



Khat: current views from the community around the UK

Findings from Community Engagement Forums

Jez Buffin, Yaser Mir and Imran Mirza

NATIONAL DRUGS & RACE EQUALITY COALITION

NDAREC

Established in 2008, the National Drugs & Race Equality Coalition (NDAREC) is comprised of national, regional and local organisations with a special interest in promoting the needs of Black and minority ethnic populations in drug and alcohol treatment. NDAREC exists to provide leadership for and a critique of race equality within the national drug and alcohol strategies.

Acknowledgements

NDAREC gratefully acknowledges the support and contributions from the following individuals and organisations:

Hassan Isse, Consultant, West London RETI

Aboker Ajab, Khat Development Worker, DASH, Haringey

Jean Smith, Nilaari Bristol

Sue Bancroft, Bristol DST

Barnaby Webb, ComPaSS, Northampton

Abade Ahmed, Northamptonshire Somali Community Association

Mohammed Maigag, Haringey Somali Community & Cultural Association

Laila Jama, Haringey Somali Community & Cultural Association

Grantley Haynes, Birmingham and Solihull Mental Health NHS Foundation Trust

David Thomas, Manchester Drugs & Race Unit

Fariha Jama, SEVA, Manchester

Joanna Hicks, ISCRI, University of Central Lancashire

Yaser Mir, NDAREC & ISCRI, University of Central Lancashire

Imran Mirza, NDAREC and ISCRI, University of Central Lancashire

Shahid Ramzan, Manchester Drugs & Race Unit

David Marsh, Arena Rooms

Plus all those community members to whom we promised anonymity but who turned up to and took part in one of the forum events. This report would not have been possible without you.

Contents

NATIONAL DRUGS & RACE EQUALITY COALITION

Introduction

Established in 2008, the National Drugs & Race Equality Coalition (NDAREC) is comprised of national, regional and local organisations with a special interest in promoting the needs of Black and minority ethnic populations in drug and alcohol treatment. NDAREC exists to provide leadership for and a critique of race equality within the national drug and alcohol strategies.

Following a successful conference in March 2008, at which a number of BME delegates highlighted the lack of impetus and leadership surrounding khat, NDAREC decided that khat would form one of it's key priorities for 2008/9. Timed to coincide with the Home Office review of khat, NDAREC arranged a series of community engagement forums to gather up-to-date information from the communities most affected by khat use. The aim of this report is to summarise and amalgamate the findings from each of these forums; to contribute to the national picture of khat use from the community's viewpoint; and to make recommendations for the way ahead.

Since autumn 2008 khat has received increasing attention among parliamentary figures with questions being raised in both the House of Lords and the House of Commons. Much of the debate has centred on the issue of whether khat should be controlled under the Misuse of Drugs Act (1971). The control of khat under the Misuse of Drugs Act raises a number of serious implications from the race equality point of view, since it is BME communities who are overwhelmingly the largest users of khat. Furthermore the concentration of the debate around criminalisation risks over simplifying some of the BME communities main concerns and marginalising some of its needs, particularly in relation to treatment and information, and wider issues around poverty, discrimination and social exclusion.

Methodology

NDAREC's national development officer contacted community and voluntary sector organisations and local service providers based on contacts made at the conference in March 2008. Information about the purpose and nature of the forums was distributed through these networks and interested stakeholders were invited to a pre-meeting to discuss subject matter and practical requirements for the actual forums.

Forums were arranged in West London, Northampton, Manchester[1], Birmingham and Bristol between October 08 and January 09, with a women-only forum taking place in April 2009. In total over 100 people were consulted through the forums. Although the majority of participants were members of the Somali community, members of the Yemeni and Ethiopian communities were also able to participate.

Attendees at each forum came from a variety of community and professional backgrounds. Each was attended by approximately 20 people. The topic areas covered in the programme for each event were:

- Impact of khat use on families and the wider community;
- Treatment provision and support needs for khat users; and
- Legislation issues

1 The Manchester forum was scheduled for December 4th 2008. A severe weather warning on the day seriously disrupted transport and the event had to be cancelled. An existing multi-agency khat development group was thus used to provide an overview of the key issues for Manchester and to explore issues of good practice. The report for this can be seen in the Appendix section of this report.

