



Pathways to Care for Individuals with Problematic Khat Use and Their Families

Victorian Transcultural Psychiatry Unit



PATHWAYS TO CARE FOR PROBLEMATIC Khat USE:
A pilot study regarding effective strategies for individuals with problematic
khat use and their families

Dr Yusuf Sheikh Omar¹, Dr Anna Jenkins², Ms Marieke van Regteren Altena², Mr Harvey Tuck², Mr Chris Hynan³, Mr Ahmed Tohow⁴, Dr Prem Chopra², Prof David Castle¹

1 – THE UNIVERSITY OF MELBOURNE, DEPARTMENT OF PSYCHIATRY – ST VINCENTS HOSPITAL

2 - VICTORIAN TRANSCULTURAL PSYCHIATRY UNIT, ST VINCENT'S HOSPITAL

3 – NORTHERN NEXUS, ST VINCENT'S HOSPITAL

4 - ELITE ENTERPRISE GROUP PTY LTD

December 11th 2012

CONTENTS

CONTENTS	2
FIGURES AND TABLES	6
ACRONYMS (CODING).....	6
EXECUTIVE SUMMARY	7
Research findings.....	8
<i>Reasons for using khat</i>	<i>8</i>
<i>Perceived benefits of khat use.....</i>	<i>8</i>
<i>Problems associated with khat use</i>	<i>8</i>
<i>Potential harm minimisation strategies for problematic khat use.....</i>	<i>9</i>
Chapter 1: Literature Review.....	10
Introduction.....	10
Background	10
<i>A profile of the Somali community in Australia.....</i>	<i>10</i>
<i>What is khat?</i>	<i>11</i>
<i>Historical background</i>	<i>12</i>
<i>Khat use and gender</i>	<i>12</i>
Global patterns of khat use.....	13
Reasons for chewing khat.....	14
People at risk of problematic khat use.....	15
Social effects of excessive khat use	16
<i>Family breakdown</i>	<i>16</i>
<i>Khat use in young people.....</i>	<i>16</i>
<i>Unemployment and socio-economic issues.....</i>	<i>17</i>
<i>Social integration.....</i>	<i>17</i>
<i>Association of khat use with other legal and illegal substances.....</i>	<i>17</i>
Pharmacological effects	18
Physical effects of khat	18
Mental health effects of khat use.....	20
Is khat a drug of dependence?	22
Legal issues	23
What defines problematic khat use?	24
Treatment of problematic khat use	24
<i>An overview.....</i>	<i>24</i>
<i>Diaspora Somalis.....</i>	<i>25</i>

Chapter 2: Research methodology	27
Introduction.....	27
Rationale for the project	27
Hypotheses.....	28
Aims.....	28
Qualitative research methods	28
Research stages	29
Data collection	29
Focus groups.....	30
Recruitment methods	30
Research settings.....	31
The context of this study	31
Language in interviews.....	31
Participants' demographic characteristics	32
Data analysis.....	35
RESEARCH FINDINGS.....	36
Chapter 3: Reasons for using khat in Australia.....	36
Introduction.....	36
Continuation of cultural practices and cultural identity	36
Socializing with people 'in the same boat'	37
Increasing alertness	37
Escaping from social problems.....	38
Escaping from marginalization and social exclusion.....	38
Influence of peers.....	38
A breathing space from unemployment.....	39
To "kill time"	39
Lack of understanding of its harm.....	40
Chapter 4: Problems associated with khat use	41
Introduction.....	41
Health problems	41
General health and wellbeing	41
Mental-health problems	42
Family problems	43
Stereotypes and taboos	44

Unemployment	45
Neglect of roles and responsibilities	46
Financial burden	46
Waste of time	46
Excessive use causes problems	47
Chapter 5: Perceived benefits of khat use	48
Introduction.....	48
It makes your mind focused.....	48
Sense of creativity and imagination	48
Social inclusion, sense of belonging and identity	48
Sense of freedom and wellbeing.....	49
Less harmful than alcohol and drugs.....	50
It makes business	50
Zero benefit	51
Chapter 6: The association of khat use with other legal or illegal substances/drugs	52
Chapter 7: Social integration.....	53
Introduction.....	53
Poor social interaction.....	53
Khat use does not affect integration.....	54
Chapter 8: where khat is used	55
Introduction.....	55
Houses and specific user-locations	55
Common places	55
Differences between places where men and women chew khat.....	56
Isolated/hidden places.....	56
Chapter 9: Getting help for problematic khat use.....	57
Introduction.....	57
Stigma may influence help-seeking behaviour	58
Financial help from their extended families.....	58
Self-help	59
Providing culturally appropriate services for khat users	59
Role of the mosque as a culturally accepted place of help	60
Chapter 10: Suggested strategies for helping individuals and families affected by khat use	61
Introduction.....	61

Public education and awareness	61
Khat hotline	62
Research and information	63
Public debate and advocacy to raise the issue of khat use	63
Creation of community centres and recreational social activities	64
Helping through religious practices	64
Kill the snake from its head	65
Legal status of khat	65
Chapter 11: The perspectives of primary care practitioners	67
Understanding of khat use	67
Understanding when khat use becomes problematic	68
Problems associated with khat use	68
Care for individuals with problematic khat use	69
Health promotion strategies	71
Harm minimisation strategies	72
Culturally sensitive intervention strategies	74
Assistance for families	75
Research	75
Chapter 12: Conclusions	77
Limitations of the study	79
Significance of the study	80
Acknowledgments	81
APPENDICES	82
References	90

FIGURES AND TABLES

Table 1: Table 1: Somali community focus group participants34

Table 2: Table 2: Primary care practitioner focus group participants37

ACRONYMS (CODING)

The following acronyms were used for coding to refer to participants in this research in the following way:

- EM (Elder male focus group participant);
- EF (Elder female focus group participant); Y (Youth focus group participant)
 - o YM (Youth focus group male)
 - o YF (Youth focus group female)
- CR (Community representative focus group participant)
 - o CRM (Community representative focus group male)
 - o CRF (Community representative focus group female)
- PP (Primary care practitioner focus group)

EXECUTIVE SUMMARY

The purpose of this research was to investigate problematic khat use in the Somali community in Melbourne, Australia, taking into consideration the views of community members and primary care practitioners.

Khat (*Catha Edulis*) is a plant cultivated in Kenya, Ethiopia and Yemen and khat leaves have been chewed for centuries throughout East Africa and Yemen, with chewing inducing feelings of euphoria and a sense of elevated self-esteem. Global trends indicate that the use of khat has increased over the last few decades. In the Western world, including Australia, khat emerged in the 1980s as migrant communities from East Africa and Yemen settled abroad. Because it is grown in parts of Australia, khat is relatively easy to find, and marginalized migrants and refugees, particularly men, are at risk of problems associated with khat use. Trends in use across various age groups have been changing, and there is some evidence that young people are now using khat outside of culturally sanctioned settings.

To understand comprehensively the issue of khat use within the Somali community in Melbourne, the potential harms caused by khat use and the best way to minimize such harms, we adopted an inclusive approach to understand and compare the views of different groups within the Somali community as well as primary care practitioners. This study used qualitative research methods that included six focus groups with a total of 48 participants using semi-structured interviews. The research was conducted over a six month period. The domains identified in the semi-structured interviews were used as a guide for the initial grouping of key themes and data analysis.

Research findings

Reasons for using khat

The main reasons for using khat were identified to be:

- a continuation of cultural practices and identity
- a means of socializing with peers
- improving alertness and concentration
- alleviating the impact of social problems (including unemployment, marginalization and social exclusion by members of the mainstream community)
- a means of spending ‘free time’ in the absence of other pursuits.

Perceived benefits of khat use

The main perceived benefits of khat use were identified to be:

- improvement in concentration, particularly for certain occupational groups such as taxi drivers
- enhancement of creativity and imagination
- facilitation of social inclusion, sense of belonging and identity within a subgroup of the Somali community
- development of a sense of freedom and wellbeing
- financial benefits for people involved in the sale of khat.

Problems associated with khat use

The main problems associated with khat use were identified to be:

- adverse physical health effects (including gastrointestinal problems, dental problems)
- adverse mental health effects (including mood instability, disturbed behaviour, psychotic symptoms)
- social problems (including family breakdown and family violence, poor social integration, social isolation and withdrawal)
- stereotypes and taboos which force some people who use khat to isolate themselves further
- negative impact on level of functioning
- perpetuating unemployment

- neglect of social roles and responsibilities
- financial burden
- inability to spend time on meaningful activities
- adverse impact on wellbeing related to the unhealthy environment of places where khat is used.

Potential harm minimisation strategies for problematic khat use

The main potential harm minimization strategies identified were:

- adopting a health promotion strategy through education regarding the problems associated with khat use
- developing awareness of when khat use becomes problematic
- increasing public awareness of potential harms associated with khat use through the use of written information and other various means of disseminating information amongst members of the community
- the development of community centres and social programs through which people who are at risk of khat use may be assisted to expand their social activities
- providing support through religious activities for those affected by khat use
- adopting universal harm minimization strategies specifically tailored to khat use
- encouraging mainstream drug and alcohol counselling services to provide necessary assistance
- focusing on established users, who are generally mature older men, and younger men who are at risk of problematic khat use as well as other substance use
- having further discussion and debate regarding the legal status of khat
- developing culturally sensitive intervention strategies that may use an outreach approach
- engaging khat users and their families in order to provide information and also to conduct further research to understand the social, economic, and health impact of khat use in this group.

CHAPTER 1: LITERATURE REVIEW

Introduction

The chewing of the leaves of the shrub *Catha edulis*, otherwise known as khat, has a deep rooted social tradition particularly in the countries of Yemen, Somalia, Djibouti, Ethiopia and Kenya. Khat was previously used as a performance enhancer by farmers in Yemen (Klein, 2007). Opinions regarding the status of khat use, particularly in the Somali community, are divided (Klein, 2007). Khat was not widely used in Somalia in the pre-colonial era, and although many young Somalis believe that it is an inherent part of their culture, traditions regarding the use of khat from Yemen were only incorporated into Somali culture in the 1970s.

It has emerged that certain individuals may use khat to an extent that has an adverse effect on their physical health and that impairs their level of functioning (Fitzgerald, 2009; Feigin, 2009). The identification of problematic khat use is a particular challenge, and in the context of multicultural communities such as Melbourne, with a growing East African community, there is an unmet need for the development of appropriate strategies to assist this group of individuals and their families.

Background

A profile of the Somali community in Australia

A significant number of Somalis have arrived in Australia under the Refugee and Special Humanitarian Program and the Family Reunion program, particularly during the period between 1991 and 2001 (Omar, 2005; Clyne, and Kipp, 2005).

According to the 2011 Australian Census data, the number of people who identified as being of Somali ancestry was 9,589, with 54.8% of those (5,254) living in Victoria (Census of Population and Housing, 2011). 5,613 people living in Victoria identified that they speak Somali at home (Census of Population and Housing, 2011). Only twenty-four Somali-born people arrived in Victoria before 1986. The number of Somali-born individuals living in Victoria increased to 1,037 between 1996 and 2001 and was over 6,000 in 2006. The Somali community in Australia is highly urbanized. In Victoria, 98.8% of the Somali-born population live in metropolitan

Melbourne, particularly in the Local Government Areas of City of Melbourne, Banyule, Moonee Valley, Wyndham, Darebin, Maribyrnong, Hume and Greater Dandenong. There are also a number of Somalis in Brimbank, Whittlesea and Yarra (Census of Population and Housing, 2011).

What is khat?

Khat (*Catha Edulis*) is a stimulant leaf cultivated in Kenya, Yemen and Ethiopia (Kassim, et al., 2010; Hoffman and Al-Absi, 2010; Apps, Matloob, et al. 2011). Khat is also known as “qat” “qad” “jaad” and ‘miraa’¹ (Hoffman, and Al’Absi, 2010, p. 554). It contains the alkaloids cathine and cathinone which have amphetamine-like properties and produce a euphoric effect, a sense of elevated self-esteem and an increase in libido which are found with use of amphetamines in general (Hoffman, and Al-Absi, 2010). The bright leaves of Khat are 2—4cm in length, shiny with serrated edges. The stems are reddish in colour and a bundle of Khat typically weights around 250grams. The leaves and stems are wrapped and secured in banana leaves to preserve their essential freshness (Apps, et al., 2011; Hoffman, and Al-Absi, 2010). These leaves are chewed slowly over several hours and are kept in the side of the cheek² and the mouth is filled with fresh leaves which release the active components [juice] of khat that are swallowed (Colzato, et al., 2011; Hoffman, and Al-Absi, 2010).

The khat chewer is described by Somalis as “Qayile” or “Muqayil” which can be literally translated as a chewer of khat, but these terms are also associated with negative connotations of irresponsibility and an undesirable lifestyle (Nabuzoka, and Badhadhe, 2000, P. 9). Khat is described by some Somalis as “a form of Somali alcohol” (Griffiths, et al., 1997, p. 215). The place where khat is chewed is called a “Marfish” (Douglas, et al., 2011; Nabuzoka, and Badhadhe, 2000; Elbagir, 2012). The Marfish is often a “private place attended by a Somali group” of up to 8 adult males (Nabuzoka, and Badhadhe, 2000, p. 7). The environment of Marfishes is often reported to be unhygienic (Ash, 2012) (Nabuzoka, and Badhadhe, 2000). In the United Kingdom, Marfishes have surveillance cameras overlooking the locked doorways and

¹ Miraa is a type of khat grown in Kenya. There is also another type of khat called ‘Hareri’ grown in Ethiopia. The term of Hareri is derived from the historical city in Ethiopia “Harer” that was a capital city for Islamic Sultanates in Ethiopia where khat has been chewed for centuries.

² The amount of khat kept the side of cheek is known in Somali language as “takhsiin” originated in the Arabic word “takhziin” that means upholding and storing.

they are closed to outsiders (Elbagir, 2012).

Historical background

Khat has been used for eight centuries in East African countries bordering the Red Sea (Ethiopia, Kenya, Somalia and Djibouti) and the Arabian Peninsula (Yemen) (Kassim, et al., 2010; Hoffman, and Al-Absi, 2010). Khat was chewed as early as the fourteenth century by the people of the Islamic sultanates of the southern region of what is today Ethiopia, then spread to the Horn of Africa (Gebissa, 2010). Other researchers acknowledge that khat has been used in the Horn of Africa since the Islamic conquest around 640 AD (Apps, Matloob, et al. 2011). An Egyptian historian named Al-Maqrizi (cited in Gebissa, 2010) reported that khat practices were known in northwest Somalia in the fifteenth century. In southern Somalia, little was known about khat use until World War Two, however by the early 1980s, chewing khat became common among all Somali social classes (Gebissa, 2010).

Khat use and gender

In Somalia, khat is primarily used as a chewed substance. Recent reports have acknowledged that 80-90% of East African males and 10-60% of East African females use khat on daily basis; a khat session³ typically involves between six to twenty adults of the same gender or occasionally a mixture of men and women (Osman and Soderback, 2011; Apps, Matloob, et al. 2011; Hoffman, and Al'Absi, 2010). Traditionally, khat consumption by women was socially unacceptable and stigmatised in Somalia. Women used it secretly (Nabuzoka, and Badhadhe, 2000) or at home (Griffiths, et al., 2010) and women who chew khat were often labelled by men as being associated with prostitution (Beckerleg, 2010).

Baashir & Sedoun (cited in Nabuzoka, and Badhadhe, 2000, p. 8) point out that educated women and those of higher socioeconomic status are more likely to use khat in contemporary Somalia. Khat was in the past considered to be a luxury enjoyed by the urban elite (Gebissa, 2010) or a pleasurable activity for upper and middle class men (Nabuzoka, and Badhadhe, 2000), however

³ In Somalia, an average session of khat-chewing is reported to be 4 hours; but in diaspora, it may last up to 8 hours; and occur on average two to three days per week (Apps, Matloob et al. 2011, p.388; Nabuzoka and Badhadhe (2000, p. 12).

patterns of khat use have evolved and it is now a cultural practice within all social groups and classes (Gebissa, 2010). Gender differences have become less evident, with more women using it openly. Current studies estimate the proportion of Somalis in the UK who use khat to be between 34% and 67% with more use among males (Griffiths, et al., 2010, p. 581) though another recent study conducted in the UK stated that 78% of Somali men and 76% of Somali women use khat (Hoffman' and Al-Absi, 2010, p. 555). The increase of khat use amongst Somali women may be related to the influence of Western culture and feminism where gender divisions are weakened (Nabuzoka, and Badhadhe, 2000; Hoffman, and Al'Absi, 2010). There is also some evidence that Somali khat chewers may spend more time using khat following migration from Somalia (Kassim, et al., 2010; Apps, Matloob, et al. 2011).

Global patterns of khat use

The global use of khat has increased over the last few decades and has become an international phenomenon (Colzato, L. et al. 2011). In the Western world, khat emerged in the 1980s among migrant communities from East Africa and Yemen (Apps, Matloob, et al. 2011, p.387). Khat use is often associated with first-generation migrants from East Africa, many of whom acquired the habit of chewing khat before migration (Klein, et al., 2012). However khat has also gained negative publicity and notoreity from films and the popular press (Gebissa, 2010, p. 607).

Modern air transport and globalisation have allowed a wider distribution of khat around the world (Hoffman, and Al'Absi, 2010; Klein and Metaal, 2010). It is estimated that between 7 to 60 tons of khat are imported weekly into the UK (Ash, 2012, p. 2), (Apps, Matloob, et al. 2011, p. 387). Within Africa, khat use is also spreading rapidly and new markets of khat trade have been developed in many of Africa's fastest growing cities and countries including Eritrea, Sudan, Uganda, Rwanda and South Africa (Klein, et al., 2012). Somali refugees and migrants in diaspora bring khat practices with them to maintain their cultural identity and familiar lifestyle in foreign countries (Osman, and Soderback, 2011; Griffiths, et al., 1997).

