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Khat: Social harms and legislation A literature review

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Khat: Social harms and legislation

A literature review

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The views expressed in this report are those of the authors, not necessarily those of the Home Office (nor do they reflect Government policy).

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Executive summary

This study provides a literature review of material pertaining to the reported 'social harms' of khat to consumers in the UK, with commentary upon the legislation brought in to control and prohibit khat in other countries.

Key findings

1. The review found a general lack of robust evidence on the link between khat use and social harms.
2. Reported social harms associated with khat remain a concern among the UK's immigrant Somali community, yet beyond often contradictory anecdotal statements, this review found no evidence to show a causal relationship between khat and the various social harms for which its consumption is supposedly responsible.
3. Inferences about khat's social harms have largely been drawn from the experience of the Somali population, as less research has been undertaken on other communities who are also consumers of khat.
4. As well as khat, many other variables might contribute to the social problems confronting the relevant communities, i.e. the effects of civil war, displacement, gender relations, and problems of integration. These need to be more fully considered in any further research.
5. Legislating against khat in Europe and North America has had little success in curbing demand and has taken place with little consideration of evidence. In those countries where the greatest evidence on khat use has been compiled (the UK, the Netherlands and Australia), import and consumption are still permitted, albeit under the control of a permit system in the case of Australia.

What is khat?

Khat (sometimes spelt qat) is a stimulant, grown and consumed in parts of north east Africa and the Middle East. It is imported into the UK in large quantities to meet demand among Ethiopian, Kenyan, Somali and immigrant communities. It is prohibited/controlled in many countries, including several within the EU. It remains unrestricted in the UK.

Khat in the UK

Several studies have been undertaken looking at khat use in the UK since the 1990s (National Drugs Intelligence Unit, 1990; Griffiths, 1998; Turning Point, 2004; Patel et al., 2005). In 2005, the Advisory Council on the Misuse of Drugs advised against classifying khat under the Misuse of Drugs Act 1971, instead recommending that educational and awareness-raising campaigns be instituted. Khat retails in the UK at £3 to £6 per bundle (Carrier, 2006). VAT on khat imports is now imposed, raising £2.9 million in 2010 when around 3,002 tonnes of khat entered the UK, a large increase since the late 1990s.¹

Consumption in the UK is almost entirely limited to diaspora communities, primarily Ethiopians, Somalis, Yemenis and some Kenyans. Among Somalis, chewers tend to be older than non-chewers, while more men than women consume. The majority of consumers chew khat moderately, though there is evidence of heavy use by some. Data on the prevalence and patterns of khat chewing in the UK among Ethiopian, Kenyan and Yemeni consumers are meagre with most of the literature concentrating on Somali consumption. The first estimates of khat use in England and Wales were published in 2010 with 0.2% of the general population reporting using khat in the last year (Hoare and Moon, 2010). Literature on khat use in the UK has not yet adequately explored gender differences, nor how divergence of use and attitudes towards khat within particular immigrant groups is linked to such factors as faith and region of origin.

What social harms are linked with khat?

Anecdotal evidence reported from communities in several UK cities links khat consumption with a wide range of social harms. However, beyond the anecdotal, there is no evidence to demonstrate a causal link between khat consumption and any of the harms indicated. Unemployment is often cited as a key problem among khat consumers but no clear causal link emerges from the literature, although heavy, frequent khat consumption may well affect employment prospects. There is little evidence of any kind linking khat consumption with criminal behaviour except where the crime is a function of khat's legal status, while there is limited evidence that khat consumption is associated with minor anti-social behaviour, such as spitting in public. A link between khat and violent behaviour is also cited, though again a causal connection is not clearly demonstrated in the literature.

¹ Her Majesty's Revenue & Customs (HMRC) data, 2011.

Anecdotal evidence suggests that khat is the cause of family breakdown, but this is not supported by the available literature. Several studies instead suggest that this link needs to be viewed in the context of changing gender relations among Somalis in the diaspora. Income diversion is also mentioned as a source of tension within families, especially when those chewing are on low income, and where male unemployment is high. The idea that khat hinders migrant integration is raised in the Scandinavian literature, though again the evidence is sparse and anecdotal.

Legislation around the world

Khat is not subject to international controls and a recent World Health Organisation study (2006) rejected the scheduling of khat. Nonetheless, khat's alkaloids – *cathine* and *cathinone* – became scheduled substances under the UN Convention on Psychotropic Substances in 1988. Though not intended to provoke legislation against khat this led some countries to introduce khat prohibition.

Under US Federal law, both *cathine* and *cathinone* are restricted substances. There was no review of khat consumption in the USA conducted prior to introducing the legislation (*cathine*, 1998 and *cathinone*, 1993) and no official reviews have been conducted since. Rising seizures suggest demand remains high. Canada controlled khat in 1997, making import, export and trafficking illegal. This legislation was enacted without a review of evidence. Norway and Sweden prohibited khat in 1989, both without research. Demand remains high in Norway and it is estimated that out of 9,000 Somalis in Oslo, 1,000 are consumers. Khat has been illegal in Denmark since 1993. No review was conducted prior to legislation. Penalties for khat have recently been raised. Local research has revealed that while demand remains strong among older generations of immigrant Somalis in Denmark, the young are not chewing.

Khat is unrestricted in the Netherlands where a review in 2008 concluded that the harm potential was low. Khat imports there are taxed, as in the UK. *Cathine* and *cathinone* are controlled under Australian law, but khat imports are allowed under licence. A review conducted in 2009 found no substantive evidence of social or medical harms and recommended no change to Australian legislation.

1. Introduction

Background

As part of a review of khat and its social implications for immigrant communities in the UK, this study provides the findings from a review of national and international literature pertaining to the social harms (including unemployment, crime, family breakdown, poverty, educational problems and lack of integration into host societies) associated with khat, and an overview of the history and impact of khat legislation in a number of countries. The review was framed to respond to the following six questions:

1. *What are the social harms associated with khat use in the national and international literature?*
2. *What is the evidence on the impact of harms on khat users, their families and community?*
3. *In countries where khat has been controlled, what was the evidence base for this decision?*
4. *What is the evidence on the impact of control on social harms and on the khat trade?*
5. *What is the evidence on the impact of control on attitudes to khat?*
6. *What is the evidence on prevalence, trends and patterns of khat use?*

The review selected seven countries in which to examine the issue of legislation against khat: the USA, which has led the international campaign for khat prohibition; Canada, Norway, Sweden and Denmark, all being countries with significant immigrant communities who are khat consumers and where there has been considerable public debate about khat use, and each having issued legislation against khat; and the Netherlands and Australia, also being countries with significant khat imports but where investigations of khat use resulted in the decision not to prohibit.²

² It must be acknowledged at the outset that the data on khat use are highly uneven from country to country, and it has not therefore been possible to make a direct cross-country comparison on all aspects of social harms to be investigated.

Khat – a brief introduction

The khat plant (*Catha edulis*) grows wild in highland regions throughout Africa, from the Cape and Madagascar in the south to north east Africa, and beyond, in Yemen and the Saudi Peninsula (Anderson *et al.*, 2007). The leaves and stems are consumed by chewing and the cud is stored in the cheek. The taste is described as bitter, although consumers assert higher quality khat has a sweeter taste.

The principal alkaloid is *cathinone*, known to be more powerful than the secondary alkaloid, *cathine* (Kennedy, 1987). *Cathinone* affects the central nervous system in a manner “like a mild amphetamine” (Graziani *et al.*, 2008; Zaghloul *et al.* 2003). *Cathinone* degrades rapidly post-harvest, affecting potency; efficient transportation is thus essential, and transport technologies have been the critical determinant of the international market for khat.

Chewing khat renders one alert and acts as a euphoriant and appetite suppressant. In Ethiopia, chewing is associated with agricultural labour, but is also historically associated in both Ethiopia and Yemen with religious contemplation and meditation. The leisure consumption of khat has increased significantly over recent years, becoming institutionalised in much of East Africa and the Red Sea region (Anderson *et al.*, 2007; Kennedy, 1987; Weir, 1985).