Impact of khat on families & wider community

Key Themes - Families

- Khat plays a big role in the breakdown of families
- This is especially harmful in under-established communities
- The stimulant effect of khat leads to sleep disturbance which in turn impacts on children
- The 'lion's share' of family resources are often spent on khat
- Increased number of Somali children having problems at school
- Increasing numbers of women chewing khat

Young people

- Somali young people are using khat in 'excessive' amounts
- Khat use among young people could be leading to the use of other substances
- Increase in anti-social behaviour among Somali youths
- Young Somalis disengaging from education and achievement pursuits
- Young people are using khat in conjunction with alcohol
- Lack of engagement between Somali young people and the police
- Custodial sentences among Somali Young people has increased

Community issues

- Amongst the 15,000 Somalis living in Southall, an estimated 5000 are khat users
- In Southall, around 50 cases of dual diagnosis cases have been identified (i.e. problems associated with khat use and mental health)
- Women have been reported as running some khat houses or *mafreshi*
- Although generally khat use is thought to be prevalent amongst Somali, Ethiopian, Yemeni and Eritrean communities, in Southall it is thought that most users are Somali, with Ethiopians being the most likely to be khat traders
- Other communities complaining of antisocial behaviour as Somali groups coming out of *mafreshi* late at night
- Integration into mainstream society very low among khat users
- Proximity of airport (Southall) means large supply of fresh khat
- Serious impact of khat use on employment and work-life
- Khat used as performance enhancer in some jobs
- Link with domestic violence
- Lack of diversionary activities
- Community centres and community gathering places are needed
- There is a perception among many users that khat use is associated with the enhancement of sexual performance/ fertility

Women

- Family resources spent on khat
- Childcare often neglected by fathers
- Poor role models for male children
- Sexual needs of women not met
- Concerns that young people are chewing in excessive amounts
- Women also chewing more frequently alone and in groups
- Women-only *mafreshi* are now appearing
- Comparison with country of origin

Family and wider community

The impact of khat use on the family unit was raised in all of the forums. The following table (pictured right) was drawn up by participants at the Bristol forum. It compares the differential effects and impacts of khat use on men, women and children/young people respectively.

Khat has been responsible for an increasing disruption in family life. Although this is not new information, it was felt that nothing had yet been done to stem this problem. The Somali community in many parts of the country was seen as relatively under-developed and lacking the capacity and organisation of some other BME population groups. This means the family unit is even more crucial as a support network.

"The fathers, who are seen as head of the family, are becoming nocturnal fathers"

Men	Women	Young People/Children
• Wellbeing and togetherness • Financial impact • Unemployment/under employment • Relying on benefits • Mental illness	• Relationship breakdown • Same issues as those in 'men' column (women use too) • Stress • General decline in health • Loneliness	• Under achievement in education • unable to go to school • Lack of support from parents (who chew khat) • Care, growth and development suffers – parents not carrying out their duties • Money/benefits go on khat therefore depriving children • Financial pressures can lead to children turning to selling drugs • Normalisation of drug use

Participants at the forum raised concerns that khat use could be a major drain on their resources. Families with relatively small incomes could find themselves with little or no money to spend on food and daily living essentials as what little income they had was spend on khat. Men who chewed khat were also often absent from the family home at key times – either chewing or recovering from chewing sessions. This resulted in families being put under considerable stress.

It was also noted that the root causes of problematic khat use, such as integration issues, traumatic experiences in Somalia, a lack of opportunities etc. could also contribute to the domestic issues in their own right. One attendee stated that the cultural family dynamics rooted in Somalia are challenged by the experiences of moving to England and the adjustment has been problematic.

Gender issues

There was a perceived link between use of khat and domestic abuse.

The sleepless nights of the khat user has a particularly detrimental effect on the family. One of the effects of khat is that after a session of chewing, the user wants to be in a calm environment. When the children are getting ready for school, the father who might have used khat all night will not be there to share the burden. This, in addition to the large proportion of family money spent on khat, inevitably leads to breakdown in relations with their spouse, with reports of increased domestic violence, and this impacts on the children even more severely.

It was also reported that the widely held notion among men that khat use can lead to enhancement of sex drive and the perception that it also increases fertility is a key factor when addressing the barriers to reducing khat use.