In Australia, the use of khat and its associated problems has emerged with the increase of migrants and refugees from the Horn of Africa where khat use is common (Advisory Council on the Misuse of Drugs). Similarly, Fitzgerald (2009) reported that there has been a significant

increase in recent years in the amount of khat that is being imported into Australia, and despite evidence regarding the low abuse potential, gaps remain in the evidence regarding potential adverse effects of this escalation in use (Fitzgerald, 2009). The population of migrants and refugees from countries that use khat is estimated at 40,000. Because it is grown in Australia, khat is relatively easy to find and is assumed to be cheaper than other substances of abuse (Alexander, et al., 2010, p. 960). However, a study conducted on the health impacts of khat among Somali-Australians stated that the cost of a bundle of fresh khat in Australia is approximately \$50 (Douglas, et al., 2011, p. 667).

It is estimated that 80% of Somali-Australians (mostly men) use khat (Douglas, et al. 2011, p. 667), however this figure may be an exaggeration. It is common knowledge among the Perth Somali community that many Somali taxi drivers chew khat. However, there is a lack of systematic research on the impact of khat use on drivers' capacity (O'Connell, 2012). With regards to Somali youth, it is reported that some young Somalis who grew up in Australia chew khat (Douglas, et al. 2011, p. 667).

Reasons for chewing khat

Khat is chewed for multiple reasons. Traditional reasons for chewing khat such as for its euphoric effects in socially sanctioned settings have evolved (Odenwald, et al., 2009) and other reasons to chew include:

- to alleviate fatigue;
- to enhance concentration for work and study (Kassim, et al., 2010; Colzato et al., 2011);
- to maintain cultural practices and community cohesiveness particularly from the perspective of Somali men who have migrated to other countries (Griffiths, et al., 1997; Osman and Soderback, 2011);
- to cope with experiences of trauma, adversity and insecurity in the context of civil war and displacement prior to migration from Somalia (Bhui, et al., 2006);
- to provide personal pleasure or indulge in a perceived luxury (Nabuzoka, and Badhadhe, 2000; Bhui, et al., 2006);

- to socialise with other members of the community (Nabuzoka, and Badhadhe, 2000; Bhui, et al., 2006);
- to escape from the stress of poverty and deprivation (Gebissa, 2010);
- to “kill time” in the absence of other legitimate work or leisure pursuits (Griffiths, et al., 1997, p. 283) particularly associated with unemployment (Griffiths, et al., 1997);
- to improve concentration in religious practices.

While khat was originally used for religious purposes, there are differing religious views on the status of khat use in society. Historically, the use of psychoactive substances and drug abuse in religious and healing rituals has been a universal cultural practice (Gebissa, 2010). Muslim Sufis in Somalia debated whether khat was “food of saints or a satanic act” (Gebissa, 2010, p. 608). This debate has continued in Somalia until today. In general, many Muslim Sufi orders in the Horn of Africa have promoted khat use as a plant that God “revealed to faithful people” to assist them to stay awake for prayers and worship (Gebissa, 2010, p. 608). Thus, it is perceived by some Sufis as ‘Quutul-awliyaa’ or a spiritual food for saints (Osman, and Soderback, 2011, p. 214) In contrast, Ethiopian Christians perceive khat as “a sign of apostasy and as un-Christian” (Gebissa, 2010, p. 609).

People at risk of problematic khat use

In general, marginalized individuals including migrants, particularly males, are at greater risk of using drugs of abuse (Griffiths et al., 1997). Khat use is associated with adverse social conditions related to experiences of war, displacement and social marginalization (Bhui et al., 2006). In the UK, disadvantaged and unemployed young Somalis of migrant and refugee background are vulnerable to khat use, cigarette abuse, alcohol and other substance abuse as a result of frustration and lack of a sense of hope and purpose (Nabuzoka, and Badhadhe, 2000). Pregnant women are also reported to chew khat in the UK (Apps, Matloob, et al. 2011). Members of the Somali community, many of whom fled Somalia after the start of the civil war in 1991 and who have been in refugee camps before resettling in the West may already be vulnerable to mental illness as a result of their experience as refugees, and they may face an increased risk of developing mental illness as a result of khat use (Klein, 2007).

Social effects of excessive khat use

Family breakdown

There has been limited research into the adverse effects of chewing khat, particularly in poor and underdeveloped countries where its use is common (Griffiths, et al., 1997). Hence the development of appropriate treatment services has also been restricted (Griffiths, et al., 2010; Odenwald et al., 2005).

Despite the limited research on khat and questions and controversies surrounding its potential impact on physical and mental health, some studies have emphasized the negative social impact of excessive khat use. There are reports that khat use may lead to social dysfunction as a consequence of males spending long periods chewing khat away from their families. This has various negative consequences including family breakdown (Beckerleg, 2010; Advisory Council on the Misuse of Drugs (ACMD), 2005).

There is also some evidence that men who chew khat spend much of their limited income on khat at the expense of the needs of their families which may create family problems (Colzato, et al., 2011; Osman, and Soderback, 2011). Additionally, Somali women expressed their views that men who use khat prefer chewing khat to spending time with their wives, which may lead to distrust and family breakdown (Beckerleg, 2010). Furthermore, men who use khat may be prone to violence and aggressive behaviour toward their wives and family members (Osman, and Soderback, 2011), (Hoffman, and Al-Absi, 2010).

Khat use in young people

Studies conducted on perceptions of khat use among young Somalis in the UK found that young people may perceive khat as being a drug akin to other drugs and alcohol (Nabuzoka and Badhadhe, 2000, p. 19). Furthermore, there is growing concern related to the abuse of uncontrolled psychoactive substances like khat among young Western youth (Griffiths, et al., 2010). In Australia, it is reported that some Western teenagers chew khat (Douglas, et al. 2011). Recently in Sweden it has been observed that khat consumption has spread to migrant youth from non-Somali backgrounds (Osman, and Soderback, 2011). Thus, khat use has crossed the

cultural divide in several countries (Apps, Matloob, et al. 2011; Osman and Soderback, 2011). This view, however, is at odds with Gebissa's (2010, p. 608), Klein, et al., (2012), and a report by the Advisory Council on the Misuse of Drugs (ACMD (cited in Ash, 2012) that khat use has not spread to the general community.

Unemployment and socio-economic issues

It is believed that chewing khat is a barrier to sustaining employment because of the impact on the users' time in chewing khat (Osman, and Soderback, 2011). A study conducted on perceptions of khat use among young Somalis in the UK found that the majority of khat users stayed at home and faced many social problems including unemployment (Nabuzoka, and Badhadhe, 2000, p. 20). On the other hand, being educated and having employment are associated with a lower prevalence of mental disorders. Additionally, employment and education are protective factors in recovering from mental disorders (Bhui, et al., 2006, p. 405-206). Khat use is said to lead to unemployment and direct economic stress (Advisory Council on the Misuse of Drugs, (ACMD) 2005).

Unemployment has been described as part of a vicious cycle leading to depression, alienation and addiction to khat and other substances (Elbagir, 2012). The cost of khat adds to the financial burden faced by users. A study conducted on the health impacts of khat on Somali-Australians estimated the cost of a bundle of fresh khat — that is chewed in one session — is 50 Australian Dollars (Douglas, et al, 2011., p. 667).

Social integration

Studies of khat chewers among Somali migrants and refugees living in the West suggest that khat use may impede the acculturation of users. Lack of understanding of the culture and language of the host society leads to marginalization and Somalis may resort to using khat in an attempt to escape from these difficulties, which ultimately perpetuates the isolation faced by individuals and groups using khat (Nabuzoka, and Badhadhe, 2000; Griffiths et al., 1997).

Association of khat use with other legal and illegal substances

Some studies have found an association between khat use and the use of other substances including cigarettes, alcohol and other drugs (Bhui, et al., 2006). Studies in Australia have

reported an increased prevalence of cigarette smoking among khat users particularly when chewing khat; it also reported that sweet drinks are commonly used to alleviate the bitter taste of khat (Douglas, et al. 2011). Griffiths et al (1997, p. 282) found that the majority (60%) of Somali khat chewers in the UK use khat with cigarettes, and 6% use khat with cannabis. Similarly, Nabuzoka and Badhadhe (2000, p. 12) found that the vast majority (97.9%) of young Somali khat users interviewed in the UK chewed khat with coffee, coke, milk, cigarettes and alcohol.

Pharmacological effects

The active ingredients of khat are cathinone and norpseudoephedrine (cathine). Cathinone is the main psychoactive component, and has a similar action to amphetamine, inducing the release of the neurotransmitter, dopamine, from pre-synaptic storage. (Al-Hebshi, and Skaug, 2005; El-Wajeh, and Thornhill, 2009). It has catecholamine-releasing properties at central dopaminergic and serotonergic synapses as well as peripheral noradrenergic sites (Ali, 2010). Cathinone inhibits monoamine oxidase (MAO) activity more potently than amphetamine, and with greater selectivity for MAO-B than MAO-A. As MAO-B is the main isoenzyme which degrades dopamine. Inhibition of this enzyme increases the synaptic availability of dopamine. If administered chronically, however, dopamine depletion has been observed (Kelly, 2011).

The cathinone content of leaves varies depending on where they are grown and the level of freshness of the leaves; it is present in much higher concentration in fresh leaves (Kelly, 2011). Cathine is present in both fresh and aged leaves and has a similar effect to cathinone but is less potent and the effects don't last as long (Bongard, 2011). Following absorption, cathinone derivatives undergo extensive Phase 1 metabolism. Cathinone is metabolised to norephedrine, norpseudoephedrine and cathine; most cathinone derivatives are eliminated as metabolites via the urine (Kelly, 2011).

Physical effects of khat

Chewing has been associated with a variety of physical effects, which differ in their prevalence and significance.

Changes in the oral mucosa and dentition are frequently seen. Frictional keratosis is the most common oral effect of khat-chewing and regular chewers have a much higher incidence of these oral mucosal lesions, which are considered pre-cancerous (Balint, et al., 2009). There is weak evidence that khat-chewing is a risk factor for oral cancer (Al-Hebshi, and Skaug, 2005), and the risk is increased when khat use is combined with smoking and alcohol consumption (Corkery, 2011). Studies have also suggested that chewing khat modifies the nature and quantity of periodontal pathogens in patients with chronic periodontitis, which is potentially a prebiotic effect (Al-Hebshi, 2010). Staining of the teeth is significantly increased with chronic chewing, and dark pigmentation of mucosa can also occur (Yarom, 2010).

Khat has been implicated as a contributory factor in the high prevalence of head and neck squamous cell carcinoma in the Yemeni population. Additionally, babies born to chronic khat-chewing mothers have on average lower birth weights (Corkery, 2011). A recent study by Murdoch et al (2011) has suggested that chronic khat chewing may significantly influence the effectiveness of immune surveillance and anti-microbial capacity of peripheral blood mononuclear cells.

Prolonged and frequent khat use has been associated with a range of medical sequelae, including stomatitis, oesophagitis, gastritis, duodenal ulcer, constipation, malnutrition, hepatic cirrhosis, autoimmune hepatitis, liver failure, anorexia, spermatorrhoea and impotence, migraine, cerebral haemorrhage, pulmonary oedema, myocardial insufficiency and myocardial infarcts (Al-Hebshi, and Skaug, 2005; Corkery, 2011; Balint, et al., 2009). Additionally, khat chewing has been demonstrated to reduce urinary flow rates, delay gastric emptying (which can contribute to malnutrition) and increase the incidence of haemorrhoids (Balint, et al., 2009).

Khat users have been described as having a characteristic 'staring' look, associated with dilated pupils. Conjunctival congestion has been reported (Hoffman, & Al-absi 2010), and users can also experience dry mouth and thirst. Respiratory rate is increased when using and body temperature is slightly elevated (Manghi, 2009). Khat use may lead to loss of appetite and sleeping problems (Nabuzoka, and Badhadhe, 2000; Hoffman, and Al-Absi, 2010).

Cardiovascular complications are among the most concerning potential effect of regular khat use. Regular chewing is associated with elevations in diastolic blood pressure (Getahun, et al., 2010) and khat has positive inotropic and chronotropic effects on the heart. However the blood pressure elevating effects appear to be less severe in chronic users, raising the possibility that tolerance develops to the sympathomimetic effects (Manghi, 2009). While further research is needed to quantify risks and exclude confounding factors, studies have indicated that khat chewers are at increased risk of myocardial infarction and cerebrovascular accident (Al-Motarreb, et al., 2010).

Interestingly, khat chewing has a potentially favourable impact on blood glucose levels, though the exact relationship is complex. Regular chewing has been shown to reduce appetite and weight (Al-Motarreb, et al., 2010), and the risk profile of khat chewers with a history of acute myocardial infarction indicates they are less likely to have diabetes mellitus, renal impairment and obesity (Ali, 2010).

Worse in-hospital outcomes for up to a year after admission with acute myocardial infarction have been observed in regular khat-chewers. Ali et al's (2011) large observational study demonstrated that khat-chewers presented significantly later to hospital, were less likely to receive thrombolysis, were more likely to die in hospital, and were at increased risk for a range of other adverse events including heart failure, recurrent myocardial infarction and stroke (Ali, et al., 2011). Ali et al (2011) go on to indicate postulated mechanisms for these results: khat has been shown to increase heart rate, induce myocardial spasm, and alter myocytic structure and function. Cathinone is also pro-thrombotic, so thrombolysis is likely to be less effective. Furthermore, cathinone has analgesic properties, reducing responsiveness to painful stimuli, which may be related to why the khat users presented later than others to hospital.

Mental health effects of khat use

The psychotropic effects of khat are caused by the amphetamine-like compounds (Corkery, 2011). Khat is reported to have desirable initial effects including euphoria, increased confidence, increased alertness and vigilance (Al-Hebshi, and Skaug, 2005, Kelly, 2011). Users report a heightened sense of awareness and enhanced imaginative skills, which can lead to grandiose ideas (Manghi, 2009). Khat has long been used as a means to offset fatigue, and has also been

claimed to be an aphrodisiac (Kelly, 2011).

Following acute intoxication, khat has been reported to cause non-desirable effects that include depression, anxiety and paranoid ideation that may continue for a few hours (Al-Hebshi, and Skaug, 2005). Insomnia and emotional instability have been associated with ongoing khat use, especially among males (Al-Hebshi, and Skaug, 2005). Anxiety, agitation, irritability and aggression have been reported, as well as increases in depression, suicidality and mania, with depressive symptoms particularly evident during cessation (Hoffman, & Al-absi, 2010). In a recent study by Bongard et al (2011), regular khat chewing was associated with increased predisposition to experience anger, more pronounced negative emotional responses to mental stress, and less pronounced positive emotional states at all times.

Intake of amphetamine is associated with an increased risk of drug-induced psychosis (Al-Hebshi and Skaug, 2005). This is less likely to occur with khat use, most likely because of the self-limiting nature of the dose that can be chewed (Corkery, 2011), however there are reports of khat-induced psychosis. The majority of publications related to this topic are case reports and letters (Fitzgerald, 2009; Al-Hebshi and Skaug, 2005). Odenwald, et al (2009, p. 1045) have stated that excessive khat use leads to an increased risk of psychotic disorders. It has also been suggested that chewing exacerbates psychotic symptoms in those with an underlying vulnerability or pre-existing psychotic illness (Corkery, 2011), and there have been reports of violence in people experiencing psychotic symptoms caused or exacerbated by khat (Corkery, 2011).

Studies investigating the relationship between khat use and anxiety or depression have produced conflicting results (Manghi, 2009). Of note, a recent study of 180 Somali immigrants in London reported no statistically significant increased risk of psychotic symptoms, anxiety or depression in khat users, but the authors advocated for further large-scale studies (Bhui, and Warfa, 2010). Research conducted on Somali refugees and asylum seekers found a high risk of mental health disorders, particularly post-traumatic stress disorder (PTSD) among Somalis in diaspora (Bhui, et al., 2006, p. 400). Hence individuals with a prior vulnerability to mental illness may be at greater risk of adverse consequences associated with khat use. Khat use amongst individuals with a prior

history of exposure to trauma has been associated with an increased risk of developing psychotic symptoms (Tulloch, 2007; Bhui, et al., 2006; Hoffman, and Al'Absi, 2010; Odenwald, et al., 2005). Some have postulated that there is a synergistic effect of khat use and PTSD as risk factors for the development of paranoid ideation (Hoffman, & Al-Absi, 2010).

There is some evidence that prolonged khat use may be associated with impairment in concentration (Hoffman, and Al-Absi, 2010; Manghi, 2009), and khat use may have a negative effect on a broad range of everyday behaviours, including driving, work performance and learning activities (Colzato, et al., 2011, p. 5). Impaired judgement or poor risk perception may contribute to motor vehicle fatalities (Corkery, 2011). Khat-users have been shown to have impaired working memory, and show impairments in strategic planning and decision making (Colzato, et al., 2011, P. 2-5). Impaired inhibitory control has been demonstrated, which has implications for the risks associated with driving, interpersonal behaviour and societal functioning (Colzato, et al., 2011).

Further research is needed into patterns of khat use and its long-term implications in Australia as well as the impact of khat use on cognitive and mental health (Feigin, 2009).

Is khat a drug of dependence?

The status of khat as a drug of abuse or dependence has been contentious. Khat has been considered part of the lifestyle in some countries, and it could be argued that there is a spectrum ranging from non-problematic use, through to abuse and dependence (Manghi, 2009). Since craving, tolerance and a borderline withdrawal syndrome are characteristic of amphetamine addiction, and considering that khat is similar to amphetamine, it can be postulated that it is potentially addictive. However, while tolerance to amphetamine can develop rapidly and to a high level, tolerance to khat has not been observed, probably because of the physical limits on the amount of khat that can be chewed. Some have argued it is improbable that most khat users will chew enough khat to develop dependence (Nencini, and Ahmed, 1989). However Kassim et al (2010, p. 571) argue that chewers of khat tend to secure khat at the expense of other needs including food, a behavioural pattern which is suggestive of dependence. Indicators of khat abuse include using outside the context of previous social or cultural norms, using repeatedly,

and using large amounts over long periods (Advisory Council on the Misuse of Drugs, (ACMD), 2005).