Khat consumption came to public attention in the UK in the late 1980s, when links between khat and psychotic behaviour were suggested in the media (*The Observer*, 18 October 1987). This led to a first report being commissioned on khat in the UK by the National Drugs Intelligence Unit (NDIU). The report found no link to psychosis, concluding that khat consumption was unlikely to spread beyond Somali and Yemeni immigrants. Restriction was considered unnecessary (NDIU, 1990).

From 1990, further concerns about khat surfaced as consuming immigrant communities grew in size (Harris, 2004; Griffiths, 2002; Pérouse de Montclos, 2002). International demand for khat stimulated a rapid enlargement of the export markets from Ethiopia and Kenya (Carrier, 2007a; Goldsmith, 1999). Increased importation in the UK led to further media reports on khat (e.g., *The Independent*, 1 June 1994), and in 1998 the Home

Office investigated khat consumption among Somali immigrants. This quantitative study interviewed 207 London Somalis (73% men and 27% women), accessed through privileged access interviewers (Griffiths, 1998).

A key finding was that chewers reported consuming more khat in the UK than in Somalia, which Griffiths explains by reference to high levels of unemployment among the sample (*ibid.*). While highlighting concerns about khat, especially the cost of consumption for low-income groups, Griffiths explained that many chewers saw khat as a cultural practice. The majority (73%) of those interviewed opposed prohibition, while many asserted they would continue to consume khat even if it was illegal (*ibid.*).

Following further adverse media coverage of khat consumption, partly prompted by the advocacy of Somali community groups seeking prohibition (Anderson *et al.*, 2007: 176), the Home Office commissioned a further review in 2004. The resulting research was published in two reports (Patel *et al.*, 2005; Turning Point, 2004).

The key focus of this research was on Somalis – although the Turning Point study also interviewed a small number of Ethiopians and Yemenis (n=8 and n=6 respectively). The finding by Patel *et al.* (2005) that 49% of their sample (n=602) of Somalis wanted a ban on khat importation to the UK was reported widely in the media, where it was interpreted as an indication that prohibition would be imposed. This, however, ignored the general findings of this research, which informed the Advisory Council on the Misuse of Drugs (ACMD) review in 2005 (ACMD, 2005). The council advised that it would be inappropriate to classify khat under the Misuse of Drugs Act 1971, instead recommending that educational and awareness-raising campaigns be instituted, and that voluntary agreements not to sell khat to minors be introduced (*ibid.*).³

The ACMD's advice was accepted by the Home Office in early 2006, leaving the legal status of khat unaltered. In the same year, a full review of khat by the World Health Organisation (WHO, 2006) assessed the medical harms and decided that there was no evidence that khat should be brought under international control.

³ For the full list of ACMD recommendations see Appendix 1

Since 2006, the debate on khat in the UK has continued to be promoted by some Somali groups and has been taken up by some politicians. Among UK Somalis who wish to see controls imposed there is a strong feeling that khat has not been taken seriously enough because it only affects a minority group. There is also a perception among some Somalis (who do not wish to prohibit khat but would like to see its consumption by their community reduced) that while there has been much consultation with local communities about khat, there has been little or no outcome (Mirza, 2009). Those urging prohibition or control of khat often stress that khat is illegal in other countries, and that UK policy is therefore anomalous.

2. Khat literature review

Introduction

This literature review is based on an assessment of more than 140 books, articles and reports relevant to social harms associated with khat and legislation enacted against khat. A full bibliography was generated through bibliographic searches and a thorough survey of internet sources. Much key work on khat focuses on Africa and the Middle East, rather than on Europe and North America; this remains relevant for the present study, as understanding khat requires an understanding of its global dynamics. Key works consulted on producer countries include Kennedy (1987); Weir (1985) on Yemeni khat; Gebissa (2004) on the history of khat in Ethiopia; and Carrier (2007a) and Goldsmith (1994) on Kenya. A special issue of *Substance Use & Misuse* edited by Beckerleg (2008b), Anderson *et al.* (2007), Klein (2008b) and Klein *et al.* (2009) examine a broad range of topics including issues of harm and national debates over khat's legality.

Since the 1990s, the UK has been a centre of research on khat consumption. Key reports include the Home Office commissioned research already mentioned (Patel *et al.*, 2005; Turning Point, 2004; Griffiths, 1998). These reports are based on questionnaires, focus groups and interviews conducted by privileged access interviewers. All three of these reports have primarily focused on Somalis, but sample sizes have been relatively small (the largest sample [n=602], Patel *et al.*, 2005). These reports provide some indicators of prevalence, patterns of use, and attitudes to khat, but none are representative of khat-chewing communities in the UK, thus limiting the extent to which the findings can be generalised to the wider population. Two earlier reports based on questionnaires focused on male khat chewers (n=52) in Liverpool (Ahmed and Salib, 1998), and a sample of young Somalis (n=94) in Sheffield (Nabuzoka and Badhadhe, 2000) and these provide additional information on communities beyond London.

Other UK-based studies are wholly qualitative in character. The UK literature on khat has a strong Somali focus. Ismail and Home (2005) offer preliminary findings on Somali khat consumption in Bristol, while Mirza (2009) reports on community views in Northampton. A useful study of community perceptions (Buffin *et al.*, 2009) was conducted in Birmingham, Bristol, Manchester, Northampton and West London under

the direction of the National Drug and Race Equality Coalition. This study consulted more than 100 informants in a number of focus groups, most being Somalis although including some persons of Ethiopian and Yemeni origin. Useful information on Somali consumption in the UK is found in Harris (2004), Khan and Jones (2003), Nabuzoka and Badhadhe (2000) and Griffiths *et al.* (1997). Similarly, Gatiso and Jembere (2001) provide observations on khat in their Lambeth study of Ethiopian drug abuse. Kassim and Croucher (2006) focus upon the dental effects of khat consumption among Yemenis.

Elsewhere, literature on khat consumption is sparse. Anderson *et al.* (2007) examine the transnational marketing of khat, while a number of reports have been written on consumption in specific countries – notably Australia (Fitzgerald, 2009; Stevenson *et al.*, 1996), Denmark (Sundhedsstyrelsen, 2009), the Netherlands (Pennings *et al.*, 2008) and Norway (Tollefsen, 2006; Gunderson, 2006). Among Scandinavian countries, Swedish research into khat has been most extensive (De Cal *et al.*, 2009; Omar and Besseling, 2008; Olsson *et al.*, 2006).

In Canada, discussion of khat has been closely linked to debates about immigration: a dissertation on Somali perspectives on khat (Salah, 1999) and a commentary on khat as part of Canadian drug policy (Grayson, 2008) can be read alongside two important studies of Somali urban minorities in Canada (Hopkins, 2006; McGowan, 1999). For the USA there is only a scanty literature, mainly constituted by Drug Enforcement Administration reports and court case notes, although there are two commentaries on khat and the law (Armstrong, 2008; Rentein, 2004), a short study on the underground marketing of khat since its prohibition (Mohamud, 2009), and a local study of khat use in Minnesota and North Dakota (Cham, 2007).

A major weakness in all this literature is the lack of research among Ethiopian, Yemeni and East African communities, a weakness the recent Home Office-commissioned report has also identified and sought to remedy (Sykes *et al.*, 2010).

Khat in the UK

International trade in khat has grown steadily since the early 1990s, following the flows

of East African and Yemeni diaspora communities around the globe. Farmers in Ethiopia (Gebissa, 2004 and 2008) and Kenya (Carrier 2007a) earn more growing khat for export than they would from other cash crops, while the trade provides employment and often substantial rewards for many along national and transnational trade networks (Anderson *et al.*, 2007). In the UK, importing and retailing the substance offer business opportunities for many recent migrants, although profits are usually modest.