Khat has been seen as a predominantly male issue among those from the immigrant communities from the Horn of Africa and Arabian Peninsula. However, it was also reported here that some women are now using khat but in a solitary and non-social setting, often when the children are in bed and the father is out with other men during the night.

"The women are thinking, 'if you can't beat them, join them'. What can they do?"

In Southall it was claimed that women are now running some of the *mafreshi* in the locality. This poses problems in terms of engaging women around the khat issue since there is an economic dynamic to the issue now.

Young people

The perceived increase in khat use among young Somalis was a cause for concern. The pattern of use in this scenario tended to be use of excessive amounts in short spaces of time as opposed to among the adult population where consumption, although often excessive, takes place over a longer period.

There was a perception that the use of khat could be leading to the use of other substances. There is evidence of khat use with alcohol which poses issues in terms of religious conflict since alcohol is prohibited in Islam.

The increase of Somali youths engaging in anti-social behaviour is a worrying trend although it is not clear if this is directly due to khat use or wider social issues. It was mentioned that if the parent/s are using khat this will inevitably lead to poor parenting. Somali young people have

been seen to disengage from education and meaningful activity. Although this is not proven to be linked with khat, it is evidence of the risk of social exclusion if khat is being used more by young people.

An additional impact is that on the health and behaviour of young people in relation to street groups, gang and other activities, due to the issue of missing fathers. Neglect, parenting, schooling and education are important to mothers in these communities, where khat use, like alcohol has linkages to domestic violence in some households.

A growing trend is that the use of khat sticks that are chewed by children, often unbeknown to parents.

Youth congregate in and around khat houses. Khat is almost culturally accepted. Most contributors felt that khat use has become the primary gateway to the use of harder drugs such as heroin, crack and cocaine.

"They** [young Somalis] **are hanging around the streets more. The Asian youth groups are beginning to find this threatening"

Concern was expressed about apparent increases in school absence among children from the Somali community.

Employment and economic status

Some men believe their performance at work is greatly enhanced by khat-chewing. This is especially the case where the work in question involves working nights. Examples were given of men who work as security officers and warehouse/factory nightshift workers who use khat as a means of getting through a shift. The stimulant properties of khat are known to temporarily inhibit tiredness and sleep as well as increasing alertness and confidence.

Conversely, there were just as many examples where the use of khat has led to poor performance at work and has caused some to be unable to make it to work after a session chewing. Some in the group knew of people who had lost their job apparently for this reason.

More generally there was a perceived link between unemployment (or under-employment) of particularly men and problematic khat use. Men who are out of work chew khat as a way of filling their time. Excessive use then makes it increasingly unlikely that the user will find work.

"Unemployment can be a cause as well as an effect of khat chewing"

Poor economic status such as for those on state benefits is likely to lead to (increased) khat use due to the time available to do so. It is less likely that a problematic khat user will be motivated to find work and hence will remain in a poor economic class.

"We are underdogs"

Khat and Islam

One of the forums debated the issue of khat within an Islamic context. It was proposed that khat was not documented as having being discovered at the time of the Prophet Muhammed and that there is therefore no mention of its use or guidance on whether its use is permitted in the teachings of the prophet. Five hundred years later, khat was discovered in Yemen and used in much the same way as it is now. A number of sheikhs gathered to have a discussion on whether the chewing of khat was halal (permitted in Islam) or haraam (prohibited) and the outcome was that the responsibility of khat use was passed to the user – 'if the use of khat harms your soul or religious beliefs, do not use it'.

A story illustrates this choice: Two sheikhs are discussing the issue whilst watching a man working on painting a building whilst intoxicated. The question one sheikh asked was, 'is this man able to carry out his duties effectively?' and the discussion reaches the conclusion that, yes, his use does not impede his work. The point of this story is that members of the Somali community who follow the teachings of one particular sheikh may believe that khat use is harmless and halal while those who follow the teachings of a different sheikh may deem khat use haraam. This could explain the division of opinion on the issue within the Somali community. Currently the approach of some sheikhs is to discuss the benefits of stopping use while others can issue a 'fatwa' (decree) to prohibit use.

It was suggested that the religious aspect of khat use needs to be discussed and explored further.

