

ACMD

Advisory Council on the Misuse of Drugs

Khat: A review of its potential harms to the individual and communities in the UK

Acknowledgements

The ACMD wishes to thank the various organisations and individuals who gave their valuable time and attended the evidence gathering days, and those who issued invitations for us to see at first hand their work in this area, as well as to voice their concerns.

To aid the work of the ACMD community visits were made to local authorities and NGOs in London, Cardiff and Manchester, which included presentations from Police, NHS bodies and BME groups¹. A number of MPs provided representations on the issue of khat use and submitted the views of their constituents.

In particular we wish to thank Professor David Anderson for his valuable contribution, as a co-opted member of the Working Group.

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¹ The term BME (Black Minority Ethnic) used in this report includes Ethiopian, Somali, Yemeni, Kenyan, Eritreans, and Arabic people, unless otherwise stated.

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23 January 2013

Dear Home Secretary,

Thank you for your previous correspondence in which the Minister responsible for Drugs requested, on behalf of Government, that the ACMD review khat, specifically concerning its societal harms. As you are aware, it was agreed with the Home Office the review was necessarily deferred due to competing work priorities. The ACMD has now completed its review and has pleasure in submitting the attached for your consideration.

The ACMD has been inclusive in its gathering of the evidence to provide this comprehensive review. The ACMD recognises the concerns that have been raised around the social harms of khat and has therefore gone to lengths to ensure the various sources of this evidence have been collected. As well as peer review articles, surveys and other sources of information on social harms, the ACMD has undertaken community BME visits and has had discussions with Council leaders, as well as requesting information from Government bodies, to ensure the ACMD understood, captured and addressed the relevant concerns.

The ACMD last provided you with advice on khat in 2005. The ACMD's present assessment that you commissioned builds on the evidence base of the 2005 report, particularly societal harms.

In summary, the evidence shows that khat has no direct causal link to adverse medical effects, other than a small number of reports of an association between khat use and significant liver toxicity.

Some of the adverse outcomes are *associated* with khat use i.e. a complex interaction of khat with other factors to produce the outcome, but not directly caused by khat use.

It is apparent from the evidence on societal harms that it is often difficult to disentangle whether khat is the source of community problems or, to some extent, its prevalence and use is symptomatic of the problems for some individuals and groups within the community.

On the basis of the available evidence, the overwhelming majority of Council members consider that khat should not be controlled under the Misuse of Drugs Act 1971. In summary the reason for this is that, save for the issue of liver toxicity, although there may be a correlation or association between the use of khat and various negative social indicators, it is not possible to conclude that there is any causal link. The ACMD considers that the evidence of harms associated with the use of khat is insufficient to justify control and it would be inappropriate and disproportionate to classify khat under the Misuse of Drugs Act 1971. In summary the ACMD considers that the harms of khat does not reach the level required for classification. Therefore, the ACMD recommend that the status of khat is not changed.

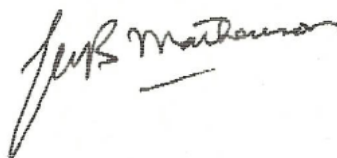
We hope there will be close attention paid to the ACMD's further recommendations, which all have our unanimous support. It is essential that communities be supported and given the appropriate resource and environment within which they can manage issues e.g. to support integration and address inequalities of health. A multi agency approach, requiring cross departmental consideration, will be essential to address the wider community issues that are well referenced in this report.

Our recommendations are based on a rigorous and systematic process of evidence gathering and subsequent analysis of what was submitted and presented to the ACMD. We would welcome discussing our findings with you.

Yours sincerely,



Professor Les Iversen CBE,
FRS



Dr Hew Mathewson CBE



Kyrie LI James

CC: Minister of State for Crime Prevention
Parliamentary Under Secretary of State for Public Health

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Executive Summary

Introduction

Khat is a herbal product consisting of the leaves and shoots of the shrub *Catha edulis*. It is chewed to obtain a mild stimulant effect and is a less potent stimulant than other commonly used drugs, such as amphetamine or cocaine.

Khat is not controlled under the Misuse of Drugs Act 1971 and is currently imported and used legally in the UK.

Khat is imported into the UK from the main khat growing regions of Kenya, Ethiopia and Yemen.

Generally, khat chewing is a social event which takes place within family homes, community parties and at khat cafes. Traditionally khat has been used as a medicine and was widely perceived to be a food, not a drug.

Background

The ACMD reviewed the harms associated with khat use in 2005 and determined that khat should not be controlled under the Misuse of Drugs Act 1971 and made a number of education and research recommendations.

The Minister responsible for drugs requested the ACMD to review and update its assessment of 2005 and provide advice in relation to control under the Misuse of Drugs Act 1971.

