounts to a serious financial burden on the meagre resources of the families concerned and has an adverse social and health impact.

Many Somalis are faced with the fact that their qualifications are not recognised in the UK and this can condemn them to long periods of unemployment. Other skills that men bring with them are not always relevant to this country. In addition to this many face barriers into education, training and jobs, not least because of language. In contrast, Somali women are held to be more flexible than men. This in the sense that they are more adaptable to change, that they will accept more menial jobs and are more likely to attend ESOL classes which may lead to unemployment training. It may be said that the men in crisis find some comfort in khat chewing. This may quickly escalate into khat abuse. The consequences of abuse, as we have seen, are poor diet with greater susceptibility to illness and breakdown of family relationships.

Finally, a word on addiction: the study did not ask the sample about khat addiction. Little is known about this and addiction itself is difficult to understand. It is probable, however, that khat chewing can set up a cycle of psychological dependence. There is no doubt that khat chewing is a problem in the Somali community. It is a problem for men in particular but it is not the root cause of the problems facing this community. The khat problem is best understood in the context of the community's socio-economic position in East London.

Nevertheless, if concerned authorities want to address the social needs of Somali young people in Tower Hamlets there is no need to do more research. The Centre for Social and Evaluation Research and London Metropolitan University did a study in 2002 on the needs of Somali young people in Tower Hamlets and CSC Regeneration & Research Consultants produced one for East London Somali Youth and Welfare Centre, which detailed the needs of Somali young people in Tower Hamlets and what can be done about them. The recommendations and findings of these studies are worth following up.

6.2 Khat and mental health

The mental health of khat abusers may also be affected by frequent chewing. It is not known whether khat alone may cause mental illness or psychosis but it may predispose those users, who are already in a very difficult social position, to mental illness.

According to Mind in Tower Hamlet's (Daryeelka Maanka Project) there is no detailed scientific study directly tying khat to mental health. However, people tend to extrapolate, as khat is a stimulant similar to amphetamines. It is hard to isolate khat from other substances, as there is a strong link between khat and alcohol. According to Mind, 10 years ago mental health issues were thought, in the community, to be something you have to live with and now that has changed. Subsequently people have taken up services and begun to talk openly about mental health issues. It was a long journey and a similar process may happen with substance misuse. **(For more please see appendix 4???)**.

6.3 Khat as a gender issue

Khat is a gender issue in the sense that far fewer women chew it than men and that creates conflict within families and puts strain on relationships. Khat makes men less available to their families and affects their chances to get employment. Some women also imply that khat negatively affects male sexual drive.

7.0 ACTIONS AND RECOMMENDATIONS

In regard to recommendations the key issue is to help people at the **right time** and in the **right place**. This research recommends:

7.1 Actions

- Place services not only where people in need are located but when they need them and at an appropriate time (1-4pm).
- Choose settings closer to where substance users are or where they gather.
- Give faith a role in service delivery. Contributions from worshipping places are to be welcomed as they can play a vital role in changing the behaviour of the individual and are well suited to give guidance to the community on this issue.
- Help peer groups to make use of their time with leisure, reading, sports, community events, tours and visiting gyms.
- Give incentives to get involved (i.e. meeting travel costs, providing refreshments and lunch for the day as necessary).

In regard to khat specifically, the research has identified issues and recommendations discussed in section 7.2.

7.2 Sense of Identity

Somalis need alternative places to khat houses in which they can gather and socialise. They need more information on existing leisure facilities and encouragement to take part in leisure activities. Young people in particular need a place of their own, such as a social club or centre. They would also benefit from sports and cultural events being organised for them. In other words, what is needed are places where Somalis can feel a sense of belonging independent of khat chewing.

7.2.1 Education, training and jobs

The experience of other BME communities in regard to employment prospects is not a model of hope for the Somali community. Nevertheless, schemes and projects that may help Somalis access education and training courses need to be developed as a first step.

7.2.2 Khat users

Somali people can be educated on the social, financial and health risks of khat chewing. This, at least, will give some choice while the main problems of the community are being addressed.