Southall specific issues

It was estimated that about one third of Somalis in Southall are regular users of khat. It was reported that there were around 50 dual diagnosis cases in Southall related to khat.

There is a risk of conflict between communities as there have been complaints of antisocial behaviour as khat users leave the *mafreshi* at night, in an intoxicated state. There were concerns that inter-community relations will deteriorate in Southall.

The view of the forum was that 95% of khat users are of Somali origin and that Ethiopians are generally regarded as traders.

Given it's proximity to Heathrow airport, the supply of khat is a significant issue for Southall:

"Heathrow is just around the corner. Every day at 8am we get a fresh batch in…almost delivered to the door"

Treatment provision & support needs

Key Themes

- Khat users are not getting support
- High numbers of khat users across the boroughs
- Urgent need for a mapping exercise to verify extent of the problem
- Perception in the community that treatment is unavailable for khat users
- No khat-specific Primary Care Trust service
- GPs ignoring signs of khat use
- Too few Somali staff working in the health sector
- No khat specific workers
- Somali support group located amidst high Somali population which poses confidentiality barriers for users
- Outreach service urgently needed
- Good practice identified in Haringey and Bristol
- Need for engagement with mosques
- Greater provision of psychological therapy including CBT
- Finance for dental treatment
- Information not reaching users
- Short training for khat users
- The provision of psycho social interventions for khat
- Single sex groups (male and females)
- Education and awareness sessions
- Satellite delivery of services in Mosques
- User and carer involvement group

The nature of health needs and the lack of treatment options

The forums noted that there are often big differences between the patterns of khat chewing in the UK and in countries of origin, such as Somalia. In the UK many people are vulnerable with nothing to do and many hours to spend – thus there is the potential for users to consume khat in far greater quantities. Cultural norms would historically have placed boundaries around both the quantities of khat consumed and the amount of time spent consuming khat. In the UK there are issues about the strength and size of bundles and it is not uncommon for users to consume more than two bundles at a time. Problematic chewing was commonly felt to develop within 3-4 years of arrival in the UK, once traditional cultural norms had broken down.

High levels of use was said to result in both physical and mental health problems, including intestinal damage, insomnia and depression.

Generally there was a perceived lack of support and treatment, although two examples of good practice were sited.

There is no structured treatment option for khat users. GPs are unaware of khat use. Users are reluctant to mention khat use during a consultation and GP's do not know enough about khat use to ask about it.

"Someone I know went to their GP and mentioned their khat use and the GP said 'what is khat?"

In addition, there are few or no khat-specific services for GPs to refer users to.

Most forum members were unaware of anywhere that users could go to get help.

Good practice:

In Bristol, Nilaari provide a range of support services to khat users. They have good links to a range of Somali community organisations and will provide support and advocacy to users including those with mental health problems. They also work closely with GPs.

In Haringey, health promotion work is being carried out in the *mafreshi* in a tier 2 initiative. This involves checking the *mafreshi* for adequate ventilation to help prevent spread of tuberculosis (TB). Also, TB nurses are being engaged to provide advice and support to those TB patients who display signs and symptoms of khat use.

GP's and mainstream services will often fail to ask about khat use. They will often deal with the presenting problems without inquiring whether khat use may be a contributing factor or a consequence.

In cases of excessive use there may be a need for a mental health intervention, but the stigma surrounding mental health means that many users and families will be reluctant to engage with this. Fears around in-appropriate or over-medication compound this.

The forums expressed strong concerns about the lack of information and education informing the community of the negative effects of khat and about where to get help. In the absence of appropriate treatment options the need for health promotion was seen as especially important. This could take the form of short training courses for khat users, the community as a whole, and those who work with or

provide services to the community. It was suggested that, given concerns about the rising level of cannabis use by young people in the community, messages about khat and cannabis could be combined.

"Somali users do not come in saying 'I'm a khat user, I need help"

Good practice

It was felt that a culturally appropriate, confidential service is needed by way of a Somali agency, with Somali workers, offering a one stop shop. Such a service could then attend to the issue of khat, with appropriate opening hours (midday to evening) and direct access. Services offered should include awareness, training, community/social space, guidance for social issues/problems and the provision of a supportive social network. Treatment services should be khat-specific but located outside of mainstream drug services and must include looking at issues around housing, immigration and income.