Khat arrives in the UK four times a week on passenger flights from Kenya, via Kenya Airways, and comes in less frequently but regularly from Ethiopia and Yemen. Until 1997, khat was traded into the UK as a 'vegetable' and so was exempt from VAT, but from the 1 February 1998, Her Majesty's Revenue & Customs (HMRC) reclassified khat as a 'stimulant drug', and so it became standard-rated for VAT at 20%. In late 2007, HMRC commenced an investigation into khat importation from Ethiopia, Kenya and Yemen. It discovered that the import value had been substantially under-declared, and subsequently collected revenues due from the UK khat trade. In 2010, HMRC established the import value of fresh Miraa⁴ originating from Kenya to be £35.00 per box (5.5 kg), fresh khat originating from Ethiopia to be £35.00 per box (9 kg), and dried chat originating from Ethiopia/Yemen to be £40.00 per box (9 kg). The total import VAT collected was £2.9 million and the total volume of consignments imported per week into UK was 57.7 tonnes (i.e. 9,136 boxes – 7,000 from Kenya and 2,136 from Ethiopia and Yemen combined).

When khat arriving at Heathrow has cleared HMRC, it is transported to a warehouse in nearby Southall. Here dealers and distributors collect their consignments before distributing them to hundreds of retailers throughout London and other UK cities. The retail trade is fragmented: most retailers take three to four boxes of khat at a time retailing individual bundles of Kenyan khat at £3 to £6 per bundle (Carrier, 2006). The retail value of a box of imported khat is thus £120. Khat entering the UK from Ethiopia and Yemen has slightly different retail values reflecting perceived quality and demand.

However, not all of this khat is consumed within the UK: HMRC believes that a small proportion of this figure passes through the UK in transit to the USA and other parts of

⁴ HMRC distinguishes 'miraa', khat from Kenya from 'khat/chat' from Ethiopia and the Yemen.

Europe. Caution is therefore required in using these figures to interpret consumption in the UK, although it is clear there has been a dramatic increase in importation since the late 1990s, when only seven tonnes per week (364 tonnes per annum) entered the UK (Griffiths, 1998). The scale of increase reflects the rise in the number of immigrants entering the UK from khat-consuming countries in East Africa over the past decade.

Patterns of consumption in the UK

Evidence strongly suggests that khat consumption is limited to diaspora communities from East Africa and the Red Sea littoral, primarily Somalis, Ethiopians, Kenyans and Yemenis (Anderson *et al.*, 2007), although there are rare reports of members of the wider population trying khat (Sykes *et al.*, 2010).

Despite recent improvements in the monitoring of statistics relating to immigrant populations in the UK, it remains difficult to establish reliable figures on the overall demography of the relevant communities, especially given the high incidence of onward migration of Somali EU citizens to the UK from other EU countries. For Somalis, the UK *Annual Population Survey* for 2008 gives an estimated figure of 101,000.⁵ For Ethiopians, estimates suggest that there are 25,000 to 30,000 in the UK, mostly based in London (Papadopoulos *et al.*, 2004). The 2001 Census gave a figure of 12,508 for the population born in Yemen. However as Yemenis have such a long history of settlement in the UK (Halliday, 1992), it is likely that there are far more people of Yemeni descent living in the UK. For Kenyans, the *Annual Population Survey* of 2008 gives a figure of 139,000.

Patterns of khat consumption are by no means uniform among these populations. Data from the countries of origin suggest that the highest proportion of chewers are among Yemenis; in Yemen as many as 82% of men and 43% of women may be chewers (Numan, 2004). In the Horn of Africa, consumption rates are much higher among northern Somalis than among those from the south (Cassanelli, 1986) and this is likely to be reproduced in the diaspora communities also. Consumption is also complex in relation to Ethiopians and Kenyans. Khat consumption has spread across ethnic, social and religious boundaries in both countries, but is still closely linked to specific segments

⁵ <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15147>.

of the population. In Ethiopia, khat is very much seen as a Muslim habit. Many Christians consequently disapprove of it, even presenting it as a social “*pollutant*” (Gebissa, 2004; Ayana and Mekonen, 2004; Adugna *et al.*, 1994). In Kenya, khat is associated with Muslims from the north and the coast and with the Meru, an ethnic group occupying the heartland of khat cultivation in highland central Kenya. Khat has also in recent years become popular in Kenya with youth in urban centres (Carrier, 2007a).

Patel *et al.* (2005) provide sufficient data on Somali consumption to develop a reasonable picture of its prevalence and patterns, although as it is not a random sample the findings cannot be said to be representative of the wider UK Somali population. Out of the sample of 602 Somalis, 204 were recent khat chewers. These had a mean age of 39 years, tending “*to be older than those in the group who had not used it*” (*ibid.*). There was a marked gender difference: recent khat consumers constituted 51% of male respondents, but 14% of females. Consumers varied greatly in how often they consumed khat: 26% chewed once a week, while 10% chewed daily, with most in the one to three day(s). The largest percentage (48%) chewed two bundles in a session, and the majority chewed between 6 p.m. and midnight, the average session lasting six hours. Khat-chewing sessions were almost always single-sex, although a number of respondents reported chewing in mixed groups. In contrast to the earlier Griffiths (1998) research in London, fewer khat consumers claimed they chewed more in the UK than back in Somalia (35% said they chewed more in the UK, 34% less, and 31% declared there to be no difference (Patel *et al.*, 2005). While individual respondents revealed great extremes in consumption (one chewed up to five bundles a day, while another chewed for sessions of more than nine hours), the majority could be described only as ‘moderate’ consumers (*ibid.*).

Quantitative data on the prevalence and patterns of khat chewing in the UK are meagre, a fact that owes much to the limited population data available for khat-consuming communities and the consequent difficulty in obtaining representative data on khat’s use in the UK. However, for the first time estimates are available for the prevalence of khat use in the general population. The British Crime Survey started asking questions about khat use in October 2009. Preliminary results based on the first six months of data estimate that 0.2% of the general adult population reported using khat in the previous year (Hoare and Moon, 2010).

Some small-scale studies are available, which provide an indication of use within some khat-using communities. A general study of Ethiopian drug use in Lambeth (Gatiso and Jembere, 2001) provides data on khat chewing. Out of 55 reported drug users among the sample of 250, 45 (41 men and 4 women) had used khat (*ibid.*)⁶ Turning Point (2004) reports that khat consumption was less frequent among Ethiopians and Yemenis than among Somalis, though the sample was very small (n=8 and n=6). Among Yemenis, it was stated that many restrict consumption to Saturdays only, in order not to interfere with working life. Yemenis also acknowledged that Somalis generally chewed for longer than other communities. As one respondent explained: “*While [our] community had been in Britain for many years, including into a second generation, many Somalis were war refugees who had been here for only a few years and who were more likely to be unemployed and to have nothing to do.*” Among other immigrant groups, perceptions of Somali khat consumption is linked to economic and social status, unemployment and a relative lack of integration.

Perception of increasing consumption among youth is a common cause for concern in both producing countries and in the diaspora (e.g., Buffin *et al.*, 2009). In contrast with Kenya, where there is evidence that khat has become fashionable among urban youth (Carrier, 2005b), it does not have the same cachet among young Somalis in the diaspora. Here the evidence strongly indicates consumption of, and approval for, khat concentrates in older age groups (Patel *et al.*, 2005). While Nabuzoka and Badhadhe (2000) found khat use to be popular as a cultural marker among a small sample of Somali youth in Sheffield, other reports suggest that young UK Somalis find other drugs more attractive (Klein, 2008b). Most Somalis born in the UK in the Patel *et al.* (2005) sample had never used khat. Reports from elsewhere in Europe, notably Denmark, also suggest that khat use is less popular with younger immigrants (Sundhedsstyrelsen, 2009).

Consumption among women is another issue often debated (Buffin *et al.*, 2009). Among

⁶ In the Patel *et al.* (2005) report this research is cited, suggesting that it revealed 73% of the sample to have used khat. This is incorrect, as it is in fact a misreporting of another statistic: 73% of the sample answered ‘khat’ to a question about what types of drugs are used by Ethiopians.