Khat Use – International

There are no international comparable prevalence estimates for use of khat and no reliable published evidence as to the rates of khat use in European countries. However within Europe khat use is primarily amongst BME immigrants from the Horn of Africa countries.

Rates of khat use appear high among the general populous in Somalia, Yemen and Ethiopia. However prevalence of khat use is far less among the Somali community living in the UK than in the population living in Somalia.

Khat Use – UK

Based on VAT data from HM Revenue and Customs there has been a reduction of importation of khat to the UK since 2005.

During this period the relevant BME population in the UK has increased by 18.4%. This strongly indicates that khat use within the same UK population has decreased.

Northern Ireland and Scotland do not report any figures on prevalence or treatment data of khat users engaging with the NHS.

Only 6 referrals are recorded on the Welsh National Database for Substance Misuse since 2009.

The NHS data for England for 2010/11 shows 112 clients began treatment for the first time citing involvement with khat at any point in their past.

The ACMD is cognisant that NHS and other data may not fully represent the treatment needs of khat users due to the difficulties in engaging with all groups within communities.

The Pharmacology of Khat

Fresh khat has a short lifespan for use as a chewable stimulant, approximately 36 to 48 hours, from picking to consumption; when transported under optimal conditions. Khat can also be dried and juiced, but both forms have significantly lowered levels of active ingredients, if any at all.

Cathinone and cathine isolated in pure form from synthetic compounds are stable and controlled under the Misuse of Drugs Act 1971. This is in direct contrast to the unstable nature of cathinone in the khat plant, which quickly degrades to cathine.

It is easier and less expensive to manufacture synthetic cathinones and cathines than to extract it from fresh khat.

Although chewing khat is an efficient method of extracting the active ingredient, it is not extracted rapidly, hence the long period of chewing needed to elicit an effect: and it does not have a fast onset of action. Khat's bitter taste and method of consumption make it unattractive to most potential consumers.

Medical Harms

The addictive potential of khat is likely to be less than the consumption of the pure drug cathinone.

Khat has no direct causal link to adverse medical effects, other than a small number of reports of an association between khat use and significant liver toxicity.

Overall the reporting of physical harms of khat in the media is at odds with the medical evidence. A number of concerns raised may be due to other factors and contributory associations, which should be placed within the wider context of obstacles and lack of opportunities facing the user demographic, overseas nationals and those seeking asylum within our society.

Social Harms

Anecdotal evidence reported from communities in several UK cities link khat consumption with a wide range of social harms. Research into these concerns has been undertaken but no robust evidence has been found which demonstrates a causal link between khat consumption and any of the harms indicated.

Somali groups that made representations to the ACMD claimed khat use was a significant social problem within their local areas and in domestic settings. In contrast it was asserted that the Yemeni community had no problem with khat use, as it takes place within the family setting and is integrated into other social domestic events.

The majority of this group use khat in an unproblematic manner.

Existing legislative frameworks in health, police and council partnerships working with relevant BME Communities have shown they can successfully address anti-social behaviour concerns voiced.

The comparative research undertaken in London and Minneapolis draws attention to the ongoing support upon arrival provided to those arriving in the USA, and how this enhanced employment opportunities, where employment was a key determination for social well being.

There is no evidence of khat consumption being directly linked with serious or organised criminal behavior in the UK or to support the theory that khat is funding or fuelling crime. This is unsurprising given khat is not an illegal drug, is not a high value substance and therefore attracts very little profit from the UK market.

In regard to international crime the ACMD has not been provided with any evidence of Al Shabaab or any other terrorist group's involvement in the export or sale of khat despite consultation with national and international official bodies.

Evidence presented to the ACMD by researchers found no link between gang crime and khat use

International Issues

Legislation regarding khat in Europe and North America has been widely introduced. It appears that decisions to control khat are likely not to have been based on robust evidence of either physical or societal harms, including issues of domestic and international crime, but other factors.

The impact of legislation is difficult to measure, however there remains a demand for khat even in those countries where it is prohibited. The outcomes of enforcement are mixed and appear fragmentary in some cases.

Fears of the UK becoming a hub for importation of khat appear not borne out by the VAT figures provided by the HMRC regarding the volume of khat imported into the UK since 2005 or by any evidence suggesting the UK is a landing point for the onward transportation of significant quantities of khat.

Concerns

BME groups are not homogenous communities, but range from well settled fourth generation families to asylum seekers fleeing civil war.

The complex multi-factorial issues facing khat using asylum seekers/refugees may include: unemployment; legal uncertainties and irregular status; trauma; no social or family networks; social dislocation; discrimination; poor English literacy; gender politics; lack of inspirational realisation; devalued refugee identity; lack of validation of previous qualifications; lack of or limited access to accommodation and health care service provision.