Where such provision does not already exist, there is a need for community and social spaces that are both alcohol and khat free. Such spaces could contain activities such as pool tables and other games whilst also providing a nexus for information and guidance on a range of issues. The focus must however remain on the social side, so as not to stigmatise users.

In order for users to successfully change, it was felt that the socio-economic position of clients would need to be addressed too. Poverty, unemployment , under-employment and social exclusion were felt to be both determinants and consequences of problematic khat use.

The process of seeking asylum and applying for refugee status was seen to significantly add to the problems faced within the community. Unresolved cases could drag on for years, with compounded problems around not being allowed to work and difficulties finding accommodation etc. These were felt to be a major factor in contributing to a sense of hopelessness thus increasing the risk of excessive khat use.

It was felt that work was necessary within khat using communities in order to help develop a new culture around khat use, much one has been developed around a new culture of smoking. Mosques were seen as one good way of getting information to the community and of shaping community norms. It was reported that currently there is little no information on khat in mosques and that this is a wasted opportunity. Many khat users attend the mosque and so leaflets would be a first step. Care needs to be taken to avoid causing conflict between members of the mosque however.

It was also suggested that community link workers/support workers should be employed to act as intermediaries between the community and statutory services to create a sense of trust. This could be a role ex-khat users.

It was suggested that regular snapshot surveys should taken to monitor community perceptions about changes in patterns of use and the associated problems. This could include an in-depth study of khat-users in case-study format as well as a snapshot of the extent of current use.

It was noted that there are currently national programmes of work to improve access to psychological therapies, including Cognitive Behavioural Therapy (CBT). Concerns were raised that these programme could develop without any consideration being given to the needs of khat users.

GPs and hospital staff need to be trained in the recognition and treatment of khat problems.

Dental care and access to appropriate dental treatment was a major concern for the community. The health effects of khat use were acknowledged to include poor dental health. Many users in the community were unlikely to get treatment because of the cost of dental treatment and the difficulties of being able to get on to a dentists list.

Legislation

Key Themes

- Community is divided on the issue of classification
- Classification will not mean cessation of use
- Risk of khat supply going 'underground' if khat is classified
- Community agree that nothing has been done
- Concern that many in Somali community who wish khat was banned are not fully aware of the implications of this
- Most people outside the community are unaware of what khat is
- No khat use among general population
- Majority of those present in some of the forums (including women's forum) were pro-ban
- Community sharply divided on ban
- Predicted use of other substances if banned
- High demand for khat in small area
- 6 varieties of khat available, varying in strength
- Establishment of regulated 'khat houses' with access to treatment
- Must avoid creating criminal records for users
- Price of khat would increase with a ban resulting in more income spent on it
- Community needs support before banning khat - need to look at reasons why men chew - unemployment needs to be tackled

Opinions across the forums as a whole were very much divided on the issue of classification, although all of the women at the women only forum were in favour of a ban.

"Of course they should ban it. What are the benefits of khat use?"

This general split is reflective of the reported situation in the wider community.

Some forum members made comparisons with other countries in Europe and the U.S. where khat is illegal and stated beliefs that there is better integration, social cohesion and employment among Somali communities as a result in these countries. Although many in the community say they want khat banned, there is concern that people will simply be expected to stop their use of khat as a result. If a ban were to come into effect forum members agreed that there would need to be a large increase in available treatment.

"How can they make it illegal when there's been nothing in place to treat users? Why not provide adequate info and advice to get help first?"

Other attendees talked about khat as a substance that can cause dependence and noted that those who cannot get khat become agitated.

"People who have chewed for years will not just give up overnight"

Forum members noted and were concerned about the risk of criminalising large sections of the community, including recreational users. There were concerns about criminalising a large swathe of the Somali community and that this will lead to further barriers to integration.

"Somalis are the new blacks"

Some attendees felt that banning khat will simply divert use to other drugs since the root problems will still be present. Other drugs mentioned included alcohol, cocaine and cannabis.

Some were concerned that the price of khat would go up significantly if a ban were imposed:

"At the moment the price is about £10 per kilo. Where it is illegal, the price is about £50 per kilo"

This would have the effect of a large increase of income for khat suppliers while the demand from users may remain unchanged. The danger of this is that people on lower incomes will spend a greater proportion of their money on khat.