Our experience suggests that telling people to stop altogether will have few results unless an alternative can be offered. It is better to advise people to restrict their chewing:

- restrict chewing to weekends only
- do not chew on consecutive days
- do not chew more than one bundle at a time
- chew earlier in the day and leave as early as possible
- avoid chewing in congested smoke-filled rooms
- clean the mouth thoroughly after chewing

There was a leaflet produced 10 years ago by Healthy Options Team and the former Health Strategy Group (now Social Action for Health), which reflected the above messages.

Endnote

The recommendations and findings of previous research deserve acknowledgement for their implementation. These include CSC Regeneration & Research Consultants (2004), Welfare Centre and Centre for Social and Evaluation Research, London Metropolitan University (2002)

This report also must be read in the context of the Centre for Ethnicity and Health's report on Drug Misuse Needs and Community Engagement produced in May 2005 for the Department of Health. The report identified 7 themes: (1) diversity of the community concerned; (2) levels of awareness and knowledge about drugs,; (3) religious perspectives; (4) the links between drugs, deprivations, disadvantage and discrimination, crime and drug dealing; (6) crime and drug dealing; (7) drug users and their experiences of services.

Acknowledgements

This report acknowledges the contribution of many people and organisations without which this work would not have been possible. Most importantly are the community workers and clients who generously gave their time to respond to questionnaires and attend focus groups. The project was funded by Drug and Alcohol Use for London and their support for this research is gratefully acknowledged.

St. Botolph's was one of the original sponsors of the work. Thanks to Jez Buffin from Central Lancashire University (ethnic unit) and Anna Collard who gave useful comments on questionnaire drafts. Thanks to David Gingell who has shown his full support for this project. Thanks also go to Mind in Tower Hamlets: Somali Mental Health Project and to Dezlee Dennise (Tower Hamlets Community Drug Team) who facilitated the Somali Community Workers focus group discussion. Appreciation also goes to the volunteer from Alhuda Mosque who helped the research tremendously, SAFH, Women's Health and Family Services and Tower Hamlets Community Drug Action Team. We are also grateful to Azad Hussein who designed and developed the database for the questionnaire and Kim Donahue for her editorial input.

Appendix A

**Somali Healthy Living Project
Questionnaire**

Name of Interviewer: _____

Date: _____

We, Community Organisations Forum, are conducting a research on behalf of Drug and Alcohol Services for London to find out the needs of Somali community in Tower Hamlets in regard to substance misuse; and would appreciate your help by answering the following questions. Please tick or circle as appropriate. Please note that interviews must take place in Tower Hamlets.

A) Substance Use

1. Do you know any Somali person who;

a. Chew khat? Yes [] No []

b. Drink Alcohol? Yes [] No []

c. Take substances Yes [] No []

(cannabis, heroin etc)

i) If so, what type of substance do they take? _____

2. How many out of every ten of people you know personally (e.g. family members, /friends/fellow students/colleagues etc), do you think

a. Chew khat? 0 [] 1-2 [] 3-4 [] 5-6 [] 7-8 [] 9-10 []

b. Drink alcohol? 0 [] 1-2 [] 3-4 [] 5-6 [] 7-8 [] 9-10 []

c. Take substances? 0 [] 1-2 [] 3-4 [] 5-6 [] 7-8 [] 9-10 []

(Cannabis, heroin etc)

d. Drink alcohol after chewing khat 0 [] 1-2 [] 3-4 [] 5-6 [] 7-8 [] 9-10 []

3. Of those you know, in a week how often do they;

a. Chew khat? Once [] two-three [] Four-five [] Six-Seven []

Don't Know []

b. Drink Alcohol? Once [] two-three [] Four-five [] Six-Seven []

Don't Know []

c. Take substances? Once [] two-three [] Four-five [] Six-Seven []

(Cannabis, heroin etc) Don't Know []

4. Where do these people chew khat/drink alcohol/take illicit drugs (Please tick):

Place	Chew Khat	Drink alcohol	Take illicit drugs
At home	[]	[]	[]
In Marfashes	[]	[]	[]
In cafes	[]	[]	[]
In Pubs	[]	[]	[]
In the Street	[]	[]	[]
In nightclubs	[]	[]	[]
Other	[]	[]	[]

5. Do you think that these people:

a. Chew Khat too much? Yes [] No [] Don't Know []

b. Drink too much alcohol? Yes [] No [] Don't Know []

c. Take too many substances? Yes [] No [] Don't Know []