Somalis in the UK, general disapproval of women chewing has been widely reported (Anderson *et al.*, 2007). Weir's comments, though dating back to the 1980s, suggest disapproval to be less pronounced among Yemenis (Weir, 1985). But while the gender dynamic of the khat debate generally presents khat chewing as a male activity, the evidence suggests that a substantial minority of Somali women do in fact chew: Patel *et al.* (2005) report 14 per cent of female respondents had recently chewed. Female consumption occurs in private, usually at home or at a friend's house (Turning Point, 2004), although Buffin *et al.* (2009) comment on the recent emergence of women-only chewing venues in the UK.

Fitzgerald (2009) commented on the prominence of immigrant women in prohibition campaigns in Australia. He notes that patterns of migration from Somalia created greater independence for married women, who were frequently separated from husbands for long periods before families were reunited. Social processes of immigration and assimilation were more transformative for women, largely through their relation to children. This 'empowering' of immigrant Somali women, reinforced by the 'rights' and 'entitlements' that Australian residence brings, provokes domestic debates about responsibilities and gender roles in which khat consumption looms large. In sum, while Somali men see khat as a means to hold on to the cultural values and behaviours of their homeland, Somali women reject khat as an impediment to economic and social progress in their adopted country (*ibid.*).

Social and cultural aspects of khat use in the UK

Consumers give many reasons for their enjoyment of khat. Studies in the producer countries (especially Weir, 1985) emphasise the social aspects of khat parties, transcending recreation to encapsulate the building of social cohesion, generational mentoring, and consolidating business relationships (Olden, 1999). Chewing sessions solidify networks of aid and friendship.

This is also true in diaspora settings in the UK, where male networks are solidified at chewing venues known as *mafrishyo* (singular *mafrish*). Here much time is spent in banter, but discussions also focus on the latest political developments in the chewers' country of origin, or giving advice on issues and problems, including job opportunities (Sykes *et al.*, 2010; Anderson *et al.*, 2007, pp 157ff; Carrier, 2007b; Ismail and Home,

2005). In the diaspora, *mafrishyo* provide a taste of home, while also providing sources of information and advice on the new life being made by immigrants.

Many studies emphasise that khat consumption helps maintain 'culture' and 'identity' for diaspora communities, a point made by commentators and by consumers themselves (e.g., Patel, 2008; Stevenson *et al.*, 1996). Identifying khat as a cultural practice does not imply approval: in Denmark more than one-half of Somalis in a sample of 848 believed khat was a part of their culture irrespective of whether they consumed or not (Sundhedsstyrelsen, 2009). Yemenis in the UK are more uniform in viewing khat as part of their culture (Sykes *et al.*, 2010).

Attitudes to khat vary widely among UK immigrants, as is clearly illustrated in Hassan *et al.*'s (2009) work with young London-based Somalis. Many Somalis actively support a ban on khat and engage in political lobbying while others defend khat consumption as a relatively harmless pastime and as part of their cultural identity (Griffiths *et al.*, 1997). Views diverge most obviously between users and non-users but also across gender (Patel *et al.*, 2005). Anderson *et al.* (2007) attribute this to a combination of distaste for khat itself, and dislike of the all-male institution of the *mafrish* and the manner in which it draws males away from the domestic environment. Patel *et al.* (2005) report that: "*Recent khat users reported more favourable attitudes towards khat use, while non-recent khat users tended to exhibit similar attitudes to non-users. Other subgroups who tended to report favourable attitudes towards khat were men; older respondents; and those who had lived in the UK for over ten years*" (see also Buffin *et al.*, 2009). Danish evidence shows that non-users claim that chewing is problematic (Sundhedsstyrelsen, 2009).

But it is important to disaggregate national and ethnic labels to avoid presenting immigrant groups as homogeneous. This is recognised in the study of migration by the term "*super-diversity*" (Vertovec, 2006). Among UK Somalis, for example, "*We will find British citizens, refugees, asylum-seekers, persons granted exceptional leave to remain, undocumented migrants, and people granted refugee status in another country but who subsequently moved to Britain*" (*ibid.*). These differences are not reported in UK khat studies. Identities can also revolve around clan, place of origin, region, religion, generation, gender and class.

Religion is a key variable ignored in previous studies. Muslims debate whether or not khat is *halal* or *haram*⁷ (Weir, 1985), the anti-khat sentiments of conservatives being well-known (Migdalovitz, 1993). The Union of Islamic Courts placed a short-lived ban on khat in Mogadishu in 2006, which met with strong local protests.⁸ In Sweden, the anti-khat campaign relies on its supposed *haram* status (Omar and Besseling, 2008), while in the UK some consumers complain that Salafi Muslims – who generally uphold a strict form of Islamic practice – are seen as representative of the Somali community at large when making public commentary on khat (Carrier, 2007a; see also Buffin *et al.*, 2009). This discussion highlights the point that the study of khat consumption in the UK has been shaped by a number of limiting features, which more recent research seeks to overcome.

1. There has been an overwhelming focus on the Somali community, largely to the exclusion of other communities. This has had the effect of bringing to the fore the role of Somalis in the understanding of khat consumption. However, recent research, such as Sykes *et al.*, 2010, has identified this weakness and sought to redress it by examining more thoroughly differences between use and perceptions of khat among Ethiopian, Somali and Yemeni immigrants. This report found that ‘culture and tradition’ played a significant role in determining views on khat usage, with people of Yemeni origin generally more positive about khat than those from other groups (*ibid.*).
2. The significance of gender differences in immigrant experience has not been adequately explored in relation to attitudes to khat consumption, although research has generally shown women to disapprove more strongly of khat than men.
3. The ‘super-diversity’ of immigrant communities from the khat-producing countries has not been appreciated in the available literature, thus masking the importance of such factors as faith and religious persuasion and region of origin in determining likely responses to khat consumption.

Social harms – what do we know?

This section examines social harms linked with khat, assessing the evidence cited in the literature. Its main focus is on the UK literature, but also includes material from

⁷ *Halal* refers to things permitted by Islamic law, while *haram* refers to those things forbidden.

⁸ See BBC online report, available at: <http://news.bbc.co.uk/1/hi/world/africa/6155796.stm>

elsewhere in the relevant diasporas. Overall, the review found little existing evidence that examined khat-related social harms in a systematic and quantifiable way.

- 1 **Unemployment:** Though khat is seen in the UK as a recreational substance, in producer countries its use is more usually functional, as farmers, nightwatchmen, labourers and even students chew khat in order to prolong periods of physical labour and to suppress appetite (Carrier, 2007a; Almedon and Abraham, 1994). This functional use is very different from that experienced in the *mafrish* of the UK where consumption is recreational. Long hours spent chewing, and then recovering from chewing (and the sleeping problems often associated with this, e.g., Patel *et al.* (2005)), may be prompted by the lack of employment but can become a barrier to obtaining employment. Many commentators identify this as a key problem with khat use in the diaspora (e.g., Turning Point, 2004).

Writing on the 'Social Aspects of Khat', Ahmed (1994) related that UK restrictions then preventing refugees working for six months gave Somali men too much free time: "*As time continued, with more problems such as language barrier, strange environment, new system, homelessness, all compounded by low income, depression and high unemployment rates, for many, khat became their real refuge*", wrote Ahmed. More recent research in other countries with a Somali refugee population suggests language remains a key factor for recent arrived migrants in their ability to find employment.⁹

The quantitative evidence on khat consumption and Somali employment in the UK gives an unclear picture. Griffiths (1998) reported 47% of this sample (n=207) as unemployed, with only 17% in employment. He thought the high rate of unemployment explained higher usage of khat than in Somalia: "*Put simply, they have more time on their hands and qat-chewing is common when groups of Somalis meet to socialise*" (*ibid.*). However, Patel *et al.* (2005) found "*no evidence that people in this sample were using khat more in England and, secondly, a smaller proportion of those who were unemployed compared with those in employment reported using khat*". In the Patel *et al.* sample (n=602), 38% were in employment. An interesting finding from this analysis was

⁹ Proceedings of a Seminar on Khat and Health, Bethnal Green, 12 December 1994. On employment patterns among Somalis in the USA, see Rector (2008, p 16)[?add to Refs section] available at: <http://www.maine.gov/labor/lmis/publications/pdf/LewistonMigrantReport.pdf>

“the relatively high number of unemployed people in the sample who did not chew khat (68%), considering the literature that indicates lack of employment being a key issue in using the substance” (*ibid.*). Chewers seem generally able to moderate their consumption to fit in with work patterns, although for some ‘problem users’ consumption does interfere. No easy causal link emerges from the literature, therefore, and it remains unclear whether khat is a cause of unemployment or a symptom (Klein, 2008b).