There has not been any consistent evidence of a clear-cut physical withdrawal syndrome; however, a rebound phenomenon consisting of mild depression, sedation or hypotension has been described (Al-Hebshi, and Skaug, 2005). Heavy chewers may also experience nightmares, referred to as ‘razim’, the first one or two nights following abstinence (Al-Hebshi, and Skaug, 2005), and may complain of feeling hot, especially in the lower extremities (Corkery, 2011). The dependence produced by regular khat use is likely to be primarily psychological (Al-Hebshi, and Skaug, 2005), but can be of moderate severity and persistent in nature (Balint, et al., 2009).

Legal issues

The legal status of khat is also contentious. Khat is categorised by WHO as a drug of abuse (Fitzgerald, 2009; Advisory Council on the Misuse of Drugs (ACMD), 2005) yet it is not controlled at the UN level (Griffiths, et al., 2010). The legal status of khat varies across the world. It is legal in certain African countries but not all. Khat has been made illegal in Canada and Sweden. A report by the UK Advisory Council on the Misuse of Drugs in 2005 recommended that the use of khat should be discouraged although it is not prohibited (Fitzgerald, 2009). It is legal in the UK but illegal in sixteen European member states (the majority of EU members) plus Norway where khat is listed under controlled substances (Ash, 2012). In other European countries, the legal status of khat remains uncertain (Griffiths, et al., 2010).

In the UK, the Advisory Council on the Misuse of Drugs (ACMD) recommended that khat not be controlled under the Misuse of Drugs Act 1971, but recognised the need to educate primary health care professionals and that individuals seeking advice should be referred to primary care services (Advisory Council on the Misuse of Drugs (ACMD), 2005). As khat is legal in the UK, it recognised the dilemma posed by the fact that khat is exported to the UK and from there distributed to other countries where it is illegal (Advisory Council on the Misuse of Drugs (ACMD), 2005).

In Australia, khat use has varying legal status across the different states and territories (Douglas, et al., 2011). In Victoria, New South Wales and Tasmania individuals with a licence may legally obtain up to five kilograms of khat per month for personal consumption (Feigin, 2009; McLean

and Kot, 2011; Douglas, et al., 2011). In other states and territories, the possession, trade and cultivation of khat is illegal (Douglas, et al., 2011, p. 666).

What defines problematic khat use?

Given the contentious issue of khat use and its addictive potential, this report refers to problematic use, rather than abuse or dependence.

The pattern of khat use has changed significantly in recent years. Furthermore, for migrants and refugees from East African countries including Somalia, the acculturation process has had a significant impact on shaping the views of individuals and their families regarding sanctioned practices. This shift in views is also relevant to the use of khat; as a result of the process of acculturation, khat use needs to be considered in the context of the use of other substances, including alcohol, which may be culturally accepted within the local mainstream culture of Australian youth.

There is a lack of a standardised approach to the assessment and definition of problematic khat use. The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for the World Health Organization (WHO) for the purpose of providing a standard approach to the assessment of substance use and related problems (Nencini and Ahmed, 1989). There is a need for a standardised approach to the assessment of substance use disorders across diverse cultures and the ASSIST represents a potentially useful tool in the detection of individuals who may have impairment in their level of functioning as a result of problematic khat use.

Treatment of problematic khat use

An overview

There is a gap in the evidence base regarding what treatments may be of benefit to individuals who are identified with problematic khat use. Particularly in multicultural settings such as Melbourne, individuals who use khat may have different ways of conceptualising the impact of khat use, including whether or not they identify khat use as a problem that may require care from a drug and alcohol treatment service. Similarly, drug and alcohol treatment service providers may have diverse expectations regarding the treatments that may benefit such individuals who

use khat. There is now a significant body of literature that supports universal interventions for substance use disorders. These strategies include measures to reduce psychological or social problems related to substance use, reduction of risk-taking behaviour associated with substance use, the attainment of controlled or non-problematic use and abstinence (Gerada, 2005). These principles are particularly important as it is likely that young people who have problematic khat use in Australian communities may abuse other substances. Furthermore, it is important that treatment is individualised, and as with people with substance use disorders, treatment needs to be available in whichever setting the individual presents, as there may be multiple pathways to care and support for individuals with substance use disorders (Gerada, 2005). Harm minimisation strategies for young people with a pattern of harmful drug use in particular needs to be considered within a broader social context that works within family systems, and is sensitive to cultural values and practices (World Health Organisation, 2011). Early intervention for young people may have significant benefits in reducing the social burden associated with problematic substance use in adulthood.

Diaspora Somalis

Some Western countries, particularly the UK, have invested in research on the effects of khat use on migrants and refugees who chew khat, which has highlighted limitations in understanding of khat use amongst health professionals. (Griffiths, et al., 2010) (Alexander et al., 2010, p. 960) A recent study about khat-chewing in Australia has emphasised the importance of a good understanding and awareness among health professionals informed by research (Alexander et al., 2010; Fitzgerald, 2009). Likewise, Fitzgerald (2009) noted the need for education campaigns to reduce patterns of harmful consumption of khat among members of the African communities in Australia (Fitzgerald, 2009).

One study of khat users in the UK found that the majority tried or wanted to stop their use (Kassim, et al., 2010). Other studies of khat chewers of Somali background living in the UK found that lack of knowledge about khat use, language barriers, cultural and religious misunderstandings contributed to people not seeking advice or help (Nabuzoka and Badhadhe, 2000).

To improve the treatment and services available for khat chewers in the UK, Nabuzoka's and Badhadhe's (2000) respondents suggested khat users should be helped by providing them with health education related to khat-chewing, advice, social activities such as sports, educational, training and employment opportunities. They also suggested that social and community workers of Somali background and doctors be educated and provided with enough information about the harm caused by khat in order to treat the users of khat (Nabuzoka, and Badhadhe, 2000). In general, employment programs have been found to be effective potential interventions for patients with a range of mental disorders, and this principle applies to Somali migrants and refugees (Bhui et al., 2006, p. 406). It has also been suggested that information about khat should be written or recorded in English, Somali and Arabic languages (Nabuzoka, and Badhadhe, 2000, p. 18). Specific support should also be given to those individuals who are at risk of chewing khat, in particular middle-aged men (Osman, and Soderback, 2011, p. 216). Overall, the community education initiatives about khat use will depend on the perception of khat use in the community, and it is important to identify the unmet needs for further education programs targeting khat use.

CHAPTER 2: RESEARCH METHODOLOGY

Introduction

This chapter outlines the research methodology for this project including: the rationale for the project, hypotheses, aims, qualitative research methods, research stages, data collection, structure of the focus groups, recruitment methods, research settings, context of the study, limitations of the study, significance of the study, language in interviews, participants' demographic characteristics and data analysis methods.

Rationale for the project

With regards to problematic khat use, there is a lack of research regarding the application of universal harm minimisation strategies. Given the nature of problematic khat use, it may be that social interventions such as reducing the time and frequency of time spent using khat would be an appropriate aim. Harm minimisation strategies need to be reflective of cultural values and beliefs that are held by members of CALD communities. It remains an unanswered question as to how such strategies may be adapted, and whether these strategies are effective.

Knowledge around khat use among health practitioners working in drug and alcohol services may be limited. This is an important systemic issue, because if individuals with problematic khat use present for assessment and treatment, drug and alcohol service practitioners need to understand the effects of khat, as well as have some understanding of the options for intervention.

Hence, whilst there is now a significant body of research into patterns of khat use, there is a need for further research regarding the identification and care of individuals with impairment related to problematic khat use, particularly within the setting of a multicultural community such as Melbourne. The project described here aimed to engage Somali community leaders and primary care practitioners in order to develop strategies for early intervention with regards to problematic khat use.

Hypotheses

The hypotheses of this study are that:

1. there are a diverse range of views in the Somali community and amongst primary care practitioners regarding interventions and pathways to care for individuals with problematic khat use
2. whilst harm minimisation strategies have universal relevance, including in working with individuals with problematic khat use, specific strategies identified by the Somali community and primary care practitioners may be required.

Aims

The aims of this study were to:

1. develop an understanding of the views of Somali community representatives and primary care practitioners regarding interventions and pathways to care for individuals with problematic khat use
2. develop an understanding of harm minimisation strategies that have particular relevance to khat use
3. develop resources that may be used by Somali community representatives and primary care practitioners to assist individuals with problematic khat use and their families

Qualitative research methods

This study used qualitative research methods to investigate the Somali community's and the mainstream primary care practitioners' experiences and perceptions of khat use in Australia. Qualitative research is a naturalistic, holistic and inductive approach which "moves us increasingly toward a 'greater understanding of how the world works' in natural ways (Strauss and Corbin, 1996, p. 4). The study was ethnographically informed. The ethnographic approach is an important method in anthropology, psychology, psychiatry and sociology because it describes and analyses peoples' ways of life, thinking and their cultures, assuming that "any human group of people interacting together for a period of time will evolve a culture" (Patton, 2002, p. 81). It can be applied to any research into individual or group lives and experiences and cultural

phenomenon or social changes, transformations and movements (Strauss, and Corbin, 1996).

Qualitative ethnographic research usually does not impose preconceived assumptions or formulated theories but puts emphasis on the context of the research situation, assuming that the natural world is not fixed or static but is constantly shifting and changing, presenting the researcher with diverse realities (Hines, 1993, p. 734). Ethnographic research can uncover the ways of life of invisible groups enabling the researcher to “lift the veils that obscure what is going on” (Hines, 1993, p. 735). This type of research is particularly well suited for studying “hard-to-access groups” such as refugees and immigrants, or groups resistant to survey methods (Hudelson, 1996).

Research stages

This pilot project was conducted over a period of six months: two months for literature review and preparation of the research protocol; two months for focus group interviews, fieldwork and transcriptions; one month for thematic data analysis; and one month for summation. Three researchers conducted the thematic analysis; after that these analyses were integrated together by the primary researcher.

6 focus group interviews comprising a total of 48 participants were conducted representing Somali youth (7), Somali elder men (10), Somali elder women (11), Somali community representatives (9), and primary care practitioners from Banyule Community Health Centre in West Heidelberg (11).

Data collection

For the purpose of this research, two semi-structured interviews were designed specifically to ascertain perspectives of practitioners regarding a range of issues associated with khat use (appendices: 1 & 2).

Data collected included audio recordings, field-work observations, and transcriptions of semi-structured focus group interviews. These data are stored at the Victorian Transcultural Psychiatry Unit and will only be accessed by researchers involved in this project.

Focus groups

The focus group technique is a tool for studying ideas in a group context. The groups should be culturally similar if not homogeneous. Homogeneity can create an environment in which participants feel comfortable expressing their views freely (Hudelson, 1996). The focus groups of this study were culturally and linguistically homogeneous. Age differences were also considered – youth were grouped separately from the community elders in order to avoid people feeling unable to comfortably express their views in the presence of community elders. The youth focus group consisted of 4 young men and 3 young women. Similarly, the community representative focus group consisted of 5 men and 4 women. Interviews with these two groups were conducted in English. For community elders, men and women were interviewed separately in Somali language so that the women felt free to express themselves. In Somali culture, women (particularly elder women) are may not feel comfortable expressing their views in the presence of elder men.

Recruitment methods

Community participants were recruited through key members of the Somali Australian Friendship Association, a Somali community organisation, as well as informal community networks. All of these community groups operate in Banyule area specifically in West Heidelberg. Primary care practitioner participants were recruited through Banyule Community Health Centre. Participant information sheets (in English) were distributed among participants prior to conducting the interviews. The primary researcher explained this information in Somali language for the community women and men focus groups whose English was limited. Signed consent and completed surveys related to participants' demographic characteristics were obtained during focus group interviews.

Additionally, participants were verbally informed that the data might be used in future for presentations at conferences and seminars, community centres, and could be published in peer-reviewed literature. Participants were also assured that no personal information would be included in such reports. The anonymity of each participant was maintained and all information remained confidential. Any information which identified a participant was kept in a secure location at Victorian Transcultural Psychiatry Unit. Participant coding numbers not their names

were used to track and manage data. No individuals were or will be identified in any reports, conference presentations or publications. The study had formal approval from St Vincent's Hospital Human Research Ethics Committee.

Research settings

Focus groups interviews were held in different locations in Melbourne. One focus group was held in a community centre in Coburg and five focus groups were held in West Heidelberg: three were held in Banyule Community Health Centre; one focus group was held in the Neighbourhood Renewal Community hub and one was held in a church that is used as a community centre.

The two primary practitioner focus groups were conducted at Banyule Community Health Centre.

The context of this study

Many of the problems associated with khat use in Australia mirror the experiences of the wider Somali community. Therefore, to understand comprehensively the issue of khat use, the harm caused by khat use and the best way to minimise this harm, it is important to investigate and compare the views of different groups within the community as well as primary care practitioners in Banyule Community Health Centre which many members of the Somali community in Heidelberg access.

The interviews themselves became an important platform for diverse Somali community voices. Participants from the community became open with the researchers and this mutual understanding was expressed by some participants in different ways such as body language or spoken feedback.

Language in interviews

From the beginning, community participants were asked to choose the language(s) they preferred to speak in. The members of the youth focus group and community representative focus group, who had all lived in Australia and in the West (UK and New Zealand) for 10 years or more, were

inclined to speak in English with minor use of Somali language. However, the community elders chose to speak in Somali including some English sentences and words. This mix of languages made the task of transcription challenging. Some elders might utter a few sentences in English but use the Somali grammatical system. Sometimes the metaphors, similes and specific connotations, which are anchored in the cultural environment were difficult to translate. For instance, a participant from the men's focus group said "kill the snake from its head". The cultural connotation of this quote is that the father figure is the head of the family in Somalis' patriarchal culture and any solution for a khat problem should start by focusing on the top male person in the family.

Furthermore, bilingual researchers observed during this research that most young people who grew up in Australia and most community representatives (who were mostly well-educated) used phrases that can be described as tentative language, such as, "it depends on", "maybe", "I think", "I assume", "it seems", "I understand" "it is logic", "in the context", "my argument", "discourse" and "balance". These phrases are probably used quite generally in schools and in Western environments. In contrast, older people do not use such phrases as often. They are more inclined to use definite phrases, such as "I am sure", "khat use is bad", "khat has zero benefit", "khat use will kill you", "khat user is a bad person", and "khat users are in the wrong path". Additionally, unlike the young generation, older people frequently used religious perspectives e.g. "I swear by Allah", "it is haram", "khat is forbidden" and so on. Additionally, the vast majority of the community participants used words "he" or "him" indicating that khat users are normally men.

Participants' demographic characteristics

As shown in Table 1 all community focus group participants who participated in this study were representative of the diversity in the Somali community with regards to age and gender. In general, youth, men and members of the community representative group were better educated than women.

As shown in Table 2, the primary care practitioners were diverse with regards to their occupational background. There was one Somali bilingual social worker, five drug and alcohol counsellors and one drug and alcohol counselling service team leader.

Table 1: Somali community focus group participants

Variable	Elder female (EF) focus group no=11	Elder male (EF) focus group n= 10	Youth (Y) focus group N=7 (4 males 3 females)	Community representatives (CR) focus group N=9 (5 males 4 females)
Country of birth: Somalia Other	10 1[Ethiopia]	10	6 1 [Egypt]	9
Age range in years	1 participant:18-29 3 participants: 30-39 4 participants: 40-49 2 participants: 50-59 1 participant: 60+	1 participant: 30-39 1 participant: 40-49 1 participant: 50-59 7 participants: 60+	All 7 participants: 18-29	5 participants: 30-40 3 participants: 18-29 1 participant: 50-59
Level of education	Primary: 1 Secondary: 5 Tertiary: 2 Postgraduate: 1 Unknown: No school at all: 1	Primary: 2 Secondary: 3 Tertiary: 2 Postgraduate: 3	Secondary school: 2 Tertiary graduate degree: 3 Tertiary postgraduate: 2	Secondary school: 1 Tertiary graduate degree: 3 Tertiary postgraduate: 5
Current occupation	4 participants: day care/child care 1 participant: nurse 1participant: bilingual 1participantn: student 1participant: house wife 3 participants: unknown	1=disability 1participant: African worker at CPS 1 participant: self- employed (community money transfer) 6 participants: pensioners 1participant: unemployed	4: students 1: teacher 1:unemployed 1: social worker	1: student 3: social/youth workers 1: medical scientist 1: artist 1: building designer 1: self-employed 1:day care manager
Length of residence in Australia (rage)	1participant: 2 months 1participant: 4 years 9 participants: 10-18 years	10 participants 10- 17 years	2 participants: 1-2 years 5 participants: 11-21 years	1 participant: 8 years 8 participants: 11-21 years

Table 2: Primary care practitioner focus group participants

Variable	Male N= 3	Female N= 8
Age range in years	1 participant: 18-29 1 participant: 30-39 1 participant: 40-49	1 participant: 18-29 3 participants: 30-39 2 participants: 40-49 2 participants: 60+
Language(s) other than English	none	Only 1 participant speaks other than English
Role at Banyule Community Health	1 participant: manager 1 participant: service access/men's shed worker 1 participant: neighbourhood officer	5 participants: drug and alcohol counsellors 1 participant: team leader/ psychologist D&A general counselling 1 participant: social worker 1 participant: health promotion officer (AOD)
Length of working in this area	2 participants: 1-3 years 1 participant: 8-10 years	2 participants: 1-3 years 1 participant: 3-5 years 1 participant: 8-10 years 4 participants: 10+ years
Previous contact with khat user(s)	yes= 1 participant no=2 participants	yes= 1 participant no= 7 participants

Data analysis

The transcripts of the interviews from the focus groups were analysed using qualitative research methods, in particular thematic analysis (Patton, 2002). The domains identified in the semi-structured interview were used as a guide for the initial grouping of key themes. An “emic” perspective was adopted in order to ascertain the views of participants. Transcripts were analysed with the objective of grouping and refining common as well as contrasting themes. The themes identified were reviewed independently by Yusuf Omar, Anna Jenkins and Prem Chopra.