(cannabis, heroin etc)

6. What do you think is the percentage of the Somali population here in London/Tower Hamlets who:

a. Chew Khat? Men [] Women []

b. Drink alcohol Men [] Women []

c. Take substances? Men [] Women []
(Cannabis, heroin etc)

7. Do you think that some social groups chew khat/drink alcohol/ take substances more than others?
Yes [] No []

If yes, which social groups are most likely and which groups are least likely to do so? (Please circle as appropriate)

Substance:	Khat	Alcohol	Substances (cannabis, heroin etc)
Group:			
Men (under 18)	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>
Men (18-25 yrs old)	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>
Men (26-39 yrs old)	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>
Men (40 yrs +)	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>
Women (under 18 yrs)	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>
Women (18-25 yrs old)	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>
Women (26-39 yrs old)	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>
Women (40 yrs +)	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>	Most Likely <input type="checkbox"/> Least Likely <input type="checkbox"/> Neither <input type="checkbox"/>

8. Do you think the users of these substances (khat, alcohol, cannabis, heroin, cocaine crack, etc) got enough sleep on regular basis? Yes [] No []

If not, please tell us why not? _____

9. Do the users of the above sacrifice essential items (like food) to purchasing these substances? Yes [] No []
if yes, please tell more how do they do that? _____

II) Effects of substances misuse

10. Rank the following substances according to how they affect the Somali community (please use the scale of 1-5, 1 causing the most problems and 5 causing the least)?

Substance	1 (most)	2	3	4	5
Khat					
Alcohol					
Cannabis					
Heroin					
Cocaine					
Crack					
Other drugs					

11. Do you see the use of these substances as increasing or decreasing in the Somali community at the moment?

Substance	Increasing	Decreasing	Don't Know
Khat	[]	[]	[]
Alcohol	[]	[]	[]
Cannabis	[]	[]	[]
Heroin	[]	[]	[]
Cocaine	[]	[]	[]
Crack	[]	[]	[]
Other drugs	[]	[]	[]

If you answered increasing to any of the above, please explain why do you think so?

12 Has the use of any of these substances affected your life directly?

Substance	Yes	No
Khat (1)	[]	[]
Alcohol (2)	[]	[]
Cannabis (3)	[]	[]
Heroin (4)	[]	[]
Cocaine (5)	[]	[]
Crack (6)	[]	[]
Other drugs (7)	[]	[]

If so, what problems do these substances cause in the community in relation to each substance mentioned?

Domestic Violence [] affects children [] financial difficulties []
 Commit petty crime [] anti-social behaviour [] loss of work []
 Depression [] Shame [] family breakdown []
 Health problems [] lack of nutrition []
 Other [] please specify _____

13. What do you think the impact would be if khat were banned in Britain?

Positive [] Negative []

14. Please explain how?

III) Services and Solutions

15. Do you consider that you have any problems relating to khat, alcohol or substances affecting your daily life?

Yes [] No []

16. If yes, have you ever sought counselling or support for these problems?

Yes [] No []

17. If not, why do you think it is so ?

18. In general, do you think Somalis use counselling services? Yes No
19. If you answered no, why do you think it is so? _____
20. Have you ever sought help from welfare services? Yes No
21. If not, why do you think this is? _____
22. Do you think that there are any ways in which Somali persons with substance problems can be helped?

23. Do you think that the authorities in the UK (London Borough of Tower Hamlets, health services and central government) have done enough to help the Somali community use support services? Yes No
24. Do you have any suggestions on how to help the Somali community use support services more?
What help do you think people need to avoid substance misuse?

IV) Profile of Interviewee:

25. Gender: Male female
26. Age Group: under 18 18-25 yrs old 26-39 yrs old 40 yrs +
27. Family status:
Single single parent a couple with a couple without children
Single parent etc
28. Length of time in UK: born here less than two years 2- 5 years
5-8 years 8-10 years 10years and plus
29. Housing status: temporary accommodation permanent 'nomadic
rough sleeper other
30. Type of accommodation hostel room flat house
31. Immigration status; Asylum Seeker , Full Refugee status , Indefinite Leave to remain , British citizen , other please specify _____

Thanks for your collaboration and patience. For more information and the findings of this research please contact Mohamud Ahmed, Community Organisations Forum, Norvin House, 45/55 Commercial Street, London E1 6BD. Tel; 020-7426-9972; or email: mohamud@towerhamlets.org.uk

Appendix B

Somali Healthy Living Research A guide for group discussions

Guide for group discussions

The questions listed below are a general guide for the facilitator of the group session. The facilitator of each discussion shall probe out if any unforeseen, interesting or useful points are risen from the discussion.