- 2 **Crime:** There is little evidence of any kind linking khat consumption with criminal behaviour except where the crime is a function of khat’s legal status; where khat is illegal and still smuggled those trading and using it become criminal by definition. The Patel *et al.* (2005) study summarised the UK situation thus: “Overall, the qualitative interviews and focus groups supported the notion of a very low level of offending among Somalis across the research sites, and little evidence of offending associated with khat use. Khat was seen as an activity that actually prevented people from offending as it is time-consuming and makes them feel relaxed” (*ibid.*).
- 3 **Public order:** There is limited evidence that khat is associated with public disorder in the UK and elsewhere in the diaspora. Klein (2008b) mentioned that there was concern about khat among residents of Streatham focused on the associated spitting of chewers and the congregation of Somali men on streets. There were reports of similar concerns in one of the areas studied in the Sykes *et al.* (2010) report, and in the Netherlands, where there have also been complaints about Somali chewers “*hanging around, spitting of khat leaves on the street, yelling, fighting*” (Pennings *et al.*, 2008).
- 4 **Violence:** Since the collapse of the Somali state in the late 1980s, media reports in the West have often played up a link of khat with violence, due to its consumption by militia (Anderson and Carrier, 2006). This association with violence exists in the diaspora too, mainly in connection with domestic violence. The notion that khat causes psychosis (Warfa *et al.*, 2007) also seems to support a relationship between khat and violence.

However, the evidence in the existing literature is mixed. While the Turning Point (2004) report claims that “*violent behaviour was seen by many women as directly caused by khat chewing*”, data suggest this perception that khat causes violence is not based on many actual cases: e.g., Patel *et al.* (2005) reported six respondents (out of a sample of 602) being victims of domestic violence perceived to be related to khat. The association of khat with domestic violence is mentioned by Somali women in the studies cited above, though is not mentioned by Ethiopians or Yemenis (the relative lack of research among

these groups complicates drawing any firm conclusions from this). Due to the lack of evidence, caution is required in interpreting any supposed causal link between khat and violence.

- 5 **Family breakdown:** The evidence on khat's association with family breakdown is equally mixed. UK Somali women report family breakdown "*as probably the most serious consequence of khat use*" (Turning Point, 2004). But this is not supported by other studies. Patel *et al.* (2005) found that 13% of respondents reported being personally affected by another person's khat chewing. Only 4% of the sample of 602 (23) claimed they were personally affected by "*family difficulties or breakdown*", and 10% said they had "*experienced their partner's mood swings or temper as a result of him/her using khat*". Evidence from Denmark does, however, associate khat use with marital breakdown reporting that two-thirds of male "*heavy khat users*" in one study were divorced (Sundhedsstryelsen, 2009), double the number among other males in the sample. However, heavy khat use might be an effect of divorce as much as a cause – it is difficult to judge the significance of such a statistic without more information.

This perceived link of khat with family breakdown also needs to be put in the context of what has been termed a 'gender crisis' faced by Somalis in the diaspora (Anderson *et al.*, 2007). Harris (2004) reports that from the mid-1990s most Somalis arriving in the UK were mothers and their children; the men came later, by which time the women had already established themselves, and had become attuned to their rights in the UK, and learnt English. By the time they arrived, the men were lagging behind the women, who had established a high degree of economic and social independence. In the Canadian context, McGowan (1999) describes a similar situation indicating that the migration context is clearly crucial to an understanding of family dynamics and stability, with or without the added issue of khat consumption.

- 6 **Income diversion:** Another commonly expressed concern with khat is the proportion of income spent on its purchase (Milanovic, 2008), though the stereotype of the 'indolent chewer' spending excessive amounts on khat has been challenged by some commentators (e.g., Gezon and Totomarovario, 2008). In the diaspora literature for the UK, income diversion is often mentioned as another source of tension between khat-chewing Somali men and their wives, especially when those chewing are on a low income (e.g., Turning Point, 2004). Also, the majority of young Somalis in Nabuzoka and Badhadhe's (2000) sample (n=94) reported that khat caused them financial problems,

while a substantial proportion of consumers in Griffiths' (1998) sample saw their spending as problematic: 33% of all consumers often worried about how much they spent on khat, 24% occasionally worried, 20% rarely, and 23% never. A greater proportion of women (42%) never worried about their khat expenditure than men (16%) (*ibid.*).

Such concerns in the Griffiths study are connected with high rates of unemployment amongst his sample; with few resources to call upon, even small expenditure on khat might be a cause for concern. However, chewers interviewed in the Patel *et al.* (2005) study, when asked what they do when they cannot afford khat, most frequently responded that they would go without (37%). Also, compared with the amounts consumers spend on khat in countries where khat is illegal, the cost of khat in the UK is quite low (with bundles ranging in price from £3 to £6), though this still might constitute a significant expense for low-earners.

- 7 **Integration:** The notion that khat consumption prevents migrants from integrating into the wider society is a key issue in the Scandinavian literature (De Cal *et al.*, 2009; Sundhedsstyrelsen, 2009; Omar and Besseling, 2008; Tollefsen, 2006). This issue is raised by the wider population, by policy makers, and by Somalis themselves. In Denmark, there is the feeling among some Somalis that their integration into the wider society is threatened by khat; a majority (64%) of Somalis in the Sundhedsstyrelsen (2009) report believed that khat consumption caused problems for integration (39% were users, 80% were non-users). There is no evidence for khat holding back integration beyond the anecdotal, however. Furthermore, other factors affecting integration are mentioned in the literature, language in particular being seen as a key factor in the UK, with younger Somalis fluent in English regarded as better able to integrate than older Somalis with less fluency (Patel *et al.*, 2005).

In conclusion, despite social harms often being highlighted in relation to khat, there is a general lack of research in this area and no clear evidence that khat is a crucial factor in determining the social harms indicated. Robust epidemiological research has yet to be conducted. Indeed, a key aspect of all debates on khat and social harms is that of causality and as this discussion of the social harms associated with khat in the UK reveals, ascribing causality for these problems to khat itself is problematic.

3. Regulations and legislation

Khat and international law

The World Health Organisation (WHO) first undertook research into the pharmacology and health implications of khat in the 1950s. The publication of its findings in 1964 led to the UN Commission of Narcotic Drugs ruling against the need for international legislation, leaving it to individual countries to decide whether health advice should be given to consumers.¹⁰

Further research on the pharmacology of khat led in the 1970s to the discovery of its principal pharmacologically-active compound, *cathinone*. Concern over *cathinone*'s potential abuse as an amphetamine-like drug led the WHO Expert Committee on Drug Dependence (ECDD) to recommend its addition to the UN Convention on Psychotropic Substances in 1988, and it was then added as a Schedule I substance – meaning it was placed among those substances subject to the most stringent international restrictions. Khat's less potent principal compound, *cathine*, was added to Schedule III of the UN convention, a much less restrictive legal category. These moves applied only to the isolated compounds, and this move was not intended to subject khat itself to international control. Despite this, some countries have used the scheduling of *cathine* and *cathinone* as a reason to prohibit khat. Indeed the ECDD's most recent critical review of khat (2006) affirmed that khat should not be prohibited or controlled, stating:

“The Committee reviewed the data on khat and determined that the potential for abuse and dependence is low. The level of abuse and threat to public health is not significant enough to warrant international control. Therefore, the Committee did not recommend the scheduling of khat.”