The participants were coded in the following way:

- EM (Elder male focus group participant)
- EF (Elder female focus group participant)
- Y (Youth focus group participant)
 - o YM (Youth focus group male)
 - o YF (Youth focus group female)
- CR (Community representative focus group participant)
 - o CRM (Community representative focus group male)
 - o CRF (Community representative focus group female)
- PP (Primary care practitioner focus group)

Each participant was also assigned a number for their particular focus group. For example, YF6 refers to participant 6 in the Youth focus group who is female.

In addition, data analyses are presented here both directly and indirectly. The research team then undertook the development of specific resources that may be made available to members of the community, primary health care practitioners and also drug and alcohol practitioners regarding pathways to care for individuals with problematic khat use and their families. This step encompassed a collation of the key themes to emerge from the focus group research supplemented by the relevant literature.

RESEARCH FINDINGS

The results of the thematic analysis of the Somali community participant focus groups will be presented separately from the primary care practitioners (see Chapter 11).

CHAPTER 3: REASONS FOR USING KHAT IN AUSTRALIA

Introduction

Diverse reasons for using khat in Australia were identified by the participants; some reasons were linked to khat use prior to migration while other reasons were linked to the post-migration phase. The main reasons for khat use in Australia were perceived to be a continuation of cultural practices, cultural identity, socializing, escaping from problems and assisting people to work hard and concentrate while studying.

Continuation of cultural practices and cultural identity

Some participants believed that khat use in Australia is a continuation of what khat users were practicing prior to migration in Somalia, particularly for older men who constitute the majority of khat users in Australia.

“Most of khat chewers are the people who were chewing in Somalia...” (EM3.)

“...When you come to a new country you tend to hold onto your original like hobbies and things that you normally do, outside of the place that you come to; so in a sense...I believe it’s a sense of grasping to something you are familiar with.”(YF6).

“I think when people came to [this] place they’re bringing all their packages with them, so khat is part of them.” (CRF1).

“They brought the culture of chewing khat from their country...” (EF4).

In addition, some respondents described khat use as important to cultural identity and cultural practices. EF7 tells “I think they also chew it for cultural reasons because khat was culturally used in Somalia. When they use it they defend it saying it was used in Somalia.” Young participants also believed that khat is “embedded in Somali culture, regardless of being in

Somalia regardless of being anywhere” (YM7).

“Somalis in Australia use khat because it is socially driven, and determined by the social, as well as it’s culturally driven.” (YM3).

There was one woman participant from the community representative focus group who argued that khat use has not been part of Somali culture that long, but it came to Somalia a few decades ago. “I say it hasn’t been that part of the culture that long, maybe a few decades and I am, it is probably because it...doesn’t have the haram label like the alcohol does and it is speed you know so that maybe.” (CRF5).

Socializing with people ‘in the same boat’

Another reason identified for using khat was to engage with friends and engage in other social activities:

“You want to, you know, socialize with people who are in the same boat as them” (YF6).

This was seen also in a negative context, as khat users may preferentially spend time with their friends rather than with family members:

“They [khat users] prefer to engage with their friends and share with them chewing khat instead of staying at home and helping their families or instead of studying” (EF4).

Old men are generally believed to be the main group who use khat in the context of socializing. EM2 describes these kinds of socializing as “fadhikudirir” [an aimless talk], in which they talk about Somalia, tribal conflicts and politics.

Increasing alertness

One of the reasons for chewing khat includes remaining alert and awake, particularly amongst taxi drivers and students. This is because they want to work hard or concentrate when studying. This was particularly identified in the EM focus group:

“Taxi drivers also argue that they chew khat because it helps them remain awake when driving...they say it helps them do their work (EM2).”

Escaping from social problems

Participants from the four focus groups from the Somali community identified the theme that khat use is linked to an attempt to escape from social problems:

“They escape from the reality, the [harsh] reality they are now living.” (CRF1)

“They chew it to escape from the stress, to escape from their own problems. That is the justification for chewing khat” (EM3).

“I think it is the problem because people didn’t have much to do and every day they are home; the guys are just frustrated so they go out and eat khat every day” (YM2).

Similarly, EM10 put it:

“There is a reason behind using khat heavily particularly by youth. The reason Somali youth chew khat is to escape and forget hardships and life challenges created by the civil war. In general, drugs are used to escape from misery...there is no money and there is no job then they [youth] take drugs and khat and spend their time with it...”

Escaping from marginalization and social exclusion

Khat use in Australia is also believed to be perpetuated by a lack of adequate English and cultural understanding which entails lack of proper communication and interaction with the mainstream community. Similarly, khat use is linked to coping with marginalization and social exclusion from the mainstream community:

“I think it [khat use] has a lot to do with marginalization, an exclusion from the mainstream.” (CRM10).

This view was endorsed by EF2:

“It is possible that khat is chewed because of ... lack of adaptation to the new society, lack of educational background lack of adequate language and cultural understanding which force him [khat user] to isolate himself and go to his [khat chewer] own ghettos.”

Influence of peers

Some participants from all community focus groups believed that khat users could influence their friends to join them and chew khat; others believed that the older generation could influence the younger generations to chew khat:

“The way they normally start chewing is imitating others, imitating their friends who are

chewers.” (EM8).

“Here in Australia, those young people: boys and girls who chew khat follow and imitate old people who chew khat. If old people continue to chew khat, young people will also use khat and become uncontrollable.” (EM1).

A breathing space from unemployment

Participants from all community focus groups acknowledged that the unemployment rate is high among the Somali community in Australia and therefore many khat users resort to spending their free time using khat. The elder Somalis in particular identified that it is difficult for them to seek employment because of language difficulties, local experience and cultural understanding. These issues lead them to chew khat to escape from frustration:

“People use khat...because of the scarcity of employment” (EF4).

“But because we are newly migrated the males or the men or whatever, have problems finding work so there is unemployment and so because khat is a breathing space for them.” (YM7).

To “kill time”

Men, women and community representative focus groups but not youth expressed the view that people use khat in a negative way to ‘kill time’.

“When you have a lot of time in your hands, then you can try to do khat, you know.” (CRM10)

Other participants also recounted:

“They [khat users] wanted to kill their time. They were sitting around, particularly when there were no jobs; in Somalia if there were jobs, the working hours were very short, you see. People were finishing their jobs at 1pm and there were no afternoon activities; in Somalia there were no organized sports, recreational activities or libraries in which you could go and read. So, everyone used to go with his friends who chewed khat.” (EM8)

“...some people chew it to kill their time because they have a lot of time and they don’t have other activities.” (EM7)

Lack of understanding of its harm

Interestingly, participants from the EF focus group identified that one of the reasons for chewing khat is a lack of understanding of harms and problems caused by khat use. These problems could be individual, family or social problems, ill-health or financial difficulties:

“They chew it because they don’t understand its harm” (EF6).

The same view was expressed by another female participant:

“They don’t understand khat problems for their families, for their financial situation, for their health and wellbeing. If they understand problems caused by khat use they wouldn’t have used it.” (EF4)

CHAPTER 4: PROBLEMS ASSOCIATED WITH KHAT USE

Introduction

I tell you something: you may get high and pleasure because of khat but khat-chewing will finally kill you; the khat will finally defeat you; it will finally put you down and throw you on the ground (EM6).

An old man from the EM focus group stated that the meaning of the term “khat” is “bahalkuqaaday” (be taken and eaten by a predator). He argued that khat use destroys the two most important things in people’s lives: *health* and *wealth*. Similarly, an old woman from the EF focus group summarized khat problems in short words: as wasting of time, loss of job, loss of family and loss of everything. She recounted “intellectually, khat user does not think properly. If he thinks properly he would have understood harm caused by khat use. Khat use leads to a waste of money, waste of time, loss of job, loss of family and loss of everything. If khat chewer uses khat today he cannot go to his job tomorrow”. Despite the fact that all groups mentioned a lot of problems caused by khat use, the EF focus group elaborated most on these problems, putting a lot of emphasis on family problems created by khat use.

Health problems

Khat use was linked to health problems including mental problems, behavioural problems, stomach problems and heart problems. Interestingly, these problems were highlighted by the older generation represented by the EM and EF focus groups and a few participants from the CR focus group. The Y focus group did not talk in depth about health issues. These generational differences could be associated with differences in experience and knowledge.

General health and wellbeing

General health problems of khat use identified by some participants, particularly the older generation and community representatives, included stomach problems such as constipation and loss of appetite. Some participants had the view that the constipation is caused by lack of appetite. CRF8 said: “I know someone who got operation because of constipation created by

khat use”. Other health problems included diabetes caused by using a lot of sugary drinks with khat and problems associated with lack of exercise, particularly for taxi drivers:

“...it is awful because of the health impact it may have on the individuals, drinking all the sugary drinks and not exercising also can affect the heart of the person... also there are a lot of back problems... I spoke to couple of men who drive the taxi and eat khat and majority of them got back pain.”(CRF8).

“I heard that people chew it for a long time and during that time they use khat [with] black tea only and nothing else... That creates stomach sickness, fatigue, sleepless and headache.” (EF1).

Dental problems were also mentioned by some participants as CRF5 put it, “I’ve worked with young people as well. Now I see a lot of young people whose teeth, you know, really in bad shape, really bad shape... and they even smile without showing their teeth and this is creating whole different sense of identity”.

Many participants from the EM focus group associated khat use with sleeplessness that could bring sickness. “...khat leads to sleeplessness. And sleeplessness brings sickness. A person who chews khat becomes nervous. Sleeplessness leads to lack of appetite” (EM2).

Mental-health problems

A few participants from EF focus group expressed the view that khat use could lead to mental health problems. This was not the case with the other three focus groups, perhaps because women have observed khat use through husbands and males from their extended families:

“At the end of the day, it is possible for khat chewer to become mentally sick and taken to hospital and finally lose his memory. That is the biggest problem.” (EF3).

“Many khat users were dealt with by psychiatrists, and many developed sense of fear; they see something that doesn’t exist; they feel they are chased by something unseen to the point they become suspected and then arrested by police. He [khat user] feels he

is spied by others. Therefore, I think khat harms people mentally particularly for those who add to other substances when they use khat.” (EF7).

Two participants noted the potential for serious mental illness related to khat use:

“In relation to brain and mental issues, khat user is mad. Before chewing it, he is like us but when he starts chewing khat his mood and attitudes change soon. Khat user suspects even his own shadow...I remember a khat chewer who while he was chewing khat wanted to change his shirt and hang it on what he thought it was a nail on the wall. He saw a fly on the wall and he thought it was a nail on the wall and when he wanted to hang his shirt on it the fly flew to the other corner of the room, and then the khat chewer ran after the fly thinking it is a nail because he [khat chewer] doesn’t understand that this is a fly.” (EF5).

“... When people use it [khat] they have something called “thubab” which means when people chew [continuously] at least two or three days and they stop and they don’t chew, they experience... hallucination and they see things which obviously is not a normal thing.” (CRM3).

Many participants from the women focus group plus a few participants from the community representative pointed out that khat use leads to mood instability and unexpected behavioural changes to the extent that khat users cannot differentiate between what is important and what is not important for their life:

“If he [khat chewer] tries to wake up for work, he may not do any work because he is not mentally normal...he is not stable and he could be understood clearly that he is not in a good condition.” (EF1).

“When time for khat chewing comes closer khat chewer stops everything he is doing because of the expectation of having khat.”(EF2).

Family problems

The theme of family problems associated with khat use emerged strongly as many participants particularly participants from EF focus group expressed the association between khat use and a

diverse range of family problems such as family breakdown, conflict and divorce. This is because khat users are mostly away from their families and when they come home they either go to sleep without helping their families or ask for more money and return to places where khat is chewed. This creates tension between spouses and can lead to violence:

“I know a family that has a problem created by khat; they sometimes fight with each other; he is sometimes away from home for days because he is chewing khat in a restaurant and then he comes home after three days. Such person does not help his family.” (EW11).

“There are family friends of mine who... chew khat. They are normal when they are chewing khat but when they finish, they sometimes beat their wives and then they fight. He is not aware of what he is doing because in his body there is something like alcohol... This is the biggest problem that leads to family break downs. This man is not aware of his actions particularly after he finishes chewing khat (EF9).

A participant in the EM focus group related his own personal experience, consistent with the theme of khat use and its association with family violence:

“A khat chewer ...commits sexual violence and fighting with his wife. Myself, I had that kind of experience; I had been chewing khat over twenty years and I stopped it in 1997 when I realized that I was beating my children and committing violence against my wife. Khat has no any benefit and any person who thinks it has benefits, I tell him it has no any benefit and therefore, I advise him to stop it.” (EM2).

Stereotypes and taboos

Some participants from all focus groups with the exception of the EM focus group agreed that khat use is, to some extent, taboo; therefore some people chew it in hiding. Khat use is particularly taboo for women as YF6 put it, “It’s taboo I think for women. It probably does happen behind closed doors”. Similarly CRF5 stated, “I have seen boys in particular, so girls may chew it, but... it will not be part of their appearance”. Khat use was associated with stigma and negative stereotypes, particularly amongst younger men and women of all ages:

“ it is more acceptable for an older person, probably in their 50s or above who grew up in Somalia ... it's acceptable for them to do it because that is something that they were used to back in Somalia ...but for younger generations... in my belief, it is something that is looked down upon.” (YF6).

Two participants from the Y and CR focus groups questioned the mental fitness and competence of khat users to work as taxi drivers. Both participants emphasized that they don't feel safe being driven in a taxi by a khat user:

“If I was a client and I was in the car I wouldn't like the taxi driver to be chewing while he was driving me, cause I wouldn't kind of be safe.” (YF5).

“If you were driving a taxi and you were hallucinated... if you are taking me to the airport, what guarantees me I am getting there safely?” (CRF8).

On the other hand khat use by taxi drivers was also observed to be a stereotypical view and responsible for misplaced perceptions:

“I think it's a stereotype that all taxi drivers eat khat; like they're old men who don't work, I think it's a stereotype and there are many taxi drivers who don't eat khat ... I don't think it does any justice to a particular type of a Somali man who is trying to do the best for his family when he's labelled as, ok, you drive a taxi therefore you eat khat therefore you don't look after your family.” (YM7).

Unemployment

Khat use is also believed by a few participants to lead to unemployment. This is because khat use takes long hours which are not good for work. As a woman from the community representative focus group put it “Some of them can't work because they have been chewing all night” CRF1). Similarly, EM2 said, “[The] khat chewer is not ready to do anything; therefore he fails his education and work and then he will be sacked from his job”.

Neglect of roles and responsibilities

Some participants from the women and youth focus groups described khat users as irresponsible and careless people who don't think about their children's education and wellbeing, creating pressure on women to take leadership of the family:

“...the thing is they forget their responsibilities as a father, and so what happens is they go out all night chewing, get up like 6am to go to work, by the time the person comes back he is very tired, so he falls asleep, forgets about what is happening in the house, so that means like the mother becomes the father and the mother and everything; takes care of bills...you know, women are taking care of the household, like a man is supposed to do.” (YF5).

“A khat user does not help his family and children because he is in sleep when he is supposed to be awake and he is awake when he is supposed to be in sleep...The biggest problem is when he has children who need his support; so khat chewer does not seem to be a family man (EW2).

Financial burden

Some participants from the EM and EF focus groups clearly explained financial hardships created by khat use. A few participants from the Y and CR focus groups also mentioned financial difficulties associated with khat use. Khat chewers are accused of using what they earn to purchase khat and cigarettes rather than feeding their children and families. Participants from the EF focus group articulated the theme that khat users may force their wives to share with them their children's social security benefits:

“Some khat chewers ask their wives to give them some money or some government's social benefits given to their children.” (EW4).

“... It causes economic problems. This is because he spends his money with khat instead of his children and family.” (EM8).

Waste of time

Khat use is described by some Y focus group participants as a waste of time because one khat

session could take several hours:

“...it is time wasting because while he is eating khat for several hours he could be helping his family clean the house for argument’s sake or doing something more proactive with his time.” (YM3).

Excessive use causes problems

Finally, some participants argued that the problem is not khat itself but rather how Somalis use khat. That is, the theme of excessive use being problematic was identified. The theme was identified that the excessive use of anything would cause harm. CRM3 gives an example saying, “if you consume coffee all day, every night it will ultimately kill you. So, the way Somalis use this thing...causes mental problem, health problem and all these other problems”.

CHAPTER 5: PERCEIVED BENEFITS OF KHAT USE

Introduction

Diverse views were expressed regarding the perceived benefits of khat use. Themes emerged around a spectrum of khat use, whereby excessive use in particular may be associated with problems, whilst many participants identified that limited use may improve concentration, facilitate socialization with peers and strengthen one's sense of identity.

It makes your mind focused

Some participants believe that khat use makes the mind sharp and focused. In that sense it was considered to be good for studying and preparing for exams. As CRM2 stated "It focuses your mind like you can build anything within that time... why I used it for that time was to study... I could go back through ten books in three hours and actually not forget a word from all of them".

Sense of creativity and imagination

Many participants, again mostly men, stressed the theme that khat use provides a sense of imagination and creativity. Some participants went further suggesting that khat use helps creativity:

"... it gives you the benefits of thinking outside the box – you know you plan a whole city and then tomorrow it collapses." (YM2).

"When it comes to people...who play music and write songs and stuff like that and poetry and when they use [khat] they compose best songs, the best music...it puts him in a mood where their brain is more functioning than the normal way." (CRM3).