Sessions must be tape-recorded with the permission of participants; otherwise an assistant must take notes. The group facilitator can use any participatory tools as deemed necessary.

N.B. The group facilitator should, under no circumstance, ask a leading question nor answer these questions at all.

Khat chewing

How problems people face in the UK are different from those you experienced back home?

How khat chewing in Somalia was different from the one in the UK?

How khat chewing helps or damages health as you think?

Are there any problems related to khat chewing? If yes, please tell us.

Would you elaborate the times of khat chewing in the UK?

Does it have any implications to family relationships?

What about the time keeping of khat chewers (i.e. punctuality, keeping appointments etc)??

If you think there are detriments related to khat, please tell us something about them in terms of culture, religion, and social acceptability and to personal income?

Alcohol

How drinking alcohol in Somalia was different from the one in the UK?

Are problems with alcohol people face in the UK are different from those experienced back home?

Do you think there are problems with alcohol? If so, would you tell us about them?

Does alcohol help/damage health as you thinks? If so, please explain.

Would you elaborate the times of alcohol use, during the day, in the UK?

Does it have any implications to family relationships?

What about time keeping and alcohol (i.e. punctuality, keeping appointments etc)?

Compare khat and alcohol in terms of culture, religion, social acceptability and detriments to personal income?

Are you aware any other substances people take in this country? If so please name them?

Cannabis

Did people use cannabis in Somalia?

If so, how cannabis use in Somalia was different from the one in the UK?

Are there cannabis problems people face in the UK? If so, please explain

Does cannabis help/damage health as you think? If so, please explain.

Would you elaborate the times of cannabis use and where it is used in the UK?

Who uses it as you think? Who uses it most as you think?

Does it have any implications to family relationships?

What about time keeping and cannabis users (i.e. punctuality, keeping appointments etc)?

Compare khat and cannabis in terms of culture, religion, social acceptability and detriments to social income?

Crack

How crack in Somalia was different from the one in the UK?

How problems people face in the UK are different from those you experienced back home?

How crack helps/damages health as you think?

Do you think there problems related to use of crack?

Would you elaborate the times of crack use and where it is used in the UK?

Who uses it as you think? Who uses it most as you think?

Does it have any implications to family relationships?

What about time keeping and crack users (i.e. punctuality, keeping appointments etc)??

Compare khat and crack in terms of culture, religion, social acceptability and detriments to personal income?

Heroin

Did people use heroin in Somalia?

How heroin use in Somalia was different from the one in the UK?

Are there problems related to heroin use people face in the UK? If so how different from those they had in Somali in relation to heroin use?

Does how heroin use help/damage health as you think? If so, please explain

Would you tell us the other problems related to heroin?

Would you elaborate the times of the day heroin is used and where it is used in the UK?

Who uses it as you think? Who uses it most as you think?

Does it have any implications to family relationships?

What about time keeping of heroin?

Compare khat and heroin in terms of culture, religion, social acceptability and detriments to income personal?

Seeking help

What is misuse as you think?

How would you know if someone is misusing any substance: khat, alcohol, cannabis, cocaine, crack etc?

Where do you think people go for help in regard to misuse of above anyone of the above substances?

Do you know anyone who sought help from a counselling service? If yes how that person felt about their help?

Are there any traditional way people help and support each other when they have problems of substance misuse?

Which social group (men, women, old, middle aged, young people, unemployed etc) need most help than others? And please elaborate why it is so?

How do you think individuals of problems with substances misuse can help themselves?