Recommendations

Without the necessary data and robust evidence to support proportionate intervention, the ACMD does not recommend that khat be controlled under the Misuse of Drugs Act 1971. The ACMD considers that the 'coalescence of concerns' around the use of khat can be addressed through the recommendations made.

1. The ACMD recommends that the status of khat is not changed and is not controlled under the Misuse of Drugs Act 1971.

2. It is recommended that Commissioners and Directors of Public Health from Local Health Boards, NHS Boards, Health and Wellbeing Boards, and Health and Social Care Boards should:
 - Include khat in local needs assessments, particularly where there are population groups of relevant BME groups;
 - Where khat use is found to be present in local communities, this substance should be included in local generic substance misuse education and prevention initiatives;
 - Where khat use is found, the commissioning of culturally specific and tailored treatment and recovery services incorporating ‘mutual aid’ models of support should be considered;
 - Consider dialogue and partnership working with appropriate NGO, third sector, voluntary organisations and BME communities, so holistic needs of health and social issues are met.
3. It is recommended that where concerns are expressed about social harms associated with the use of khat, Local Authorities and new Police and Crime Commissioners should address them through engagement and dialogue with the local community and good inter-agency working, supported as necessary by the use of existing measures coordinated through the relevant Community Safety Partnerships and the use of community remedy.
4. It is recommended that Commissioners of Public Health services, as well as Criminal Justice System bodies and the new Police and Crime Commissioners should include the use of khat in regular monitoring returns required from treatment and enforcement agencies and publish annual figures. This data should form the basis of future research on khat to address the concerns raised in this report.

There is a need for further research on khat to develop the evidence base of any findings. The ACMD echoes the view of the European Monitoring Centre for Drugs and Drug Addiction that “knowledge gaps in this area remain considerable, and little is known about the social or health consequences of [khat] use”².

² EMCDDA. Khat use in Europe: implications for European policy. Lisbon: EMCDDA. 2011.

1. Introduction

Background

1. After reviewing the harms of khat in 2005 the Advisory Council on the Misuse of Drugs recommended that khat should not be controlled under the Misuse of Drugs Act 1971³.
2. In the 2005 report the ACMD concluded the prevalence of khat in the UK was relatively low and the evidence of harm resulting from khat use was not sufficient, in comparison with controlled drugs, to recommend its control. The ACMD did believe there was value in education and more widely providing information about khat use and its impact, and as such it made a number of recommendations on this issue.
3. The ACMD report stated there was a need to educate primary health care professionals and others directly involved with members of communities in which khat use is prevalent; specifically, education about the health and social problems and requirements of these populations. The Government accepted the ACMD's recommendations on khat in full.
4. In October 2010 the Minister Responsible for Drugs asked the ACMD to review khat by considering the available evidence and to advise the Government as to the current situation in the UK: the "harms caused to individuals and the societal harms in the affected UK's Somali, Yemeni and Ethiopian communities".
5. As was indicated in the ACMD's letter to the Home Secretary, of 17 March 2011, the Home Office agreed the delivery of the review of khat was agreed to be delayed, from original timelines, due to competing work priorities.

³ This report is available at http://www.homeoffice.gov.uk/publications/alcoholdrugs/drugs/acmd1/khat-report2005/Khat_Executive_Summary.pdf?view=Binary

Role of the ACMD

6. The ACMD was established as an independent expert advisory body under the 1971 Misuse of Drugs Act and its remit is to keep under review the drug situation in the United Kingdom and to advise Government Ministers on measures to be taken for preventing the misuse of drugs or for dealing with the social problems connected with their misuse. This includes providing recommendations on the following matters if considered appropriate based on the evidence before it:
 - a) for restricting the availability of such drugs or supervising the arrangements for their supply;
 - b) for enabling persons affected by the misuse of such drugs to obtain proper advice, and for securing the provision of proper facilities and services for the treatment, rehabilitation and after-care of such persons;
 - c) for promoting co-operation between the various professional and community services which in the opinion of the Council have a part to play in dealing with social problems connected with the misuse of drugs;
 - d) for educating the public (and in particular the young) in the dangers of misusing such drugs and for giving publicity to those dangers; and for promoting research into, or otherwise obtaining information about, any matter which in the opinion of the Council is of relevance for the purpose of preventing the misuse of such drugs or dealing with any social problem connected with their misuse.
7. The ACMD has considered the evidence of the harms of khat to inform its advice on classification as set out in Schedule 2 of the 1971 Misuse of Drugs Act:

Class A: (most harmful) includes cocaine and heroin.

Class B: (intermediate category) includes cannabis and barbiturates.

Class C: (least harmful) includes anabolic steroids and benzodiazepines.