Social inclusion, sense of belonging and identity

Unlike female participants, a number of male participants suggested that khat use provides a sense of identity, of belonging and of social inclusion:

"Khat brings people together; they'll be in a room and...everyone is kind of

overexcited and then so they're really, really happy and they're with people they get along with, they have the same views." (YM7).

Khat use provides a warm social and inclusive environment, particularly for older men who do not understand the mainstream culture, do not speak English and cannot follow the Australian media:

"Social benefits obviously, bringing people together. I think it's a sense of pride, regardless of whether we are open to admitting that we like it or not, it's a sense of pride; the older men will come together, they'll be reciting poetry and other stuff." (YM9).

"There are old generations...they don't have a lot of English language, they can't follow local media and once they get together they remain all days with [each other] and this makes happy, provides them with the relief whether we agree or not you know and also it provides them sense of identity and social inclusion...you can ...feel safe, feel included, and you know feel welcomed and even stupid comment you make are valued. So it provides them with identity and social inclusion." (CRM10).

Sense of freedom and wellbeing

Again some male participants (but not females) identified that khat use can contribute positively to mental health, emotional security and social wellbeing as it provides a sense of freedom. This is because khat users can express their feelings freely, talk together and not feel lonely or isolated:

"It will contribute to their mental wellbeing because they don't feel lonely and isolated as they would you know otherwise" (CRM10).

"I think they feel the freedom when they chew; it gives them freedom to speak up" (YF4).

Less harmful than alcohol and drugs

Participants from EM and Y focus groups in particular highlighted that khat use could prevent youth from getting involved in other harmful drug or alcohol related activities. In that sense it was perceived to have some benefit. The theme emerged that it may be better to allow young men to chew khat in order to stay at home or stay within the Somali community and that this may prevent them from taking unfamiliar substances like alcohol and drugs or becoming involved in criminal and gang activities:

“Even though, for younger people I would say that’s not a good thing but, socially it is a lesser evil and people tend to accept it more, so when you are going to a place like for example you know drug rehab, that is something that is known to be harmful.”(YF6).

“Let’s face it – you know there are some other drugs that really destroy people in that sense so I guess khat is something we are familiar with, so if a family had to deal with an addiction, I’d rather deal with khat.” (YM1).

“I saw some young people who wanted to chew but they were hesitant to chew. I advised them to chew khat “if khat use prevents you from a bigger problem for their religion like drinking alcohol or taking drugs.” (EM3).

It makes business

Interestingly, some male participants perceived businesses made out of khat and shisha as being of value. These participants agreed that some individuals who trade khat make money and wealth. However, participants noted that khat traders are anecdotally not of Somali background:

“I have been to these houses where the wife and husband agreed to rent their house or their living room for khat use...” (YM2).

“People who trade are other African ethnic groups; Somalis are just consumers...80% of traders who sell khat or import khat from overseas are not Somalis.” (CRM10).

Zero benefit

Many participants, mainly women, dismissed any benefit associated with khat use in Western countries. Some female participants noted that the use of khat in socially sanctioned settings for a limited time, as it occurs in Somalia, may be accepted whilst excessive use of khat for long hours has adverse consequences, as is often the case in Australia:

“In Western countries, khat has no benefit...Originally, there were some benefits when old people used to chew it for a few hours in socializing ways particularly after they have finished their work but it has no any benefit in Western countries. This is because it destroys the person mentally and intellectually when chewed it excessively (EF2).

One participant also cautioned about the risk of problematic khat use emerging gradually in individuals who may begin using in a more limited manner.

“Khat is a part of drug it cannot bring any benefit for human beings...some people use khat moderately but if you investigate you will find that those who use it excessively were at the beginning using it moderately. They start slowly, step by step and then they do it heavily. Therefore, it has no any benefit for human beings; it is on the drug list and it is addictive (EW11).

CHAPTER 6: THE ASSOCIATION OF KHAT USE WITH OTHER LEGAL OR ILLEGAL SUBSTANCES/DRUGS

With regards to the relationship between khat use and other drugs, the Y and CR focus group participants felt that there is a lack of research-based evidence pertaining to khat use in Australia, which made this a difficult question to answer. Most participants with the exception of the Y focus group participants underscored the strong relation between khat use and cigarette use. CRM9 stated, “Khat-chewing and cigarette go together. There is no a khat chewer who does not smoke or if there are, they are very few” (CRM9).

Khat users are also said to be using alcohol and other drugs. EF2 recounted, “Khat, drug and alcohol are the same project, [and] they lead to the same way of thinking and the same attitudes. Users of these substances attract each other”. Anecdotal associations with marijuana were mentioned. Additionally, a former khat user from the men’s focus group explained how he and his colleagues used other substances like ginger and clove in order to enhance the effect of khat:

“Imagine the side effect when you combine khat-chewing with ginger, clove, chewing gum and cigarette... He [khat user] keeps all these things in his cheek and he chews it for long time” (EM6).

Two male participants from community representative focus group rejected the view that khat is similar to alcohol and other drugs and justified khat use as an alternative to other drugs. They were also not convinced that khat use was associated with alcohol or other drugs:

“I think they use khat as an alternative to other substances like marijuana or whatever so, in that sense it is actually good...there is no evidence or anecdotal evidence or lived experience where people combine illegal drugs with khat...they use khat as an alternative.” (CRM10).

CHAPTER 7: SOCIAL INTEGRATION

Introduction

[It is] possible to say that the reason behind the poor social integration of Somalis into Australian society is related to chewing khat

(EM2).

Most participants from the EM and EF focus groups believed that khat use is a barrier to social integration. Some participants from the CR focus group believed that the capacity of khat users to interact in social situations is related to the degree of use. With regards to the views of Y focus group participants, some of them insisted that khat use is a matter of community culture and identity, whilst others shared the view that khat use is a barrier to social integration, as noted by the other groups.

Poor social interaction

Some participants identified the theme that khat users are isolated and do not engage actively with non-khat users of Somali background, let alone the wider community. Khat users are said to engage more and interact with other khat users. The reasons behind their poor engagement with non-khat using Somalis was attributed to their altered sleep-wake cycle. Khat users also have their own subculture. In relation to wider society, Australians are unfamiliar with and do not understand the issues around khat use and associated cultural practices:

“It is impossible to chew khat and at the same time to mix and interact with other Somalis who do not chew even those from your own village let alone to interact with non-Somalis. Khat-chewers get along only with those [they] understand them and have something in common.” (EM8).

“Khat is a barrier to social integration not a facilitator...A khat chewer is distancing himself from Australian society.” (EM9).

Two participants from the CR focus group explained that khat users’ level of social interaction is largely based on their level of intoxication with khat:

“They are very anti-social when they don’t have [khat] in the system. And so the ones I know almost everybody I know is exactly in those two terms: very good, very social

and they can talk to anybody and can relate to anybody when they using khat and when it is in their system. However, when it is not in their system which is in the break days...they are not in that situation. They are quite anti-social (CRF2).

Khat use does not affect integration

In contrast, most participants from the Y focus group argued that khat use does not affect the process of social integration into wider Australian society. In their view, khat use is a cultural matter that helps Somalis keep in touch with their own culture and identity in a multicultural Australian society:

“I think that the fact is it has absolutely no effect on. This is something that Somalis like to do, while they’re gathering themselves perhaps you know, talking about their life back in the day or reminiscing on certain things that their Dad taught them.” (YM1).

“I don’t think it has any sort of relevance in terms of assimilating within the wider society, because, you know, assimilation in the sense doesn’t mean that you stop what you know, like what your culture is, or what you normally do, and adapt to the country that you’re trying to assimilate with, to their cultures.” (YF6).

Additionally, some respondents from the Y focus group differentiated that khat use will keep the older generation in their own environment and segregate them from contacting and negotiating with the wider Australian society due to their lack of English language and Australian social norms. In that sense, khat use is a barrier to social integration:

“There is a difference between the older generation and the newer generation because, say for example a person that came from Somalia came here when he was about 50, he will probably most likely stick with what he knows which is Somali people; where does he socialize with them? At the restaurants, and if they are chewing khat then he sticks within that social grouping so that stops him in a sense to build new relationships outside of you know the Somali community. So in that sense I think it does affect the assimilation process.” (YF6).

CHAPTER 8: WHERE KHAT IS USED

Introduction

Participants had diverse views on conditions in the places where khat is used in Australia. These differences could be ascribed to the fact that youth have less experience and contact with such places, and hence may have more stereotyped views. However, the general perception was that places outside the home environment are unhygienic and undesirable.

Houses and specific user-locations

Most participants believed that houses in which khat is chewed are clean. As CRM3 expressed “people are chewing in their house[s] nicely and cleanly”. Likewise, special places for khat use are well maintained and equipped with “fadhicarbeed”, which is a comfortable sitting system attributed to Arabs.

Common places

Common places such as restaurants are said to be bad, messy and the most unhygienic places. The vast majority of participants in this study agreed that common places in which khat is used frequently are unhygienic and unhealthy. Additionally, used and leftover cigarettes and other rubbish associated with khat use are thrown around to the point EM9 stated that, “A khat chewer does not feel comfortable and excited in clean places... khat and rubbish are interrelated”. Another participant emphasized that khat users do not understand health requirements when chewing khat. For that reason, “most places where Somalis get together and chew khat do not obtain such health certificates” (EW7). YM3 described emphatically these common places as “disgusting and dirty...some situation is the most filthiest person can ever walk into it... if they use that venue frequently, it’s going to be...disgusting...and then there is the filthy people, they don’t really care; they’re probably dead and gone”.

“Large institutionalized places of khat usages mainly restaurants and of those places are not hygienically in the best shape. There is also high risk of combinable and transmissible diseases like if you got infection into the cloth and like that, because there is a sharing of

utensils; but the number one problem associated with the presence of khat is the cigarette smoke...” (CRM10).

Rooms in which khat is used are also overpopulated as participants of one khat session are estimated to range from 10 to 20 people, such that passive cigarette smoking associated with khat use is an additional hazard:

“It is a very smoky environment. Suppose there are 10 to 20 men who all smoke. A cloud of smoke covers everywhere and possibly no one can see the other because of the smoke.” (EF5).

Differences between places where men and women chew khat

Interestingly, some participants from EF claimed that there are some differences between places where women use khat and places where men chew khat. Places where women could go for khat use are much cleaner and in better condition than men’s places. “I can’t generalize but they [men] can’t even clean the cups they use for drink. On the other hand, women who chew khat use “uunsi” and other good smelling stuff and they dress well compared to men” (EF7).

Isolated/hidden places

Places for khat use are described as isolating places where khat users hide in dark rooms and at the back of restaurants. These places are described as ‘hot spots’. CRF6 explained that you can see khat users “at restaurants down the back where there’s a room with the Arabian seats and all that, and they sit down and might not have any lights”. Similarly CRM7 described khat users “to be hiding somewhere...in the room; they can’t go outside, they have to smoke there and the condition of the room is really unhealthy”.

CHAPTER 9: GETTING HELP FOR PROBLEMATIC KHAT USE

Introduction

So in terms of going to a place, I think, you know it has to be identified as a problem; if a person is not identifying it as a problem, then they're not going to see it as needing help. Within the Somali community, I don't think we believe...in something called addiction
(YF6).

Respondents of this study provided diverse and interesting views in regard to places where someone affected with khat use may get help. Many participants argued that Somalis do not identify khat use as a problem and subsequently do not seek help, while some acknowledged that stigma may also influence help-seeking behaviour. Some participants tend to believe that khat users seek financial help from their extended families or social security benefits in order to purchase more khat. In contrast, participants from the EM focus group emphasized the use of self-help strategies for those with problematic khat use. The importance of providing culturally appropriate services was identified by some participants.

PROBLEM AWARENESS AND HELP-SEEKING BEHAVIOUR

Many respondents agreed that khat is not seen by Somalis, particularly the users of khat, as a problem, but rather as a socially and culturally accepted practice, and hence users may not see the need to seek help. For example EM8 claimed that he has “never seen any person who is seeking help because of harm caused by khat use”. Similarly, a young woman from YFG recounted:

“So in terms of going to a place, I think, you know it has to be identified as a problem; if a person is not identifying it as a problem, then they're not going to see it as needing help. Within the Somali community, I don't think we believe... in something called addiction.” (YF6).

“There is no way to seek help or solution if the khat chewer does not see chewing khat as a problem. As Somalis, we don't see it as a problem. Khat chewer doesn't think that

he is creating a problem. As a result, it doesn't come in his mind to stop it.” (EM9)

A male participant from the community representative focus group argued that when it comes to seeking help from khat problems, it is not sought by khat users themselves but by non-khat users who are affected indirectly, including extended family members, children and wives:

“when it comes seeking help for khat problems it is often those who're affected by it [khat]: extended family members, children, wives who actually do, who initiated seeking help or help seeking; it is hardly the person who uses the khat that would come across as needing help or seeking help and that again goes back to khat [has] not been perceived as being problem”. (CRM10).

Stigma may influence help-seeking behaviour

A few participants, mostly young people, underlined that the community does not openly talk about problems associated with khat use and subsequently does not talk openly on how to help individuals and their families. This is because it is very hard for any person to openly express that he is seeking help because he is not going to expose all his secrets to others. “There is also the issue of stigma associated with khat users if they seek help” (EM2). Similarly, YF6 said, “But I think that in the Somali community we tend to be a lot less vocal about the issues facing our own community. I don't know whether it is because it's a taboo, I don't know, because it's shameful or what; there needs to be conversations”.

Financial help from their extended families

Few participants except the Y focus group participants highlighted that some khat users seek financial help from other khat users, from their families, relatives and friends, from community leaders; and from social security benefits:

“.... He can't go for work, and he can't study. He is unproductive. He endeavours only on how to receive Centrelink benefits. He goes to doctors again after again in order to get some reasons that allow him to receive Centrelink benefits.” (EF4).

Self-help

Some participants, mostly from EM focus group, mentioned that the harm caused by khat use could be solved through individual initiatives and decisions. This is because khat users were perceived to know what is good or not good for them. To make good decisions, it is suggested that khat users need to realise the side effects of khat use on their families, health and general life:

“I think people deal with it individually. So, you know, some say I have this sort of problem so I have a problem as a result of khat so I will go and see the doctor, I will go and see the dentist”. (CRM5).

“Khat chewer can stop chewing without seeking any help from any person. I have been chewing khat over 20 years. One day, I remember, I couldn’t get khat, then I stopped it. I reflected and said to myself, “Why I am slave for khat?” From that time I stopped chewing it and since that time, I have never touched it.” (EM7).

Another way of helping individuals with problematic khat use is believed to be giving them advice. “You can go to him [khat user] and provide him some advice telling him that khat use ruins his family and his children. You can make him realize the disaster that khat use can bring him” (EM8).

Providing culturally appropriate services for khat users

Some participants, mostly from the Y focus group, highlighted the lack of culturally sensitive services. Some participants suggested that people with problematic khat use and also their family members may seek support from general counselling services:

“In the Australia, we don’t have any counselling of khat...my understanding is the family members who are affected can go to the places where counselling is or to social work.” (CRM9).

“I would say, if you wanted to go somewhere you would go to any of the drug centres; if you are trying to get off something, regardless of what it is, you know, those places do help people out.” (YF1).

“The way I think is to establish places where khat users —who have khat problems— are helped...There is lack of knowledge of the support and services available for khat users; these services are needed by khat users. People [khat users] are not connected to the mainstream services.” (EW2).

Role of the mosque as a culturally accepted place of help

Some participants acknowledged that some people with problematic khat use seek help from mosques and religious centres as an alternative to drug and alcohol counselling services. Some participants believed that the best way to help khat users minimize harm caused by khat use is to take them to an environment that is free of khat use:

Since I think Somalis in general are at least outwardly religious, I think religion could play a big role, in helping, in terms of not making it hard; as in forbidden or not forbidden - like that's almost irrelevant at some point; but speaking of like wasting time, being productive, cause we're a shame- based culture... (YM7).

...it is possible to provide khat users some help through religious treatment such as taking them to an Islamic environment like mosque and religion sessions; that may enable him [khat user] to perceive khat as a wrong thing and then to stop chewing it (EM8).

I've seen people who want to get clean then they turn to religion and they go to the ...they turn to religion and they start going to the mosque and you know when you start turning to religion you know Islam it cleanses you so pretty much they give up their bad hobbies and you know what they do so that kind of becomes like an alternative kind of like a rehab thing for them and its better than a person coming up to you and saying you've got this problem, this drug problem, something like that... (YF5).

I would say that it is good to relocate him into a different environment where he can meet religious people. I personally would suggest helping him [khat user] through religious teachings and values and anything that is good for him in religious perspectives (EM3).

CHAPTER 10: SUGGESTED STRATEGIES FOR HELPING INDIVIDUALS AND FAMILIES AFFECTED BY Khat USE

Introduction

I think we need to create a situation where the ice is broken where families are not actually ashamed to say my son has a problem and let's say on...national TV or national Radio I have this problem. Because we all know this if there is an issue even in the West when there is an issue it's great to be broken for the other people to come out. And only when other people come out, they will be able to be willing to be helped

(CRM2).

A range of strategies to help individuals and families affected by khat use were identified by the participants of this study. These strategies include: increasing awareness, creating treatment and counselling services, conducting research into effective treatments and using family and social resources to facilitate treatment, as well as resolving the legal status of khat.

Public education and awareness

The EM and EF focus group participants did not place as much emphasis on education. However, many respondents from the CR focus group plus some Y focus group participants believed that education is the key strategy to help people with problematic khat use. It was identified that public education can take different forms, including seminars, producing fact sheets, pamphlets and documentaries, or using community radio:

“First of all in any similar cases to these, education is the key...producing pamphlets and certain things that based on factual things: this is what the problem is if you consume this, this is what happens to you. It will also help the family, the wife confront people who use it and [say to them] you know what? This has been proven this is bad for you so you should stop using it ...”(CRM3).