(WHO, 2006)

However, recognising, *“that social and some health problems result from the excessive use of khat”*, the ECDD suggested that national educational campaigns be adopted to discourage use leading to *“adverse consequences”*.

¹⁰ UN Economic and Social Council, 'Resolutions Adopted by the Economic and Social Council', 11 August 1964.

Legislation in selected countries

Khat's legality varies greatly even within the region of its main commercial production (Cassanelli, 1986). It is legal in Ethiopia and Kenya and is a major livelihood for farmers and source of tax revenue and foreign exchange (Anderson *et al.*, 2007; Carrier, 2007a; Gebissa, 2004). In Djibouti and Somaliland, khat is legally consumed, but, as it is imported, politicians often lament that the trade only serves to fill the coffers of their Ethiopian neighbours (Anderson *et al.*, 2007). In southern Somalia, khat is widely available, although the Union of Islamic Courts banned it briefly in Mogadishu in 2006. Elsewhere in East Africa, khat is illegal in Eritrea and Tanzania, and while technically legal in Uganda its status is subject to much confusion (Beckerleg, 2009). In Madagascar it remains legal despite a recent debate (Carrier and Gezon, 2009). In Yemen, khat is legal (Kennedy, 1987; Weir, 1985), while in neighbouring Gulf states, including Saudi Arabia, it is banned.

In 1981, following publicity given to investigations by the WHO, Finland, Germany and New Zealand legislated against khat. Norway and Sweden acted in 1989, followed by Italy in 1990,¹¹ and Denmark and Ireland in 1993.¹² The USA brought measures (see below) against khat's compounds in 1988 (*cathine*), and 1993 (*cathinone*), while Switzerland¹³ and Canada acted against both compounds in 1996 and 1997 respectively. In Europe, Cyprus, the Czech Republic, Greece, Malta, the Netherlands, Portugal and the UK have not legislated (ACMD, 2005). This review now looks more closely at legislation in a number of countries.¹⁴

United States of America

Population data: Estimates of the Somali population varies from 30,000 to 150,000. It is estimated that 40,000 Somalis have settled in the US in the last 30 years (Kusow, 2006). The 2000 Census gives 69,530 Ethiopian-born residents,¹⁵ and 19,210 Yemeni-born.¹⁶

Legislation: With the 1988 scheduling of the two alkaloids under the 1971 UN Convention, *cathine* and *cathinone* were controlled in the USA: *cathine* became

¹¹ See: <http://www.unife.it/centri/sista/allegati/sicurezza/tabella-dpr-309-90/view>

¹² See: <http://www.irishstatutebook.ie/1993/en/si/0328.html>

¹³ See: <http://www.admin.ch/ch/fr/rs/8/812.121.2.fr.pdf>

¹⁴ See Annex 2, Table 1 for an overview of the legislation

¹⁵ <http://www.census.gov/population/cen2000/stp-159/STP-159-ethiopia.pdf>

Schedule IV in 1988 (Federal Register Vol.53, no.95), while *cathinone* became Schedule I (i.e. subject to the most stringent restrictions) in 1993 (Federal Register Vol.58, no.9). The Drug Enforcement Administration (DEA) defined khat as a Schedule IV substance when it contains *cathine*, and a Schedule I substance and when it contains *cathinone*. In effect, this prohibited the possession, use, import and supply of khat under US Federal law.

In court, the defence is often used that fair warning of khat's illegality has not been provided as khat itself is not listed as a scheduled substance, or that defendants are unaware that khat contains *cathinone* and therefore do not understand its status.¹⁷ Further confusion is caused by differences between States. For example, the District of Columbia had never added *cathinone* to its scheduled substance list. Consequently, those charged under State law for khat possession could only be faced with the minor offence relating to a Schedule IV substance (*cathine*) (*Washington Times*, 13 October 2008). However, if the quantity of khat was very large and the Federal drug authorities were asked to handle the case, the charge would be upgraded.

Current situation: There are no published data on khat consumption from either before or after the legislation. DEA officials admit that khat is "*low on their radar*" (Carrier, 2007a), although seizures have been rising: 40 tonnes of khat were seized in 2006, 33 tonnes in 2007, and 74 tonnes in 2008.¹⁸ Smuggling into the USA employs two principal mechanisms: hired couriers (mainly Europeans) bring fresh khat in airline passenger luggage, while consignments are sent through mail services. Prohibition has dramatically raised prices: it is claimed that a £3 bundle in the UK sells for ten times that price in the USA (Anderson *et al.*, 2007). Lawyers claim that a relatively low number of khat prosecutions are successful, but a Federal operation against khat importers (Operation Somali Express in 2007) saw three Somalis convicted in New York, two receiving sentences of 21 months, the third 12 months.¹⁹ Commentary on khat in the US media is dominated by associations with conflict in Africa and the Middle East, especially a supposed link to the funding of terrorism although there is no solid evidence to back this up (e.g., Kushner, 2005). No research has been reported on attitudes towards khat among immigrant communities in the USA.

¹⁶ <http://www.census.gov/population/cen2000/stp-159/STP-159-yemen.pdf>

¹⁷ For examples of court cases involving khat, see: <http://openjurist.org/395/f3d/521/argaw-v-ashcroft>

¹⁸ DEA website information about khat. Available at: http://www.dea/diversion.usdoj.gov/drugs_concern/khat.htm

¹⁹ <http://www.usdoj.gov/dea/pubs/states/newsrel/nyc100807.html>

Canada

Population data: There were 37,785 Somalis, 23,400 Ethiopians, 4,955 Kenyans and 2,300 Yemenis resident in Canada in 2006,²⁰ although unofficial figures for the Somali population are much higher (Hopkins, 2006).

Legislation: Legislation was enacted in 1997 (Salah, 1999), following negative media coverage (Grayson, 2008) and condemnation of khat by Muslim clerics (Anderson *et al.*, 2007). Canada lists khat itself as a controlled substance of Schedule IV, making it illegal to import, export or traffic in the plant (INCB, 2006). While it is not illegal to possess a Schedule IV substance, it is illegal to seek to obtain one.²¹ This creates confusion even for the police, who seem unsure as to the precise status of khat (*National Post*, Friday 28 September 2007).

Current situation: There are no published reports on prevalence or patterns of khat use in Canada. Khat continues to be chewed regularly despite occasional seizures. In 2007, 23 tonnes of khat were seized in Canada (RCMP, 2008). Police officers reportedly see khat as low priority and even a nuisance (Anderson *et al.*, 2007). However, local Somalis feel that police now target them because of the khat ban (*ibid.*, p 198). Media coverage reflects the polarised nature of the khat debate with typical headlines such as “*Khat: a dangerous drug or harmless ritual?*” (*National Post*, Friday 28 September 2007). Within the Somali community opinion is also divided.²² A Canadian MP recently called for a scientific review of khat to consider decriminalisation, suggesting that a multicultural society should tolerate such practices as khat chewing.

Norway

Population data: There are around 18,000 Somalis in Norway (Gunderson, 2006). There are no available data in regard to Ethiopians and Yemenis.