Despite the divisions on banning khat, all were in agreement that treatment covering the whole-picture and support were urgently needed. Those that were pro-ban wanted assurances that any ban must come with funding for comprehensive treatment and support packages. Those against stressed that these packages were the only way forward.

It was suggested that greater regulation of khat use might be an option. For example, khat houses could be established where information and advice would be available. Arrangements could be brought in to license vendors, and restrictions on the age of people who can purchase khat could be brought in (i.e. not to be sold to under 18's). Currently there are 4 *mafreshi* in a small area of Northampton indicating a very high demand for khat. There are around 6 different varieties of khat with the strongest known as 'gizza'. This will mean there is a sliding scale of harm associated with different varieties too. This kind of issue could be brought under control with regulation.

Recommendations

1. It is key that planning agencies have access to accurate and up to date information about khat and khat use on a regular basis. NDAREC believes that the khat forums established as a result of this work should be maintained as a means of testing the water around any planned new initiatives and for taking snap-shot pictures on a regular basis.

2. NDAREC does not take any position on the issue of whether khat should be criminalised. The community is not united on the issue and it in not clear whether the potential risks (criminalisation of sections of the community; increase in price; diversion in into other drugs) outweigh the potential benefits.

3. In the absence of any change in legislation NDAREC is supportive of greater regulation of khat houses, perhaps through licensing, and the feasibility of such schemes should be tested, piloted and evaluated.

4. There is currently a lack of effective treatment for problematic khat users. NDAREC believes that a small programme of treatment should be piloted and evaluated, building on the notions of good practice that have already begun to be highlighted. Effective treatment is likely to be delivered in partnership with those communities who are most affected; to include the provision of both khat specific and broader health and social care interventions; to include social space; to cater for the needs of carers as well as users; to include an element of outreach.

5. NDAREC believes that PCT's with significant populations from the Horn of Africa or the Arabian Peninsular should be asked to take specific steps to take account of the needs of these communities as they roll out the new Increasing Access to Psychological Therapies (IAPT) programmes.

6. NDAREC believes that there is a need for a specific and on-going information and harm reduction campaign to be developed and run in conjunction with khat using communities .

7. Local Strategic Partnerships should demonstrate how they are taking account of the needs of khat using communities in actions that they are taking to decrease social exclusion, increase educational achievement, improve employment skills, and capacity build and strengthen local communities.

8. NDAREC believes that the National Treatment Agency for Substance Misuse should consider appropriate mechanisms for ensuring that workers in drug and alcohol services are equipped to deal with and respond to khat related problems. Training also need sot be developed for mainstream health and social care providers.

9. NDAREC recommends that in reviewing the provision of dental carer, the Department of Health takes specific notice of the concerns that the Somali and other khat using communities have in relation to access to dental care.

10. In order to ensure effective roll-out, all of the above recommendations will require national funding and support via the Home Office, Department of Health, Department for Communities and Local Government and the National Treatment Agency with performance management and monitoring through local community safety partnerships, local authorities and primary care trusts who should ensure – as part of local needs assessments – that the needs of khat users and the issues of community inclusion are supported through active partnership and funding activity.

Appendix 1

Khat Users Support Project A summary of Manchester's approach to khat

Introduction

On 22nd December 2008, the National Drugs and Race Equality Coalition (NDAREC), with support from Manchester Drugs and Race Unit (MDRU) held a forum in Manchester to explore the impact of khat use on communities in the North West.

However, attendance on the day was extremely poor, in spite of confirmations being received from a number of key individuals and organisations across the region. As a result, the decision was taken to cancel the event.

It is plausible that the low attendance could probably have been due in part to an extreme weather warning broadcast on the morning of the forum. This may have put people off travelling into Manchester. Another possible reason for this is the fact that the event was publicised through MDRU, which may have led to some confusion about it being open to people from across the North West.

Whatever the reason for this poor showing, it should in no way be seen as a reflection of the significance of khat on communities in the region. On the contrary, the impact of khat is of real concern and has been the subject of a number of detailed studies undertaken in Manchester, Bolton and Liverpool. To this end action is currently being taken to address this issue in each of these localities.