“There should be some sort of NGO that should be set up specifically for teaching the young ones about all sorts of drugs, you know, especially khat, which is well hidden;

you know, just educate them.” (YM2).

Some participants suggested that the public awareness of khat could be modelled on the public awareness education programs on cigarette and alcohol use in the West:

“This public awareness should be provided through TVs, radio, public gatherings and through orientations... to educate the problems of khat misuse.” (EM7).

While the importance of education is articulated by many, some participants argued that educating khat chewers of Somali background, particularly the older generation, in Western style is not conducive to a good outcome, because Somalis are an oral society and do not place as much value on the written word. The alternative, therefore, is to educate through word of mouth, verbal and visual education through community radio and television:

“Printing pamphlets and giving to someone and saying here you got, you’re chewing, this will explain, he will not actually [be] reading and he will tell you, what is this? [he will say] can you tell me ... because he doesn’t want to read it, he wants you [tell him], we are oral society...so by educating people not with pamphlets and graphics and stuff like that but by Somali way; the certain way we communicate in our society, we pass the knowledge and we educate them.” (CRM2).

“We got a lot of people listening to Somali Radio for example. If we had the facts, the fact sheet, we can say oh you know, khat can do this, this, this, because we listen as Somalis but we don’t read, we are not good at reading maybe, and if you talk it in Somali is even better because tomorrow they know that there is a hotline and they can ask help as well.” (CRF8).

Khat hotline

Some participants suggested developing a telephone hotline that anyone who is affected with khat use may contact directly and ask for advice and help. CRF8 said, “...maybe we can have a hotline for the people, one of the ways we can help them, you know how there is gamblers’ hotline...and they will tell you what they used to deal with it.” (CRW8).

Research and information

A significant number of participants from the CR and Y focus groups identified a paucity of research on khat use in Australia. They felt there was a need for further research that investigates the social, economic, and health impact of khat use on khat users and the community in general. They expressed confidence that research would provide reliable information about khat use and that the outcomes of research could be translated into factual information sheets and disseminated into the target community:

“We need to investigate [and] research; we need to know about the chemical properties of what is in there because I don’t know much about khat ...” (CRF8).

“If there is a sickness, what is needed is to know root causes of that sickness. There should be studies about factors causing a person to use khat. Appropriate medicine can be prescribed after identifying causes of the sickness...” (EF7).

Public debate and advocacy to raise the issue of khat use

Another strategy suggested by a few participants was to bring East African and Yemeni communities, who are also affected by khat use, into community advocacy work to jointly tackle problems associated with khat use in the community. Development of organizations that facilitate public discussions and debates through which people affected by khat use may explain their problems was also identified as a potentially helpful strategy. In addition, the suggestion was made that professionals and experts in khat and drug problems including medical practitioners and drug and alcohol counsellors could be invited to explain the problems associated with khat use in public forums:

“I think we need a public discussion on this topic; the discourse, a balanced one. The problem is we failed to get the message of the harm of khat causes to the users and we only talk about the negatives...there is no denial there are some positive ways whether it is lived or not, it has to be a balanced, a social discourse that says there might be some elements of khat usages that might be beneficial to you as individuals or to the groups of people that do but the harm khat [causes].” (CRM10).

“I think we need to create a situation where the ice is broken where families are not

actually ashamed to say my son has a problem and let's say on...national TV or national Radio I have this problem. Because we all know this if there is an issue even in the West when there is an issue it's great to be broken for the other people to come out. And only when other people come out, they will be able to be willing to be helped." (CRM2).

"The person who is expert in this – a doctor or someone who is a community leader but who is expert in this so has to be a health professional; not like just someone I'm a community leader I'm going to approach this." (YM3).

Creation of community centres and recreational social activities

In response to the impression that khat users are often seeking a social outlet, some participants identified the potential value of setting up well-equipped community venues and centres in which khat users and non-users may attend:

"We've talked a lot about why people have actually gone into doing khat and what it is that actually drives them was the aspect of socialisation and meeting people and networking with people, so in my view we need to set up avenues for people to socialise in a less harmful way." (YF6).

"It is also important to have a community centre in which people can come and get advice about khat problem. What is needed is a community centre equipped with a lot of facilities in which youth can go and play games and have other leisure activities. That can prevent them from going outside and have shisha and something else that is bad." (EM6).

Alongside suggested community centres and social activities, some respondents tend to believe that the best strategy to help people affected with khat use is to assist them in their resettlement process by providing them with employment opportunities, education and social inclusion programs.

Helping through religious practices

As noted previously, a number of participants, particularly older men, identified the potential to

help people who are affected by khat use through religious practices. Suggestions included taking khat users to mosques for spiritual and religious guidance:

“It is possible to provide khat users some help through religious treatment such as taking them to an Islamic environment like mosque and religion sessions; that may enable him [khat user] to perceive khat as a wrong thing and then to stop chewing it.” (EM8).

“I would say that it is good to relocate him into a different environment where he [khat user] can meet religious people. I personally would suggest helping him [khat user] through religious teachings and anything that is good for him in religious perspectives and also telling him to think and compare advantages and disadvantages of khat use.” (EM3).

Kill the snake from its head

Many participants from the EM focus group agreed that the patriarchs in Somali family are primarily those who use khat and this subsequently creates family problems. “99% of khat chewer in the family is the father” (EM7). For that reason, participants believed that the best strategy to help families affected with khat use is to find solutions for the fathers and help them stop their use of khat and in turn reduce the exposure of their children to their use of khat. This argument was provided eloquently by EM5:

“One of the Somali proverbs says, “When killing snake, kill it from its head”. If it is not hit on its head it bites you; but if it is killed from its head it dies quickly. Problem of khat is from parents and particularly fathers; mothers chew it secretly... The best way to fight chewing khat is to focus on fathers who chew khat; encourage them to leave khat.” (EM5)

Legal status of khat

The legal status of khat raised controversy across all groups. Some participants were in favour of the illegalization of khat use in Australia as the best strategy to help with those affected. However, concerns were raised regarding the potential for khat users to turn to other drugs:

“I think like state legislation would change it. That would definitely reduce it...but also what I’m scared of is that once khat is illegalized, we might replace it with another drug...Khat is something I’m familiar with, my family, their family’s familiar with...I think yeah getting the state legislation changed, that would definitely stop, if Somalis knew they would cop a fine I don’t think they would be chewing.” (YM2)

Some participants argued that illegalization of khat could criminalize an entire generation of older men who use khat as part of their everyday life. As expressed by some participants, criminalization of khat use may shift khat as a soft drug to an illicit drug. It may also increase the risk of further marginalizing men who are already vulnerable, leading to family disharmony and impairment in level of functioning. Hence harm minimization was identified as a meaningful approach:

“We could also actually make a lot of men criminals, which is something I’m also against in that sense. This is something that these people are so used to. All of a sudden today it’s illegal, you are making a lot of people criminals and you’re going to put them through systems with that attitude.” (YM1).

“I think there should be shift from the discussion of criminalization to the harm-minimization... if you remove that without a dialogue and discussion from the community, then it shifts to more an illicit drug (CRM10).

CHAPTER 11: THE PERSPECTIVES OF PRIMARY CARE PRACTITIONERS

Understanding of khat use

A key theme that emerged from the views of khat use amongst health care practitioners was the lack of knowledge and understanding in general. With the exception of the single Somali participant in Group 1 (PP5), the majority of participants had very little knowledge about khat and a couple of participants said they had never heard of it at all. No one, other than the Somali participant, identified that they had worked with a client who they were aware used khat:

“...I’ve not heard about this drug until today...” (PP1).

“...I’ve heard it mentioned amongst some of the other professionals...” (PP7).

Nonetheless, there was some general understanding about the nature of khat identified by a number of participants. Participants were aware that the leaves of the khat plant are chewed and that it has a stimulant effect. There was an identified need to further understand khat’s relative impact and potential for dependence in order to better understand the nature of problematic khat use:

“...It’s a stimulant...it’s addictive...Are they any less addicted to what they are buying legally from the supermarket?... I use coffee for that purpose. I would say that I would have some fairly serious withdrawals. Where is khat on that continuum? And where do you kind of draw the line to make it a clinical problem rather than just a socio-economic problem?” (PP3).

The participants were able to indicate an understanding of the reasons individuals may use khat. There was an acknowledgement of the role of khat use within Somali culture, particularly amongst men, provided its use is not excessive.

“...the others if you talk to them and they say, you know, ‘Wow my husband is good, he’s a good father to his children and he deserves to have time with his, you know, mates and you know, have Khat and, you know, um, to feel de-stressed because he will feel fresh on Monday to go back to work...’” (PP5).

There was also an understanding of the potential positive effects, in particular increased alertness, and this was specifically identified as being of perceived value to taxi-drivers.

“...some they chew while they driving taxi so it makes them... awake and alert...” (PP5).

With regards to customs associated with khat use, some practitioners had a basic understanding of accepted practice and social norms with regards to khat use within the Somali community. One participant identified that unlike other drugs, khat use may be a particular issue amongst older Somali migrants.

“...it’s quite unique in that it it’s an older generation that are using the drug...drugs are generally for...youth, it’s generally the youth that they’re targeting” (PP4).

As identified by the Somali participant, as a result of the ‘silent’ nature of khat use in the community, its use as well as problems associated with its use are also not widely known:

“...it’s a silent drug that’s in use. And because it’s silent the harms of it are probably also silent” (PP1).

Understanding when khat use becomes problematic

With the exception of the Somali practitioner, health practitioners expressed that they lacked specific knowledge about when khat use becomes problematic. However they suggested that khat could be compared to other substances of abuse, including amphetamines or marijuana, and hence that it would become problematic when it interfered with people’s lives and level of functioning:

“...Being a stimulant I guess people are staying awake and then crashing out and sleeping so that’s obviously affecting their family life. But personally and in our experiences with working we can’t really answer that...” (PP2).

The understanding of when dependence on khat may develop if at all was identified as an area of uncertainty. Other areas that were identified by participants as worthy of clarification included the question of its legal status, relevance to religious practices and whether it could be a ‘gateway’ drug, or a stepping stone to other drug use.

Problems associated with khat use

For all members of the groups other than the Somali worker, comments on the problems

associated with khat use were mainly postulated in the context of comparisons with other drugs. Nonetheless, a range of problems were identified with its use, indicating the diverse ways in which khat may impact on social and occupational functioning, including:

- Time spent chewing khat is time away from the family
- Burden on women
- Financial impact
- Relationship conflict
- Impact on mood
- Impact on employment
- Health effects due to self-neglect and the possible effects of withdrawal on functioning

Participants identified that khat use may be problematic if it leads to pressure on families and consequent changes in accepted social roles, particularly for men who may be unemployed and who may not be in a position to provide for their family.

“...those that are very addicted to it can’t stay away from it, don’t have anything to do with their family, don’t know what grades their kids are in school... It also takes away money, resources from the family...” (PP5).

The burden of khat use and its impact on women emerged as a key theme, as problematic khat use may have a pervasive effect on normal social roles.

“...Somalis like to have...large families and large number of kids and she can’t cope looking after all the kids and the father is...absent, because he’s away chewing...khat and when he comes he’s catching up with sleep...” (PP5).

A key theme that emerged related to the perspectives in the community on the nature of khat itself, and whether it may even be perceived by members of the Somali community as a drug.

“...they deny, you know, that khat is a drug.....they don’t actually you know understand...” (PP5).

“...people who are using it wouldn’t actually see there being many problems associated with it because they’re using it to solve their problems...” (PP2).

Care for individuals with problematic khat use

Despite the limited understanding of the specific issues related to khat use overall, one of the key themes that emerged was the need for mainstream drug and alcohol counselling services to be in

a position to provide necessary assistance. Primary care practitioners expressed the view that an expansion of their knowledge would be useful, but even without specific knowledge about khat, treatment approaches, in particular harm minimisation strategies used for other addictive substances, could still be helpful and applied effectively:

“...I’m not saying it’s a perfect system...but that’s the system that exists...” (PP1).

“...I think it’s an addiction. It doesn’t really matter what the substance is...” (PP10).

“...what there is in these services is specialised knowledge about treatment of addiction...and treatment of problematic drug use...” (PP1).

Hospitals and telephone counselling services were also mentioned by two participants as additional potential places for individuals and their families to seek help.

Another key theme that emerged throughout the discussion was related to the challenges of engagement of Somalis in general. Several participants made reference to their experience that very few Somali people access counselling services.

“...they don’t consider counselling a priority or something that can be helpful...” (PP10).

Another key theme identified was the need to actually reach khat users. It was noted that individuals may only seek treatment if khat is viewed as a drug.

“...if there’s a lack of acknowledgement of it as a drug then it’s hard to...put a drug treatment service around it...” (PP1).

Khat users may also face the prospect of potential loss of social connections if they were placed in a position to cease their use of khat.

“...for people to change their use they have to identify that they have a problem, and they actually have to withdraw from their social network ...” (PP10).

It was commented that appointment-based systems are not always utilised by the Somali community.

“...We get hardly any Somalis through the service so I guess again it’s trying to find a way for us to take the service to them in a way that fits with their culture in order to

provide care...” (PP7).

It was noted that general practitioners and maternal health nurses may be able to provide assistance, as Somali people may be more likely to present to these particular professionals rather than to a drug and alcohol service.

A couple of participants re-iterated the issue that the perception of khat as a drug will influence decisions made regarding whether individuals seek assistance at all, and if so from a drug and alcohol treatment service.

“...there’s a...lot...of...grey area...” (PP3).

“...What is their perception of...khat...? Do they see it as normal pastime thing, socialisation? Or do they see it like something that makes them high like other drugs?” (PP5).

A theme emerged regarding other potential points of access for care of individuals with problematic khat use and their families, such as through the involvement of coordinated government agencies including councils, health services and schools:

“...the service planners...the councils, the health services...it’s on the radar but then you’re actually trying to... take an approach towards... putting a framework around it...” (PP3).

“...in schools too because there a lot of Somali students going to our schools now...you can create awareness within that setting...” (PP6).

Health promotion strategies

In addition to the need for education of health care practitioners, another key theme to emerge related to the value of health promotion amongst the Somali community, to highlight the issue of problematic khat use, and to encourage individuals and their families to seek assistance if required.

With respect to the nature of the approach that is required, one of the key themes that emerged focused on the need for a holistic approach to health promotion:

“...it probably needs to be addressed as a public health issue...it would seem that treatment options are not going to have any impact at the moment...because people

aren't presenting there so... raising the awareness of the drug seems to be really important, raising it within...the Somali community... raising it with young people...raising it with young men" (PP1).

One group member commented that little has been done thus far to formulate a consistent approach to khat treatment, and that government assistance was necessary. The legal status of khat was also mentioned as an important consideration, with discussion around how immediately criminalizing culturally sanctioned practices by making khat use illegal, particularly without the involvement of the community, has the potential to cause further problems.

"...if we made use of this drug illegal we'll be essentially turning all users of this drug into criminals straight away and you'd put them into a new system ..." (PP1).

The potential for legislation to restrict khat use in parallel with health promotion strategies was raised by one participant.

"...at a higher level...policing going hand in hand with the primary health approach" (PP3).

The need for education was another key theme, with an emphasis on provision of information in a range of different contexts, including:

- Education for health professionals
- Education for users
- Education for families
- Increasing awareness and education in schools
- Increasing awareness in the Somali community, particularly targeting young men
- Learning from the users themselves what strategies they think would be helpful

One participant identified the need for khat to be more widely recognised so that screening could be done.

"...the assessments that have been done...it's never been mentioned..." (PP10).

Harm minimisation strategies

With respect to specific harm minimisation strategies, one of the key themes to emerge was the

potential application of universal strategies with adaptation to khat use.

In the development of strategies to address khat use, a theme emerged that guidance may be found from considering strategies that have been successful in reducing the harms associated with tobacco, alcohol, marijuana, amphetamine and heroin use:

“...basic strategies like maybe reducing the amount that they’re chewing, maybe reducing the frequency, if they’re attending these group meetings every day for instance I don’t know if that’s feasible really or realistic that they could attend every second day...” (PP7).

Several participants expressed the view that there would be similarities in the treatment approaches to all addictive substances that remain relevant. One participant suggested that in particular, cannabis treatment models could provide guidance, given the fact that in many circles marijuana use is socially sanctioned and perceived to be not as potent or harmful by many people in the community as other substances of abuse and dependence.

“...there may be similarities in treatment with cannabis ... cannabis users quite often they call it a ‘soft drug’ and it’s not causing them any harm and eventually it does cause them some problems and they need to do something about it, and perhaps that’s the same with khat users.” (PP9).

There was discussion around the need for motivational strategies. This included both the potential for individual motivational interviewing, as well as the potential for motivational work in a group setting.

“Doing some motivational interviewing...trying to encourage them to see the pros and cons of using, the pros and cons of reducing... being...able to control their use because obviously it seems like it does have certain benefits but it’s even impacting on families...so it seems like it’s got a lot of negatives attached to it as well. So...encouraging them to get some insight around it...” (PP7).

It was noted that there is potential for role models within the community to act as advocates for change. It was noted that sometimes there is the potential for one group member’s behaviour to provide a catalyst to change in other members of the group.

“...sometimes there are a group of users and one of them will be having a lot of

problems in their life but want to do something about it and will go and do something about it and then everyone else in that group will start to see that person making changes in their life, so it's kind of a bit of a snowball effect.” (PP11).