Legislation: While adding *cathinone* and *cathine* to the list of controlled substances, Norway also prohibited khat in January 1989, yet according to Tollefsen (2006), author of a recent study of khat in Norway, at that time “*there were no studies conducted to*

²⁰ <http://www12.statcan.ca/english/census06/data/highlights/ethnic/pages/Page.cfm?Lang=E&Geo=PR&Code=01&Data=Count&Table=2&StartRec=1&Sort=3&Display=All&CSDFilter=5000>

²¹ <http://blog.lawyerahead.ca/uncategorized/possession-and-trafficking-of-substance-in-canada/>

²² CBC report *Some immigrants want Canada to legalize khat* available at: <http://www.cbc.ca/canada/ottawa/story/2007/06/11/khat-070611.html>

show whether criminalisation was a good idea or not.²³ Punishments for khat use and smuggling are not severe compared with neighbouring countries. In a recent case a Somali man fled into Norway when his khat consignment of 100 kg was intercepted by Swedish authorities. He did so as conviction would have resulted in a year's imprisonment in Sweden but only 45 days in Norway.²⁴

Current situation: Price is now high compared with, say, the UK – a bundle costs around 180 kroner (£20) (Gunderson, 2006) compared with £3 to £6 in the UK – yet mounting seizures suggest demand remains strong. In the first year of anti-khat legislation (1989), 20 seizures were made of only 189 kg in total. Seizures climbed steadily in the 1990s (in 1996, there were 102 seizures weighing over 1.5 tonnes),²⁵ and the upward trend continues. In 2006, 3.7 tonnes were seized, over tripling to 11 tonnes in 2010 (Norwegian Customs & Excise)²⁶. Of Oslo's 9,000 Somalis 1,000 are consumers (Gunderson, 2006).

Opinions about khat are divided among Somalis in Norway, some call for tougher restrictions while others argue for legalisation (Gunderson, 2006). Women are among the most vocal anti-khat campaigners and the time men spend away from families chewing is seen as a factor in divorce (*ibid.*, p 45). Tollefsen (2006) has called for a full re-evaluation of khat's status, an assessment that was not undertaken when the law was introduced. Thus far no such further assessment has been made.

Sweden

Population data: Sweden's Somali population is estimated at 15,000 (Anderson *et al.*, 2007). Data for other relevant populations are unavailable.

Legislation: Following the addition of *cathine* and *cathinone* to the UN Convention on Psychotropic Substances in 1988 and the ban on khat enacted in Norway in January 1989, Sweden enacted legislation prohibiting khat in October 1989. During that year Gothenburg had become a smuggling *entrepôt* for Norway-bound khat (Hartelius,²⁷ 1995). Khat was not then viewed as a social problem by the Swedish authorities given the small population of East Africans (Socialstyrelsen, 1988). Khat smuggling is not

²³ Translation by Gunvor Jonsson.

²⁴ <http://www.nrk.no/nyheter/distrikt/ostfold/1.6378249>

²⁵ See: http://www.regjeringen.no/nb/dep/hod/dok/rapporter_planer/rapporter/1997/new-trends-in-drug-abuse-in-norway.html?id=420006

²⁶ http://www.toll.no/templates_TAD/Topic.aspx?id=218995&epslanguage=no

²⁷ Translation by Nika Rasmussen.

considered a serious offence except in quantities above 200 kg.²⁸ Penalties average four to six months' imprisonment overall (Anderson *et al.*, 2007).

Current situation: Estimates suggest that khat is still chewed by 30% of Somali men in Sweden (Anderson *et al.*, 2007). A bundle sells for 200 to 400 Kronor (Omar and Besseling, 2008) – around £18 to £36. Smuggling remains prevalent with seizures of around 9 tonnes each year (WHO, 2006).

Khat is a low priority for police, and this is criticised by campaigners who claim it shows a lack of interest in minority welfare. Prosecutors pressing for longer sentences for smugglers caught with large quantities²⁹ are supported by the National Association of Somali Women and the Swedish National Association of Immigrants Against Drugs, who have produced a document using Islamic teaching to denounce khat (De Cal *et al.*, 2009; Omar and Besseling, 2008).

Denmark

Population data: Denmark has a Somali community of 16,550 (Sundhedsstyrelsen, 2009). There are no available data for other relevant populations.

Legislation: Khat has been illegal to sell, import or possess since 1993.³⁰ Soon after the bans in Norway and Sweden, Denmark became the major *entrepôt* for khat smuggling. The Danish legislation of 1993 was enacted in the face of pressure from Sweden (Estievenart, 1995). The police initially dealt with khat possession by cautions, but fines are now given. The fines for quantities up to 1 kg are minor, and rise to 2,000 kroner (around £230) for 1 to 10 kg, while imprisonment is the penalty for quantities above 10 kg.³¹

Current situation: Smuggled khat sells at 100 kroner (£12) per bundle (Sundhedsstyrelsen, 2009). A recent study revealed that 15% of 15- to 50-year-old Somalis (within a sample of 848), chewed khat (*ibid.*). More restrictive legislation in Sweden makes Denmark an attractive destination for Swedish-based consumers (Anderson *et al.*, 2007). Community anxieties about increasing khat use and adverse effects upon Somali youth³² are not supported by recent research, which suggests a

²⁸ Summary of a conference held in Sweden on 20 June 2007, available at: <http://tempecad.co.cc/svnet/etc/khat.pdf>

²⁹ See, for example: <http://www.drugnews.nu/article.asp?id=4055>

³⁰ See: <http://www.logir.fo/foldb/bek/1993/0000698.htm>

³¹ See: <http://khatforebyggelse.dk/alt.om.khat.html>

³² See the following website of a Danish anti-khat organisation: <http://khatforebyggelse.dk/>

“new attitude to khat among the young” with the great majority of youth not chewing and expressing disapproval (Sundhedsstyrelsen, 2009).

The Netherlands

Population data: The Netherlands’ Somalis number around 14,000 (Hassan and Healy, 2009, p 9). There are no available data for other relevant populations.

Legislation: There is no legislation against the import, trade or consumption of khat.

Current situation: The Netherlands is a major destination for khat for internal consumption by local Somalis. There is some re-export. There are no available data on quantities imported, nor on prevalence, patterns or trends. Concern over use has resulted in minor measures being taken against khat. Pennings *et al.* (2008) report that one Dutch town has prohibited khat use within 500 m of the distribution point, a measure designed to prevent malingering. A recent government report on the risk potential of khat in the Netherlands found the harm potential to be low (*ibid.*). As in the UK, import taxes are imposed on khat.³³

Australia

Population data: In 2007 there were 12,361 Kenyans, 6,981 Ethiopians and 5,286 Somalis (Fitzgerald, 2009) in Australia. Data for Yemenis are not available.

Legislation: Khat’s pharmacological compounds (*cathine and cathinone*) are restricted in Australia but the treatment of khat varies by State.³⁴ In Victoria – where most East African immigrants live – there are no restrictions on consumption, although importers must hold a licence and permit issued by the Office of Chemical Safety and Environmental Health. This allows for the import of 5 kg of khat per month.³⁵

Current situation: Khat consumption has been known since the mid-1990s (Stevenson *et al.*, 1996). Imports have grown markedly from 70 kg in 1997 to 20,130 kg in 2008.³⁶ Fitzgerald estimates that khat is sold at \$35 (Australian) per bundle: the retail market is worth \$2.2 million (*ibid.*). The Australian market is dominated by dried khat, although

³³ Report of meeting with Her Majesty’s Revenue & Customs (HMRC), 30 September 2009.

³⁴ Khat possession is unregulated in Australian Capital Territory, New South Wales, Tasmania and Victoria, but regulated in Northern Territory, Queensland, South Australia and Western Australia. See answer to questions on khat given in the House of Representatives: <http://www.aph.gov.au/house/committee/petitions/roundtables/3dec08/answerkhat.pdf>

³⁵ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ocs-tc-guidance-imp-khat.htm>

³⁶ <http://www.aph.gov.au/house/committee/petitions/roundtables/3dec08/answerkhat.pdf>

fresh khat is increasing. The khat debate here is muted in comparison with other countries. The Chairperson of the East Africa Women's Foundation took a petition demanding the prohibition of khat to the House of Representatives. This campaign prompted a review of khat in 2009, which advised against further legislation (*ibid.*).

4. Conclusion

In answer to the questions set out at the start of this review:

1. *What are the social harms associated with khat use in the national and international literature?*

On the basis of a relatively small evidence base of mixed quality the review found that khat is anecdotally associated with a number of social harms among diaspora communities in the UK and elsewhere. Those raised most frequently in the literature, and focused upon in this review, include: unemployment, crime, public order, violence, family breakdown, income diversion and lack of integration of khat-consuming communities. Of these, unemployment, family breakdown and income diversion appear to be the cause of most concern among relevant diaspora communities.