At a recent meeting of the NDAREC Executive, it was agreed that the Drugs and Race Unit would produce a brief outline report of the work currently being undertaken in Manchester. For most parts this approach reflects that which was recommended in the ACMD Report on Khat (2005). It is therefore hoped that the progress of our work will simply serve to confirm the validity of those recommendations and that if adopted, they can make a serious impact on the problems associated with khat in other localities.

Introducing the Khat Users Support Project

Background

The original drive for the Khat Users Support Project (KUSP) came from evidence which emerged from a research study undertaken by the Somali Development Trust as part of UCLan's Community Engagement Programme. The study looked into the impact of khat use on Somali communities in Manchester around education, prevention and treatment.

The research findings identified significant amounts of khat being used, mainly amongst Somali men, who in the main displayed a distinct lack of knowledge about the effects and risks associated with its use. The impact of khat on the family was also sited as a major cause for concern as was the tendency for the male khat user to spend large amounts of their time chewing in khat houses (*mafreshi*). This often meant that much of the responsibility for running the home and raising the children would be left to the women.

Issues of social exclusion, high unemployment and the effects of trauma caused by displacement were sited as major contributing factors to why people use khat. The lack of culturally relevant services in the city to help people from communities affected by its use was also felt to be a serious matter.

The study recommended that urgent action be taken to combat the issues associated with its use, in particular the need for support for khat users and their families. However, the study emphasized that for any interventions to be effective they would need to be rooted in the community, culturally appropriate and preferably led by individuals who are bi-lingual.

MDRU felt that addressing these issues required the development of a specific programme of work and through KUSP plan to raise the consciousness and build the resilience of people in communities where khat is used; at the same time equipping them with the skills, knowledge and assertiveness to make better and more informed choices in relation to khat. The project aims to reduce the harm caused by khat on the users, families and carers through engagement and by supporting access to treatment and other support services.

Overview

The Khat Users Support Project is a multi-faceted project established in 2007 by MDRU and RAMDA (previously known as Somali Development Trust). The project is supported by a number of mainstream and voluntary sector agencies, including Manchester City Council and Manchester NHS, as well as local drug and alcohol service providers and Black and minority ethnic community organisations.

The project operates at both strategic and service delivery levels, and its main objectives are to:

- Establish and maintain an accurate and up-to-date picture of khat use, related health and social issues within the city

- Increase the number of khat users actively engaging in treatment and support
- Increase knowledge and awareness of khat and related issues among communities and professionals
- Assist khat drug users, their families or carers in accessing relevant treatment and support
- Increase the understanding of khat users' needs, and those of their families, carers and wider communities, among policy makers, commissioners and service providers
- Encourage best practice in working with hard-to-reach khat users by enabling access to training and information

The project aims to achieve its objectives through the development and delivery of the following programmes of work:

- Awareness and education
- Screening and referral
- Support in accessing services
- Public relations campaign
- Work with *mafreshi* owners

Central to its operation is the recognition that community organisations are often better placed to access their community than the MDRU and other service providers. Also that without community involvement, knowledge and practice cannot become embedded into communities and sustained beyond the life of the project.

The project aims to develop across the following three distinct phases:

Phase one – Recruitment and DANOS accredited training of volunteers

Phase two – Project design and development

Phase three – Project delivery and evaluation

KUSP Steering Group

The project is overseen by a steering group made up of representatives from a number of agencies, including RAMDA, Manchester Drug and Alcohol Strategy Team, a local Council member, Community Safety Co-ordinator, Manchester Drug Service, Addiction Dependency Solutions, Eclypse - Young People's Service, Specialist Midwifery Service, SEVA Team (Somali Mental Health Specialist Team), Local Regeneration Partnership and a number of local Somali community organisations.

It is hoped that a khat user can be identified to join the steering group at a later stage and provide input from a user's perspective, shaping the project and defining the support users receive.

Steering group members contribute to the project in a number of ways, informing and advising the project to ensure its effective delivery. Drug and alcohol services have allocated staff time to support delivery of treatment interventions within the community and one of these services has also made a financial contribution towards the production of publicity materials. A financial contribution has also been received from DAST.