Culturally sensitive intervention strategies

Another key factor regarding intervention strategies related to the place of khat within Somali culture, and ensuring strategies are culturally sensitive. This was highlighted as being both a particular challenge associated with khat use, as well as an important consideration when contemplating what sort of interventions would be helpful. A theme emerged that cultural modifications may be required in order to ensure universal strategies remain applicable and culturally sensitive. One participant suggested that approaches that had been used to address other complex cultural practices deemed illegal in Australia could provide guidance. It was also mentioned that in order to develop appropriate interventions, there was a need to learn more about Somali culture:

“...knowing more about their culture and how problems are usually worked out and sorted out within that culture, the role that khat has, the role that the person using khat has in that family...” (PP8).

Given that khat is usually chewed in group settings, a couple of participants mentioned that interventions may be more useful in a group format, rather than through individual work. There would be particular challenges for individuals who decide to stop chewing, given they would need to reduce or cease their contact with a potentially valuable social network.

“I wonder if there was group work, like support groups offered, working with the Somali workers so it's integrated, like say hypothetically if you had a group here once a month so the people that were affected or the families that were affected would actually be able to meet.” (PP 10).

At a broader level, it was also mentioned that given khat is often used to cope with stresses associated with migration, there is a need to think more systemically about problems facing migrants. Hence it was noted that excessive use of khat may be indicative of acculturative stress that may need to be targeted in other ways.

“...when people from the horn of Africa come to Australia and their education and their qualifications are under and unrecognised ...it creates a level of stress...” (PP1).

Assistance for families

With respect to specific ideas around providing assistance to families, key themes included:

- Need to support family members
- Specific groups such as Family Drug Help could be helpful
- Need to identify how exactly khat use is impacting on each family and tailor interventions appropriately

As for individuals with problematic khat use, it was identified that providing information about khat and its effects would be helpful for families. This was framed by some participants within a public health approach.

“...community education, whole of community approach...you could do campaigns...” (PP6).

It was recognised that individuals may be reluctant to seek assistance, and that affected family members may benefit from different interventions that need to be individualised.

“...for instance if there’s family violence around after use, that’s going to need a different treatment approach compared to if they’re spending a lot of money buying khat...” (PP7).

Research

Another theme identified was the need for more information and research, in order to understand the impact of khat use and to understand what specific strategies may effectively meet the needs of individuals with problematic khat use and their families. Specifically the following areas were noted to be worthy of exploration:

- Investigating how khat users perceive other drugs as compared to khat
- Review studies of communities where there are significant numbers of shift workers, given taxi drivers have been reported to use khat in increased amounts
- Talking to khat users to better understand their perceptions of khat and why they use

One participant noted the lack of evidence for a specific framework in caring for individuals with khat use and their families:

“...there’s been very little done to actually... put it within a...framework that you can

respond to.” (PP3).

Given the use by taxi-drivers, the potential to learn from other contexts where drug use and shift-work co-exist emerged as a theme.

“...I wonder if there’s some work to be done in comparing to other... communities where...there’s high levels of shiftwork... to compare and contrast to see if there’s any clues there about what other drugs that are used in... mainstream...culture...whether it’s marijuana or...caffeine...and I guess changing the way that people...perceive that that usage and putting strategies in place that you can... bring to bear for khat use.” (PP3).

CHAPTER 12: CONCLUSIONS

This research highlights the controversies surrounding khat and its perceived level of harm, together with the complexities regarding possible interventions that may assist individuals with problematic khat use and their families. The diverse views of the Somali community members who participated in this research highlight that as is the case with socially sanctioned substances in Western societies, a cautious approach to identifying and assisting individuals with problematic khat use is required. There is a need for a greater level of awareness of khat use, and the problems associated with khat use. Members of the Somali community highlighted the diverse aspects of the social impact of khat use, including various ways in which excessive khat use may lead to impairments in functioning, family disharmony, and marginalization from society.

Primary care practitioners are well placed to assist individuals with problematic khat use and an approach based on harm minimization strategies provides a useful framework. It was recognized that there is a need to maintain a culturally sensitive approach in order to tailor interventions for the Somali community. Hence this research identified that outreach primary care services may be better able to engage with members of the Somali community, and hence engage individuals with problematic khat use in interventions to manage their use.

Integrating the perspectives of Somali community participants and primary care practitioners, the following recommendations can be made with regards to increasing awareness of problems associated with khat use, and interventions that may assist individuals with excessive khat use and their families:

1. Although khat continues to be used in culturally sanctioned settings, marginalised and vulnerable individuals may be at risk of excessive use
2. Khat use is common in the Somali community, and problematic khat use is indicated by
 - Physical health problems
 - Mental health problems
 - Excessive time spent on khat use

- Excessive money spent on khat use
 - Family disharmony associated with khat use
 - Pursuit of khat to the exclusion of other roles and responsibilities
3. The appropriate legal status of khat use remains controversial
 4. Public education programs focused on identifying problematic use of khat would be beneficial for individuals and their families
 5. Mainstream drug and alcohol services ought to be equipped to assist individuals with problematic khat use
 6. Drug and alcohol service practitioners would benefit from education regarding khat and indicators of problematic khat use
 7. Universal harm minimisation principles can help individuals using khat including:
 - Reduction in time spent on khat use
 - Reduction in the amount of khat used
 8. Motivational interviewing techniques can be adapted to assist individuals with problematic khat use who may be contemplating changing their habit
 9. A culturally sensitive public health oriented approach is required to address the impact of khat use
 10. Outreach interventions may be worthwhile including:
 - Adopting a family-oriented approach to interventions given the pervasive effect of khat on users and their families
 - Proactively engaging members of the Somali community who may be at risk of problematic khat use
 - Utilising different methods for intervention including telephone advice services and community-based face-to-face interventions
 - Emphasising social interventions including group activities and employment as a means of reducing the time spent by individuals engaged in excessive khat use
 - Engaging cultural leaders including religious leaders may enhance the value of such programs.

Limitations of the study

This study focuses on the Somali community's and primary care practitioners' experiences and perceptions of khat use in Melbourne, Australia, which is the Australian city with the highest number of resettled Somali people (Victorian Multicultural Commission, 2007). There are a number of limitations of this study, which need to be considered when contemplating the generalisability of the findings.

Firstly, participants were not asked to identify if they used khat themselves, so a group of problematic khat users was not specifically identified or engaged in this research. Involvement of such a group may have been able to provide additional and particularly useful information both around reasons behind khat use and potential strategies for harm minimisation and assistance.

The Somali group was also identified through community groups and contacts of the lead researcher. As such, the participants were in general actively involved in the Melbourne Somali community, rather than a socially isolated or marginalised sub-group. They were willing to give up their time and voice their opinions on this issue, which they believed was important. As such, there is the inevitability of volunteer bias. It is possible that Somali people who are less well integrated into the local community, and less enthusiastic about attending such forums, or less able to give up their time, may have quite different opinions around khat use and potential treatment approaches.

It also needs to be considered that the moderator of the focus groups was a Somali man of high standing in the local community. His presence may have influenced the responses of the participants, with participants wanting to create a good impression, particularly the group of Somali youth. Conversely, the presence of other members of the research team, as non-Somali Australians, may also have impacted on responses, given some participants may not have felt comfortable to express themselves openly in the presence of people who are less familiar with their culture.

Caution also needs to be exercised in attempts to extrapolate the views of the PP focus group to primary care practitioners in general. The group differed in their backgrounds and involvement

in clinical work, but were from a limited range of disciplines and all were based at Banyule Community Health. There were no General Practitioners and no nurses in either group. Given doctors and community health nurses may be the first point of contact for people seeking assistance around khat use, the inability to recruit them for this research was unfortunate. It also provides a reminder of the volunteer bias associated with the group, given those who attended were a group who were willing and able to give up their time during the working week. Practitioners working in different settings, in different geographical locations, and from different disciplines may have quite different understanding of the issues around khat use.

Finally it is evident that while the perspectives of 48 participants were incorporated in this research, a larger number of participants may have generated other themes of relevance.

While these and potentially further limitations are evident, as a qualitative study, the research does provide useful insights into perceptions around khat use in the Somali community in Melbourne, together with ideas around how to provide assistance to individuals, their families and the community in general. Further research may be helpful, in particular to assess the impact of specific health promotion strategies, and to investigate the effectiveness of harm minimization strategies amongst khat users. However in order for such research to generate useful information, it will be fundamentally important to maintain engagement and collaboration with the local Somali community, who are ultimately the key stakeholders in this relatively unpublicised issue.

Significance of the study

In this pilot project, diverse groups from the Somali community in Melbourne and primary care practitioners were given the opportunity to express their experiences and views on khat use and potential methods of harm-minimization. Researchers trust that this will contribute to a better understanding of khat use in the Australian context which will help service providers and decision makers to develop policies and practices that can assist in reducing harms associated with khat use. Additionally, it is anticipated that resources developed from this research will be provided to the Somali community organisations and community workers in order to help khat users and their families.

ACKNOWLEDGMENTS

The authors are grateful to the Shepherd Foundation for providing funding to allow the completion of this study.

The authors would like to thank all participants for sharing their perspectives.

The authors would also like to acknowledge the assistance of staff from Banyule Community Health (in particular Mr Michael Geary who provided invaluable assistance in supporting this research) and Northern Nexus (including Mr Simon Kroes and Mr Kevan Myers).

APPENDICES

Appendix 1 – Semi-structured interview for Somali community members

- a. In your opinion or experience, why do Somalis use khat in Australia?
- b. What are the problems/affects associated with khat use in terms of gender, individual, family and community levels? (e.g. socio-economic, wellbeing, behaviour, social interaction, time, employment and education).
- c. What are the perceived benefits of Khat use?
- d. Do you think there is any link between Khat use and other legal and illegal drugs? For instance legal substances such as tobacco, alcohol or coffee; illegal drugs such as opiates, speed and marijuana.
- e. What do you think about the role of khat use in the impediment or facilitation of the social integration process into wider Australian society?
- f. What do you know about the condition of the places/locations where khat is chewed?
- g. Where should someone go to get help for problematic khat use?
- h. What strategies may help individuals to reduce their use of khat or harm associated with khat use?
- i. What strategies may help families?

Appendix 2 - Semi-structured interview for primary care practitioners

1. What do you know about the khat use in the Somali community in Australia?
2. When is khat use problematic?
3. What are the problems associated with khat use?
4. Where should someone go to get help for problematic khat use?
5. What strategies may help individuals to reduce harm associated with khat use?
6. What strategies may help individuals to reduce their use of khat?
7. What strategies may help families?
8. What can GP's and drug and alcohol service practitioners do in order to provide care for an individual with problematic khat use and their family?

Factsheet on Khat Use

Victorian Transcultural Psychiatry Unit (VTPU), St. Vincents Hospital



What is khat?

Khat (*Cathus Edulis*) is a plant cultivated in Kenya, Yemen and Ethiopia. Historically, khat has been used in East African countries bordering the Red Sea and the Arabian Peninsula. The use of Khat has increased globally over the last few decades and has become an international phenomenon, with reports of Khat being cultivated in parts of Australia. The active ingredient of khat is cathinone which has a similar action to amphetamine and produces a variety of pleasurable and euphoric effects, a sense of elevated self-esteem and an increase in libido.

Other names for khat

Khat is also known as "qat" "qad" "joad" and "Miraa"

How is khat used?

Typically, the leaves are chewed slowly over several hours, releasing the active components of khat. Dried khat leaves can be made into tea or chewable paste. It can also be smoked or sprinkled on food. In most cultures it is more acceptable for men to use khat than women.

Why do people chew Khat?

People use khat for different reasons. Typically, groups of men may meet to socialise, talk about a range of issues, and during these sessions chew khat. Increasingly khat is being used in other contexts, and may be used by immigrants and refugees to try and escape from social problems such as exclusion, isolation and unemployment. Khat may also be used by individuals purely for its stimulant effect in order to remain alert. There is a general lack of understanding about the harm associated with khat use amongst those that use khat and support khat users.

What are the effects of khat?

Khat can affect people in different ways. The way someone is affected depends on factors such as the amount of khat taken, the persons' body size, weight, general health and mental health.

Immediate effects

- Increased alertness, excitement and energy
- Increased heart rate, breathing rate, body temperature and blood pressure which increases the risk of heart problems
- Decreased appetite
- Depression, anxiety and difficulty sleeping
- Paranoid ideas

Long term effects on physical health

- Gastrointestinal tract problems, such as constipation
- Impotence
- Inflammation of the mouth and increased risk of mouth cancer
- Staining of the teeth
- Using tobacco, other drugs and drinking sweet caffeinated drinks at the same time as khat may lead to additional health problems associated with those substances.
- Low birth weight if consumed regularly through pregnancy

Long term effects on mental well-being

- Khat use increases the severity of existing psychological problems
- Insomnia and emotional instability
- Prolonged and excessive use can lead to low mood, anxiety, irritability and sometimes lead to psychosis.

Social effects of khat use

- Family conflict and breakdown
- Strain on personal, financial and work relationships
- Difficulties sustaining employment and financial stress
- Barriers to social integration for some users



Factsheet on Khat Use

Tolerance and Dependence

It is unclear whether or not a person can develop tolerance to khat or a dependence on the drug. Problematic khat use includes any pattern of use that includes excessive consumption, and use that leads to physical or mental health problems, social problems including financial strain and family disharmony. It includes use that leads to impairment in social and occupational functioning.

Reducing harm from Khat use

- Try to find other activities if you are using khat to cope with boredom or isolation
- If you are a regular user, try to reduce the quantity of your chewing
- If you are a regular user, try to reduce the amount of time spent on chewing
- Avoid drinking caffeinated drinks such as cola and coffee while chewing khat. Drink water instead.
- Avoid using alcohol or other drugs during or after your khat session.
- If you smoke, limit the number of cigarettes you smoke while chewing khat. Avoid crowded sessions and keep windows open to allow in fresh air.
- Have a balanced diet, and ensure you eat before and after your session.
- Avoid holding the khat in your cheek for a long time, as this can increase your risk of getting an oral infection and other mouth conditions
- Talk to your family and friends about what effect they think khat is having on you.

Khat use and the law

Khat use is not illegal in Victoria however it is very strictly controlled. In Victoria, only individuals with a license may legally obtain up to five kilograms of khat per month for personal consumption.

Where can I get help?

There are organisations that assist khat users and their families to minimise the harms associated with khat use and address the underlying social causes of drug use.

If you are concerned about your own or someone else's khat use, contact your *general practitioner, local community health centre, drug and alcohol centre or relevant religious service* for referral, advice and support.

Useful resources in Victoria :

Drug Info	1300 858 584
DirectLine	1800 888 238
Family Drug Help/Family Drug Helpline	1300 660 088
www.familydrughelp.org.au	
Smoking Quitline	13 18 48
Victorian Primary and Community Health Directory	
www.health.vic.gov.au/pch/commhealth/directory.htm	
Victoria's Mental Health Services Directory	
www.health.vic.gov.au/mentalhealth/services/	
DACAS	1800 812 804
Drug & Alcohol Clinical Advisory Service for clinicians	
VTPU	(03) 9288 3300
Victorian Transcultural Psychiatry Unit (more details below)	

In a crisis phone EMERGENCY

000



Further information

Omar et. al (2012) Pathways to Care for Problematic Khat Use: A pilot study regarding effective strategies for individuals with problematic khat use and their families. VTPU

DrugInfo (2011) Khat facts. Australian Drug Foundation
www.druginfo.adf.org.au/drug-facts/khat

Victorian Transcultural Psychiatry Unit

St. Vincent's Hospital Melbourne
Level 2 Bolte Wing
14 Nicholson Street
Fitzroy VIC 3065
Phone: (03) 9288 3319
www.vtpu.org.au



Factsheet on Khat Use

Victorian Transcultural Psychiatry Unit (VTPU), St. Vincents Hospital



Qaakdu muxuu yahaya?

Qaad ama (*Cathus Edulis*) waa dhir laga beero wadamada Kenya, Yemen iyo Ethiopia. Sidoo kale, warbixin ayaa sheegaysa in qaadka laga beero Australia. Taariikh ahaan, qaadka waxaa laga isticmaali jiray wadamada Bariga Africa ee xuduudka la leh badda cas iyo Jaziiradda Carbeed. Caalami ahaan, isticmaalka qaadku waxa uu aad sare u kacay tobanaankii sano ee u danbeeyey isagoo nogday astaan ama daahiro caalami ah. Qaadka waxa laga helay walxaha lagu mirqaamo ee maanka dooriya loona yaqaano cathinone kaas oo saamayntisu lamid walxada looyaqaanno amphetamine ee maandooriyaha ah kaas oo keena mirqaan dheeraad ah, miyir xumo, khayaal, firfircooni iyo shahwo dhanka galmada ah.

Magacyada qaaka

Qaadka waxaa loo yaqaanaa qaat, Jaad ama Mira.

Sidee loo isticmaalaa qaadka?

Taqriiban, waxa qaadka la cunaa illaa todoba saacadood oo isku xiga, wuxuuna dhaliyaa walxaha lagu mirqaamo ee maanka dooriya. Caleemaha qaadka ee engagan waxa lagu daraa shaaha ama waa la calaliyaa. Sidoo kale, sigaar ahaan ayaa loo nuugaa ama cuntada ayaa lagu daraa. Badanaaba qaadka waxa cuna raga.

Maxay dadku u cunaan qaadka?

Dadku sababo kala gedisan ayey u cunaan qaadka. Badanaaba niman ayaa isku yimaada si ay u wada qayilaan uguna sheekaystaan arrimo kala gedisan. Sidoo kale qaadka waxaa loo cunaa arrimo kale. Qurbaha, qaadka waxa cuna dadka qaxootiga ah iyo maygrantiga ama soo galootiga si ay uga fakadaan masheakil dhanka bulshada ah sida in ay go'doomaan, ama bulshada ka go'aan. Dadka qaari waxa ay u isticmaalaan qaadka in ay mirqaamaan. Dhanka kale, waxa jirta wacyi yari la xiriirta waxayeelada qaadku u gaysto dadka muqayiliinta ah.

Maxaytahay saamaynta qaadku?