2. *What is the evidence on the impact of harms on khat users, their families and community?*

Much of the literature based on survey and focus group data drawn from the relevant diaspora communities demonstrates that there is concern about a link between khat consumption and such social harms. However, none of the literature reviewed provides a clear causal relationship between khat consumption and the various social harms established. Also, it is clear that opinion on khat among the relevant communities (principally, Ethiopians, Somalis and Yemenis) is divided. The literature on social harms has predominantly focused on Somali consumers, leading to general inferences about khat consumption that are largely not based on evidence on consumption among non-Somalis.

3. *In countries where khat has been controlled, what was the evidence base for this decision?*

In none of the selected countries that have banned khat was the matter researched before implementing legislation – an issue now again being debated in some countries (e.g., Sundhedsstyrelsen, 2009; Gunderson, 2006; Tollefsen, 2006). Instead, the control of khat's chemical alkaloids two decades ago triggered legal responses in several countries despite a lack of evidence that such responses were appropriate. Where khat

has been most extensively studied, prohibition has not been introduced (Australia, the Netherlands and the UK).

4. *What is the evidence on the impact of control on social harms and on the khat trade?*

Although solid evidence on prevalence of khat use in those countries where khat has been prohibited is limited, the available evidence suggests that khat use continues. Furthermore, in countries where trend data are available, seizures of khat have been increasing (which might result either from increased vigilance or increasing demand). As no research was undertaken prior to khat's prohibition, it is impossible to say how its illegality has affected prevalence, trends and associated social harms. The social consequences of its illegality should be studied in greater detail as these are likely to be profound given "*the criminalisation of users and sellers*" and the creation of "*illegal drugs markets*" (Klein *et al.*, 2009).

5. *What is the evidence on the impact of control on attitudes to khat?*

Given the limited nature of the available evidence, it is difficult to make any definitive pronouncements on how attitudes have been affected by khat prohibition. However, the available literature from Scandinavia suggests attitudes among the Somali diaspora remain divided; some call for heavier penalties to deter trade and use, while others call for its legalisation. This appears true for Canada too, where there have been calls for khat to be legalised from Somalis, and an MP has called for a review of its current status.

6. *What is the evidence on prevalence, trends and patterns of khat use?*

The current available data suggest that khat continues to be consumed by a significant proportion of those from relevant diaspora communities in countries where it is controlled. In the UK it can be discerned from the rate of import that it remains popular among a significant proportion of Somalis, Yemenis and, to a lesser degree, Ethiopians, although prevalence rates cannot be accurately quantified. Survey data suggest a significant minority of the UK Somali population consume khat, e.g., around one-third of the respondents in the Patel *et al.* (2005) sample. While the rate of import has risen due

to increased immigration from the Horn of Africa, it is unclear whether the market will continue to grow. There is no evidence of significant consumption in the wider population. Anecdotal evidence suggests that khat consumption is less popular among younger generations and second-generation migrants from the relevant communities. To better understand the impact of khat consumption in the UK more research is needed across all the immigrant communities involved. More rigorous monitoring of consumption patterns in the UK would certainly help in generating a solid evidence base and improve upon the currently meagre quantitative data on the trends and patterns of khat chewing in the UK.

Appendix 1:
Discussion points and recommendations from the Advisory Council on Misuse of Drugs review of khat 2005

Discussion

- Existing evidence suggests that khat use is widespread in the UK among immigrant communities from the Horn of Africa and the Arabian Peninsula. There is no evidence of its use by the wider community.
- Khat is a much less potent stimulant than other commonly used drugs such as amphetamine or cocaine. However, some individuals use it in a dependent manner.
- Khat use is a risk factor for oral cancers and possibly for myocardial infarction. Residual pesticides on the leaves of khat represent a health risk.
- There is some evidence of an association with chronic khat use and development of psychological symptoms. However, as yet there is no proven causal association.

Recommendation 1

The Advisory Council on the Misuse of Drugs (ACMD) recommends that khat is not controlled under the Misuse of Drugs Act 1971.

Recommendation 2

The Council felt that there was a need to educate primary health care professionals and others directly involved with members of these communities about the health and social problems and requirements of these populations, and specifically about the problems associated with khat use.

The need for education was in the following areas:

- the health risks associated with khat use;
- the dangers of khat use;
- risk reduction and safer khat use;
- treatment options for khat use;
- prevention of khat use.

The Council felt that this education should be, at least partly, focused through local communities, including peer education models, and through primary care services and NOT exclusively through addiction services.

It was agreed that this education activity had to ensure that it reached female users – who often use in an isolated manner, at home alone and at night. As such, in designing and delivering education strategies, providers should do so with an awareness of the particular sensitivities of dealing with women in these communities.

Recommendation 3

The Council overwhelmingly felt that khat users, when seeking advice and help, should not automatically be encouraged to attend addiction services. Drug Action Teams should focus on ensuring that local communities and primary care services use the best approaches to treatment, prevention and education.

As with education, particular consideration needs to be given by service providers, to ensure that advice and treatment services are appropriate for female, as well as male, users. Interventions involving families should be considered.

In addition to the harm reduction and education approaches above, the Council felt some concern over the nature and location of retail and consumption of khat. There was evidence of khat-use by children under the age of 18, and by significant numbers of users in poorly ventilated, often unhygienic *mafrishyo* (khat chewing dens).

Recommendation 4

In response to the concerns in Recommendation 3 above, the Council recommends that the Government/relevant local authorities explore the possibility of a voluntary agreement among retailers of khat on excluding sale of khat to those under 18 years old.

Recommendation 5

Furthermore, the Council recommends an awareness-raising campaign of the health and safety implications of chewing khat in *mafrishyo* (e.g., health implications from poorly

ventilated, smoky environments) and a voluntary undertaking from community leaders and *mafrish* owners to adhere, wherever possible, to current health and safety regulations on ventilation, lighting, fire escapes, etc.

Appendix 2: Overview of legislation in selected countries

Table 1: Legislation at a glance

	Legal status	Date of legislation	Khat reports +/-or reviews	Levels of recent imports	Scale of recent seizures
USA	Scheduled compounds <i>cathine</i> and <i>cathinone</i> are prohibited under Federal law, thus effectively prohibiting khat, but legal status varies under State law	<i>Cathine</i> controlled in 1988, <i>Cathinone</i> controlled in 1993	No reviews conducted	Prohibited	40 tonnes in 2006 33 tonnes in 2007 74 tonnes in 2008 ¹
Canada	Khat is a controlled substance. Consumption legal, import and trade prohibited	1997	No reviews conducted	Prohibited	28 tonnes in 2007 ²
Norway	Consumption illegal, import and trade prohibited	1989	No reviews conducted	Prohibited	4 tonnes in 2006 9 tonnes in 2007 ³
Sweden	Consumption illegal, import and trade prohibited	1989	No review prior to ban; review in 2009	Prohibited	9 tonnes in 2006 (estimate) ⁴
Denmark	Consumption illegal, import and trade prohibited	1993	No review prior to ban; review in 2009	Prohibited	No available data
The Netherlands	Uncontrolled	None	Review of khat in 2008	No available	Not prohibited

				data	
Australia	Importation under licence	1990s	Reviews of khat published in 1996 and 2009	20 tonnes imported in 2008 ⁵	Not prohibited
UK	Uncontrolled	None	Reviews of khat in 1990, 1998 and 2005	58 tonnes per week (estimate of 3,002 tonnes per year) in 2010 ⁶	Not prohibited

1 Source Drug Enforcement Administration

2 Royal Canadian Mounted Police

3 Norwegian Customs & Excise

4 World Health Organisation estimate

5 <http://www.aph.gov.au/house/committee/petitions/roundtables/3dec08/answerkhat.pdf>

6 Her Majesty's Customs & Excise

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