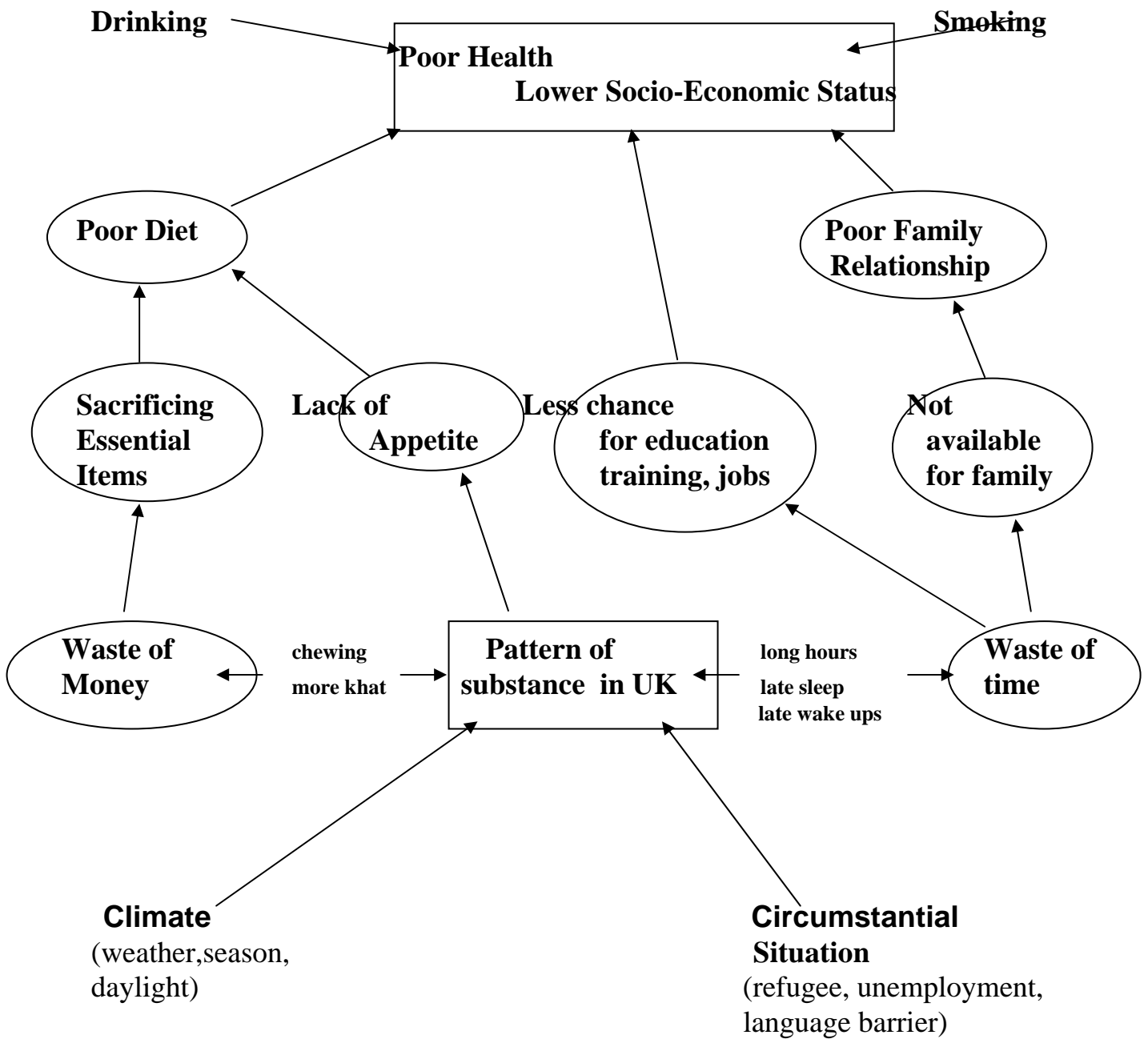
How Somali community groups and other voluntary groups can help them?

How would you like authorities, local and central government, help Somalis when it comes problems with substance misuse like Khat, alcohol, cannabis etc?