Recruitment and DANOS accredited training of volunteers

In June 2007, MDRU supported RAMDA to secure a small amount of money through the Community Network for Manchester to commence phase one of KUSP. This saw the recruitment and training of a small team of volunteers (five) to Drugs and Alcohol National Occupational Standards (DANOS) level 2.

The idea was for these volunteers to eventually become the paid staff of the project and whose primary role would be to engage khat users and their families. All of the volunteers went on to successfully complete their training, are now qualified and all but one of them are actively involved in delivering the service to the community. Further funding is currently being sought for project staff to continue their professional development.

Project design and development

In June 2008, funding was secured through Comic Relief Small Grants Programme to kick-start phase two of the project. This saw the development of the specialist khat service and has enabled the project to secure its own premises and establish the basic infrastructure needed to ensure the smooth and coherent delivery of the project.

The work in phase two has seen the development of internal systems, policy and procedures, and the implementation of a clinical governance framework. Bi-lingual publicity and marketing materials have also been produced, as have harm reduction information for both khat users and their families. Further funding was received from Manchester City Council in the latter part of this phase, as was a small contribution from Addiction Dependency Solutions, one of the partners in the project.

The decision was taken to involve the volunteers trained in phase-one in the continued design and development of the project. This was seen as a way to both increase ownership of the project amongst the team and at the same time ensures that the model used is congruent with the needs of the community.

The eventual model decided upon has a number of distinct strands, for example:

- Awareness and education sessions are being delivered targeting both communities and professionals.

- An outreach service undertaking street work, including regular visits to local *mafreshi* where khat users are known to frequent. Project staff are able to provide harm reduction information and where appropriate, screen and/or refer individuals to treatment or other support services.

- Advice surgeries operating from a number of GP practices located in areas across the city where high numbers of khat users are known to reside. As with the above workers are able to offer advice to users and carers, and where appropriate can screen and refer individuals to treatment and support services.

- Specialist khat drop-ins/group sessions are delivered in partnership with treatment services from the premises of local community organisations. Khat users, their families and carers are able to access help and support of specialist stimulant workers and therapists.

- Work is also being undertaken with *mafreshi* owners on the development of a voluntary code of practice. *Mafreshi* owners will also be provided with training in the area of health and safety, and have agreed to allow project staff to visit on a regular basis to engage khat users accessing their establishment.

Project delivery and evaluation

Phase three of the project has now commenced and although still in its early stages, a number of problematic khat users and concerned others have already been engaged through the project. Group sessions have also taken place with both women and young people, and a positive response has so far been received from *mafreshi* owners, although there remains a lot more work to be done in this area.

The main findings

Views about the project

Almost universally, the partners in this project – those being the commissioners, MDRU staff, representatives from drug and alcohol services and community organisations, feel that this programme is innovative, worthwhile and valuable.

The 'asset' model employed in the KUSP is strongly valued. This sees communities as agents capable of contributing to constructing their own solutions, rather than more traditional 'deficit' models which see communities as the sight of problems requiring professional input.

The partnership approach adopted by the project is seen as an example of good practice and will go a long way to ensuring knowledge of khat is both integrated and sustained.

Service users and stakeholders have suggested that the project materials are of good quality and well structured. The information provided has been greatly appreciated.

Service users also value highly the KUSP staff who are said to be approachable. Being from the community has been very helpful and helped to remove some of the barriers to engagement.

Partners found the khat training, which was delivered by a colleague from the Hounslow khat project, very informative. Further requests for training have been received which is encouraging and shows a willingness to increase knowledge and improve practice in working with khat users.

Concerns about the short-term funding of the project remain. However, based on the evidence thus far, we are confident that demand for the project will be high and that if the project continues to deliver this will not be a problem.

A valuable by-product of the programme has been the training and development of the five volunteers. Many had gained skills and confidence from delivering the service to their own communities. The holistic approach to the project is seen as beneficial and ensures that issues related to khat are viewed in wider context.

Khat awareness sessions have thus far been delivered to a number of treatment agencies, job centre plus staff and other local strategic partners. Feedback has been extremely positive and has confirmed that more formal training is needed at both professional and community levels.





NATIONAL DRUGS & RACE EQUALITY COALITION

National Drugs and Race Equality Coalition
c/o ISCRI
University of Central Lancashire
Preston
PR1 2HE

Tel: **07812 653376**