Saamayn kala gedisan ayuu leeyahyaa cunitaanka qaadku. Saamaynta qaadku waxa ay ku xirantahay kolba inta laga cuno, qofka cuna quwadiisa, miisaanka qofka iyo weliba caafimaadka qofka.

Saamayn dhaqso ah oo cunitaanka qaadku keeno

- Mirqaan dheeraad ah, dareenka oo xoog u kaca iyo firfircooni
- Wadno garaac, neef, kulayl, dhiig-kar iyo wadno xanuun
- Cunto xumo
- Isku-buug, welwel iyo hurdo xumo
- Islahadal.

Saamaynta qaaka ee jirka ee waqtiga fog

- Gaastarikh iyo qabsin
- Tabaryari
- Af-olol iyo khatar kansar oo ku dhaca afka
- Nadeefad xumo iyo huuro dhanka afka ah
- Qofka qaadka cuna waxa laga yaabaa in uu isticmaalo tobako, macmacaan, coffee IWM arrimahaas oo u keeni karo dhibaatooyin kale oo caafimaad xumo
- Haddii qof dumar ah oo uur ahi cunto qaadka waxa dhici karta in ay dhasho ilmo miisaankiisu yaryahay or tabar yar.

Saamaynta qaadka ee maanka iyo dhimirka waqtiga fog

- Isticmaalka qaadku waxa uu sare u qaadaa masheakilka dhanka cudurada ku dhaca maanka iyo miyirka
- Hurdo xumo iyo degenaan li'i dhanka dareenka
- Xadgudub u cunitaanka qaadku waxa uu keenaa niyo jab, murugo, caro badan iyo maskax wareer.

Saamaynta qaadka ee dhank bulshada

- Isku-dhac iyo burbur qoys
- Dhaawac iyo hoos u dhac dhank shakhsiyaada qofka, dhaqaalaha iyo shaqada
- Qofku in uusan ku daahin shaqada
- Dadka qayila qaarkood in aysan bulshada reer galbeedka si fiican u dhexgeli Karin ulana qabsan Karin.



Factsheet on Khat Use

Dulqaad iyo ku Tiirsani

Ma cadda in qofka qaadka cuna kobciyo dulqaad iyo ku tiirsani la xiriirta Qaadka iyo darroogada. Mashaakilaadka ka dhasha cunitaanka qaadka waxaa kamid ad isagoo si xadgudub ah loo cuno arrinkaas oo laga yaabo in uu qofka u soo jiido mashaakilaad la xiriira dhan dhimirka, jirka, dextalka bulshada, dhaqaalaha, qoyska iyo shaqaysiga qofka.

Khafiifnita Waxayeelada Cunitaanka Qaaka

- Si aad uga hortagto caajiska iyo cidlada ka dhalata cunitaanka qaadka, isku day in aad hesho waxyaabo kale oo aad qabato kuna mashquusho
- Haddii aad qaadka u cunto jootgo, yaree cunitaankiisa
- Inta aad qaadka cunayso ka fogow in aad isticmaasho Koolada iyo kafeega laakiin cab biyo badan
- Ka fogow in aad cabto Khamro ama darroogo kale
- Haddii aad cabto sigaarka, yaree cabitaankiisa marka aad qaadka cunayso. Ka fogow in aad ku cunto qaad meelaha dad badani ku cunaan qaadka, islamarkaana fur dariishadaha marka aad cunayso qaadka si hawadu u soo gasho
- Cun cunto isu dheeli tiran kahor iyo kadib cunitaanka qaadka
- Ka fogow in aad waqti dheer qaadka ku hayso daanka ama afka. Arrinkaasi waxa uu keeni karaa in afka iyo ilkaha kaaga kaaga dhaco cudur
- Waydii qoyskaaga iyo saaxiibbadaa fikrada ay ka aaminsanyihiin saamaynta qaadku kugu yeeshay.

Cunitaanka Qaadka iyo Sharciga

Cunitaanka qaadku mamnuun kama aha Victoria laakiin aad ayuu u xadidan yahay. Victoria dhexdeeda, qofka haysta ogolaansho waxaa loo ogol yahay illaa iyo shan kiilo-garaam in uu keensado bishii si uu u cuno.

Xegeee ayaan kaalmo ke helaa?

Waxaa jira ururo dadka qaadka cuna iyo qoysaskooda ka caawiya sidii ay isaga yarayn lahaayeen waxyeelada ka dhalata cunitaanka qaadka.

Haddii aad waxayeelada qaadka uga welwelayso lafahaaga ama qof kale, la xiriir dhakhtarkaaga, xurumaha caafimaad ee comyunitiga, xarumaha kaalmeeya dadka khamradu iyo darroogadu waxyeelada u gaystaan ama sidoo kale xarumo diimeedka dadka u fidiya adeegyada, naseexada iyo talooyinka.

Hayado faa'iido kuu leh ee Victoria:

Drug Info	1300 858 584
DirectLine	1800 888 238
Family Drug Help/Family Drug Helpline	1300 680 088
www.familydrughelp.org.au	
Smoking Quitline	13 18 48
Victorian Primary and Community Health Directory	
www.health.vic.gov.au/pch/commhealth/directory.htm	
Victoria's Mental Health Services Directory	
www.health.vic.gov.au/mentalhealth/services/	
DACAS	1800 812 804
Drug & Alcohol Clinical Advisory Service for clinicians	
VTPU	(03) 9288 3300
Victorian Transcultural Psychiatry Unit (more details below)	

Telefoonka XAALADDA DEGDEGA AH 000



Macluumaad dheeraad ah

Omar et. al (2012) Pathways to Care for Problematic Khat Use: A pilot study regarding effective strategies for individuals with problematic khat use and their families. VTPU

DrugInfo (2014) Khat facts. Australian Drug Foundation
www.druginfo.adf.org.au/drug-facts/khat

Victorian Transcultural Psychiatry Unit

St Vincent's Hospital Melbourne
Level 2 Bolte Wing
14 Nicholson Street
Fitzroy VIC 3065
Phone: (03) 9288 3319
www.vtpu.org.au



Appendix 5– Participant survey- community members

PATHWAYS TO CARE FOR PROBLEMATIC Khat USE

A pilot study regarding effective strategies for individuals with khat use and their families

PARTICIPANT SURVEY – COMMUNITY MEMBERS

Please circle the relevant response to the following questions. All responses are confidential and you will not be identified in this research project.

1. Gender: Male Female

2. Age:

- 18-29
- 30-39
- 40-49
- 50-59
- 60+

3. What is your highest level of education?

- Primary school
- Secondary school
- Tertiary graduate degree
- Tertiary postgraduate degree

4. What is your occupation? _____

5. What is your country of birth? _____

6. For how many years have you been living in Australia? _____

Appendix 6- Participant survey- primary care practitioners

PATHWAYS TO CARE FOR PROBLEMATIC Khat USE

A pilot study regarding effective strategies for individuals with khat use and their families

PARTICIPANT SURVEY – PRIMARY CARE PRACTITIONERS

Please circle the relevant response to the following questions. All responses are confidential and you will not be identified in this research project.

1. Gender: Male Female
2. Age:
 - 18-29
 - 30-39
 - 40-49
 - 50-59
 - 60+
3. Do you fluently speak a language other than English? Yes No
4. Please specify your role at Banyule Health: _____
5. Please specify for how long you have been working in this area for:
 - 1-3 years
 - 3-5 years
 - 5-8 years
 - 8-10 years
 - 10+ years
6. Have you had any contact with individuals who use khat in your professional role? Yes No

REFERENCES

1. Colzato, L. et al, *Long-term effects of chronic khat use: Impaired inhibitory control*. Frontiers in psychology, 2011(1).
2. Advisory Council on the Misuse of Drugs (ACMD), *Khat (Qat): Assessment of Risk to the Individual and Communities in the UK*, M. Rawlins, Editor 2005, Home Office: London.
3. Alexander, J., R. Staugas, and O. El-Domeiri, *Khat concerns in Australia: hyperbole or understated?* Australian and New Zealand Journal of Psychiatry, 2010. **44**(10): p. 960-961.
4. Al-Hebshi, N., A. Al-Sharabi, and et al, *Effect of khat chewing on periodontal pathogens in subgingival biofilm from chronic periodontitis patients*. Journal of Ethnopharmacology, 2010. **132**: p. 564-569.
5. Al-Hebshi, N. and N. Skaug, *Khat (Catha edulis)—an updated review*. Addiction Biology, 2005(10): p. 299-307.
6. Ali, W., K. Al Habib, and et al, *Acute Coronary Syndrome and khat herbal amphetamine use: an observational report*. Circulation, 2011. **124**: p. 2681-2689.
7. Ali, W., et al., *Association of Khat Chewing with increased risk of stroke and death in patients presenting with acute coronary syndrome*. Mayo Clin Proc., 2010. **85**(11): p. 974-980.
8. Al-Motarreb, A., M. Al-Habori, and et al, *Khat chewing, cardiovascular diseases and other internal medical problems: the current situation and directions for further research*. Journal of Ethnopharmacology, 2010. **132**: p. 540-548.
9. Apps, A., et al., *Khat: an emerging threat to the heart in the UK*. Postgraduate Medical Journal, 2011. **87**(1028): p. 387-388.
10. Ash, L. *UK could become 'smuggling hub' for herbal high khat*. 2012 [cited 2012 10th April]; Available from: <http://www.bbc.co.uk/news/uk-16722383>.
11. Balint, E., G. Falkay, and et al, *Khat – a controversial plant*. The middle European journal of medicine, 2009. **121**: p. 604-14.
12. Banyule Community Health Centre. *Banyule Community Health Centre*. 2012 [cited 2012 July 10,]; Available from: <http://www.bchs.org.au/youth/aboutbch.php>.

13. Beckerleg, S., *East African discourses on khat and sex*. Journal of Ethnopharmacology, 2010. **132**(3): p. 600-606.
14. Bhui, K., et al., *Mental disorders among Somali refugees*. Social Psychiatry and Psychiatric Epidemiology, 2006. **41**(5): p. 400-408.
15. Bhui, K. and N. Warfa, *Trauma, khat and common psychotic symptoms among Somali immigrants: a qualitative study*. Journal of Ethnopharmacology, 2010. **132**(3): p. 549-553.
16. Bongard, S., M. Al'Absi, and et al, *Khat use and trait anger: Effects on affect regulation during an acute stressful challenge*. European Addiction Research, 2011. **17**: p. 285-291.
17. Centre, B.C.H., ed.
18. Chapman, M.H., et al., *Severe, Acute Liver Injury and Khat Leaves*. New England Journal of Medicine, 2010. **362**(17): p. 1642-1644.
19. Chemistry. *Khat*. Unknown August 1, 2012]; Available from: <http://chemistry.about.com/od/medicalhealth/ig/Drug-Photo-Gallery/Khat.htm>.
20. Chemistry. unknown.
21. Clyne, M. and S. Kipp, *On the Somali Language in Melbourne*, in *Migration Action* 2005: Melbourne. p. 19-22.
22. Colzato, L.S., et al., *Khat Use Is Associated with Impaired Working Memory and Cognitive Flexibility*. Plos One, 2011. **6**(6).
23. Corkery, J., F. Schifano, and et al, *Overview of literature and information on "khat-related" mortality: a call for recognition of the issue and further research*. Ann Ist Super Sanita 2011. **47**(4): p. 445-64.
24. Damena, T., A. Mossie, and et al, *Khat chewing and mental distress: a community-based study, in Jimma City, Southwestern Ethiopia*. Ethiopian Journal of Health Sciences, 2011. **21**(1).
25. Damena, T., A. Mossie, and et al, *Khat chewing and mental distress: a community-based study, in Jimma City, Southwestern Ethiopia*. Ethiopian Journal of Health Sciences, 2011. **21**(1).
26. Douglas, H., M. Boyle, and N. Lintzeris, MJA, 2011. **11**(12): p. 666-669.

27. Elbagir, N. *Somali militants target addicts in UK's 'khat cafes'*. 2012 [cited 2012 10th April]; Available from: <http://edition.cnn.com/2012/02/23/world/europe/britain-somalia-diaspora/index.html?iref=allsearch>.
28. El-Wajeh, Y. and M. Thornhill, *Qat and Its Health Effects*. British Dental Journal, 2009. **206**: p. 17-21.
29. Feigin, A.J., *A Preliminary Investigation of Khat Use and Its Impact on East African Communities in Melbourne*, in *Centre for Population Health Burnet Institute & Department of Medicine (RMH/WH)*2009, The University of Melbourne: Melbourne.
30. Fitzgerald, J., *Khat: a literature review*, 2009, Centre for Culture, Ethnicity and Health.
31. Gebissa, E., *Khat in the Horn of Africa: Historical perspectives and current trends*. Journal of Ethnopharmacology, 2010. **132**(3): p. 607-614.
32. Gerada, L., *Drug misuse: a review of treatments*. Clinical Medicine, 2005. **5**: p. 69-73.
33. Getahun, W., T. Gedif, and et al, *Regular Khat (Catha edulis) chewing is associated with elevated diastolic blood pressure among adults in Butajira, Ethiopia: A comparative study*. BMC Public Health, 2010(10): p. 390.
34. Griffiths, P., et al., *A transcultural pattern of drug use: Qat (khat) in the UK*. British Journal of Psychiatry, 1997. **170**: p. 281-284.
35. Griffiths, P., et al., *Khat use and monitoring drug use in Europe: The current situation and issues for the future*. Journal of Ethnopharmacology, 2010. **132**(3): p. 578-583.
36. Hines, A., *Linking Qualitative and Quantitative Methods in Cross-Cultural Survey Research: Techniques from Cognitive Sciences*. American Journal of Community Psychology, 1993. **21**: p. 729-746.
37. Hoffman, R.A.-A., M, *Khat use and neurobehavioural functions: suggestions for future studies*. Journal of Ethnopharmacology, 2010. **132**: p. 554-563.
38. Hudelson, P., *Qualitative Research for Health Programs*1996, Geneva: World Health Organisation.
39. Kassim, S., S. Islam, and R. Croucher, *Validity and reliability of a Severity of Dependence Scale for khat (SDS-khat)*. Journal of Ethnopharmacology, 2010. **132**(3): p. 570-577.
40. Kelly, J., *A review of their chemistry, pharmacology and toxicity*. Drug testing and Analysis, 2011. **3**: p. 439-453.

41. Klein, A., *Khat and the creation of tradition in the Somali diaspora*, in *Drugs in Society: European Perspectives*, J. Fountain and D.J. Korf, Editors. 2007, Radcliffe Publishing Ltd.: Oxford.
42. Klein, A. and P. Metaal, *A good chew or good riddance-How to move forward in the regulation of khat consumption*. *Journal of Ethnopharmacology*, 2010. **132**(3): p. 584-589.
43. Manghi, R., B. Broers, and et al, *Khat use: lifestyle or addiction*. *Journal of Psychoactive drugs*, 2009. **41**: p. 1-10.
44. McLean, A.S. and M.B. Kot, *Cardiac collapse associated with the ingestion of khat*. *Internal Medicine Journal*, 2011. **41**(7): p. 579-581.
45. Murdoch, C., H. Aziz, and e. al, *Khat (Catha edulis) alters the phenotype and anti-microbial activity of peripheral blood mononuclear cells*. *Journal of Ethnopharmacology*, 2011. **138**: p. 780-787.
46. Nabuzoka, D. and F.A. Badhadhe, *Use and perceptions of Khat among young Somalis in a UK city*. *Addiction Research*, 2000. **8**(1): p. 5-26.
47. Nencini, P. and M. Ahmed, *Khat consumption: a pharmacological review*. *Drug and Alcohol Dependence*, 1989. **23**: p. 19-29.
48. O'Connell, R. *Somali Cabbies 'High on Drug'* 2012 [cited 2012 14 April]; Available from: <http://au.news.yahoo.com/thewest/a/-/breaking/13250011/somali-cabbies-high-on-drug/>.
49. Odenwald, M., et al., *Use of khat and posttraumatic stress disorder as risk factors for psychotic symptoms: A study of Somali combatants*. *Social Science & Medicine*, 2009. **69**(7): p. 1040.
50. Odenwald, M., et al., *Khat use as a risk factor for psychotic disorders: A cross-sectional and case-control study in Somalia*. *BMC Medicine*, 2005. **3**: p. 5.
51. Omar, Y., *Young Somalis in Australia: An Educational Approach to Challenges and Recommended Solution*, in *Migration Action2005*: Melbourne. p. 6-18.
52. Osman, F.A. and M. Soderback, *Perceptions of the use of khat among Somali immigrants living in Swedish society*. *Scandinavian Journal of Public Health*, 2011. **39**(2): p. 212-219.

53. Patton, M.Q., *Qualitative Research & Evaluation Methods*. 3rd ed 2002, Thousand Oaks, California: Sage Publications.
54. Rice, P.L., Ezzy, D., *Qualitative Research Methods: A Health Focus* 1999, Melbourne: Oxford University Press.
55. Strauss, A. and J. Corbin, *Basic of Qualitative Research* 1996, New Delhi: Sage Publications.
56. Tulloch, A. and E. Frayn, *Khat use among Somali mental health service users in South London*. Soc Psychiatry Psychiatr Epidemiol, 2012.
57. Victorian Multicultural Commission, *Victorian Community Profiles: 2006 Census-Somali Born*, 2007, Victorian Multicultural Commission: Melbourne.
58. Vimpani, G., *Getting the mix right: family, community and social policy interventions to improve outcomes for young people at risk of substance misuse*. Drug and Alcohol Review, 2005. **24**: p. 111-125.
59. World Health Organisation. *The ASSIST project - Alcohol, Smoking and Substance Involvement Screening Test*. 2011; Available from: http://www.who.int/substance_abuse/activities/assist/en/index.html.
60. Yarom, N., J. Epstein, and et al, *Oral manifestations of habitual khat chewing: a case-control study*. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2010. **109**: p. e60-e66.