Appendix C: Challenges faced and lessons learned within the course of the project

- Filling in questionnaires from members of the community proved more difficult than expected.
- Unreliable assistance from Somali community workers.
- Half-hearted commitments from Somali community workers.
- Scepticism from community workers in regard to research. In their experience studies were rarely translated into deeds.
- Many community workers pledged their support, however, many failed to ask clients to complete the questionnaires.
- Bad experience with Project Liban that decided to carry out similar project.
- No expenses were budgeted for focus groups.
- Consistent low turn out among steering group members. Changing venues did not help. Different people turned up at every meeting. Very few members came on a regular basis. In some meetings only two people turned up.
- The research did not get the full support expected from the University of Lancashire 's Ethnic Unit. They did however comment on the questionnaire, though very late.
- Research fatigue in the community, as project Liban and others were carrying out similar projects.
- The lead researcher was male, which made it difficult to recruit female interviewees.
- While it was quite easy to find men in the cafes, there are no such places for Somali women.
- Somali community workers tend to be in the age range of 30-40 years or above which may have contributed to interviewees not being as young as expected. Another possibility is that Somali youth do not use most community services.
- Ramadan slowed down activities. August 2004 also slowed the work as some stakeholders were away from their desks during that month.
- Resources allocated for the research were meagre and were enough to cover the cost hiring meeting rooms, at least a female interviewer.

Appendix D: The Patterns of Khat chewing/substance use



NB The patterns of khat chewing/substances use refer to :

the period of time khat is chewed (on average)

how much khat is chewed, how many times a week

where it is chewed and the type of khat chewed.

It also refers to what else is taken with the substance concerned (cigarettes, alcohol, tea, coke etc.)

Appendix E

Women's focus group discussions on khat

1. Positives and negatives, if khat is banned in the UK?

Positives	Negatives
<ul style="list-style-type: none">• Not widely available• No access - encourage people to give up• Users will have more money to spend on their family• Social behaviour will change• • Less family breakdown and domestic violence• Better opportunity to go for education and employment• Healthy lifestyle including mental health and physical well-being	<ul style="list-style-type: none">• Expansive -black market• Possibility to substitute khat with alcohol and drugs• For young generations it wo not make any difference if khat is banned• For older generations used to chewing, banning will not make them switch to alcohol or drugs• To those addicted to khat banning may encourage them to take more alcohol

2. What are the effects of khat chewing to the Somali community?

• Financial damage, particularly people with low-income • family breakdown (divorce, separation, domestic violence etc) • social isolation • depression • causes unemployment • less ambition and self-esteem • lack of sexual drive, especially men • it affects health i.e. causes lack of sleep, malnutrition, constipation and spread of airborne diseases.

3. Which groups are more likely to chew khat?

Men (80%) and women (20%) are more likely to chew khat.

Age groups: 40 years of age and above (men) tend to be regular users, 30 years of age and older

3. What do you think are the factors causing increase of khat consumption in the UK?

• Unemployment • difficulties to communicate: language and cultural barriers • lack of awareness/education on how the system works • breakdown of large family network/support mechanism • As the result of civil war and being refugees leads people to chew khat.

Appendix F

Notes on khat & mental health (1st November 2004)

- There is no detailed scientific study directly tying khat to mental health.
- There is an article on the internet by Pentellis. That was done a long time ago and he studied only two people.
- As things stand now there is no link between khat and mental health.
- No one knows the line that separates between use and misuse of khat chewing. The Home Office funded Mind in Tower Hamlets to research the matter.
- Suidies/researchers? tend to extrapolate, as khat is a stimulant as is amphetamine.

Services

- There are no culturally sensitive services. Among the Somali community it is a taboo while people admit khat problems and consequently advised to reduce it. So it depends on the substance we are talking about. They might be open on one and in a denial on another.
- There is a strong link between khat and alcohol.

Mental health

- Several years ago among the Somali community in the UK, mental health problems were thought to be something you had to live with (Ruux waalani wuu ladnaaday mooyee wuu bogsaday ma leh); which literally means someone could recover from mental health problems but not fully.
- Now that has changed. Mental health organisations raised this community's awareness on mental health. People now talk openly about stress, depression etc. The same thing will happen if substances misuse issues are raised in the community.
- Subsequently people will take up services. It is a long journey.

HIV

- People are now warming to the issue of HIV and AIDS. Several years ago it was a taboo to talk about it. People need sensitive services tailored to their needs.

Khat abuse and misuse research by Mind Tower Hamlets

- It is a pilot project looking at the use, misuse/abuse of khat chewing in the Somali community in Tower Hamlets.
- This research will start on 1 October 2004 and finish by 1 October 2005.

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