Remit of Review and Scope

8. The ACMD developed the specific terms of reference in its review of khat, to include the following matters:
 - Consider whether it should recommend khat be classified under the Misuse of Drugs Act 1971;
 - Report on the prevalence of khat use;
 - Identify key khat using populations;
 - Identify and quantify harms associated with khat use, specifically social harms;
 - Develop an understanding of responses to khat use, services and public information campaigns; and
 - Consider the nature of the khat trade, including international trafficking and possible links to organised crime;

Steps taken to Implement Recommendations from 2005 Report

9. The then Home Secretary accepted the ACMD's recommendations made in the 2005 report in full. This included the decision not to control khat and a need to educate primary health care professionals and others involved with members of communities in which khat use was prevalent, specifically education about the health and social problems of its use and the requirements of these populations.
10. The following update on the ACMD's previous recommendations was provided by Government Departments:

NHS

11. Khat use and any support required by users is integrated into the existing generic substance misuse infrastructure of the NHS i.e. through local drug partnerships supported by the National Treatment Agency for Substance Misuse (NTA) in regards to joint strategic needs assessments. The Department of Health supports professionals and provides information to support their development in addressing substance misuse.
12. The 2010 Drug Strategy aims to increase the number of clients recovering from their drug dependence and to reduce illicit drug use, as well as other harmful drug use. Under this Strategy local drug partnerships identify and address the needs of their communities.

13. The 'black and minority ethnic drug misuse needs assessment project' (2003 - 2006) and the Community Engagement Project, provides local partnerships with information and data. This work was evaluated by the Centre for Ethnicity and Health and included 6 projects specifically dealing with khat, including female khat users.
14. The NTA works with local drugs partnerships in England to develop annual treatment plans which reflect the needs of BME communities and the local pattern of drug misuse including community engagement projects.
15. The Home Office referred to the ACMD's 2005 report in its newsletter distributed to local drugs partnerships, requesting co-ordinators to consider whether khat was an issue in their communities and to consider implementing the recommendations locally. Little feedback was received.

Research

16. To address the research gap the Home Office have published two research studies since the review: report 44 on *Perceptions of the social harms associated with khat use (2010)* that included a short survey of Drug Action Teams (DATS) conducted to gauge the availability of treatment services for khat users and Occasion Paper 95 on *Khat: Social harms and legislation, a literature review (2011)*.
17. In August 2011 the Department of Health commissioned Liverpool John Moores University to update the previous National Addiction Centre Review on general substance misuse around khat.⁴

Training and Education

18. Guidance on education and training in substance misuse was issued to medical schools.⁵ The chapter on 'Epidemiology, Public Health and Society' provided information on local community substance misuse problems including interventions outside specialist services.
19. Funding was provided to the Royal College of General Practitioners (RCGP) to develop training in substance misuse for GPs.

⁴ A summary of the health harms of drugs: A guide to the risks and harms associated with substance, The Centre for Public Health, Faculty of Health & Applied Social Science, Liverpool John Moore's University, on behalf of the Department of Health and National Treatment Agency for Substance Misuse, 2011

⁵ Substance Misuse in the Undergraduate Medical Curriculum, The International Centre for Drug Policy, St George's University of London. April 2007

20. The NHS and Home Office funded information provision on the use of khat through the 'talktofrank' website. The FRANK helpline is equipped to take calls with a translator in a number of languages, including Arabic and Somali.
21. The Department of Health provides funding for organisations, such as DrugScope to disseminate information on substance misuse, which generically includes drugs such as khat.

Sales to under 18 year olds

22. The Home Office wrote to the Khat Distributors and Traders Association to seek their support in trying to implement a voluntary agreement not to sell to under 18 year olds. No response was received by the Home Office.
23. The Home Office has sought to engage with traders but this too was unsuccessful.

Quality of Research and Hierarchies of Evidence

24. This report is based on a detailed scrutiny of the relevant literature and all presentations and representations received.
25. The ACMD considered the current level of khat use in the UK, the evidence of health risks and societal harms as a consequence of khat use.
26. During the course of the review the ACMD received information from the medical and scientific community and research academics. This included overseas publications and those in Arabic, reporting levels of khat use, potential risks and current treatment options. A literature search of a large number of medical databases, including Medline/PubMed, as well as the Internet was made to identify relevant reports up to August 2012. Non-peer reviewed qualitative and quantitative resources were also included in the Internet searches because exploratory work revealed that data-driven literature on the search topic was limited.
27. Contributions were also made by BME community groups, Non-Governmental Organisations (NGOs) and Government bodies such as the National Health Service, Local Authorities, as well as the Police. This included data from Government Departments and other devolved administrations.

28. The ACMD received oral testimony from organisations and individuals with a special interest in khat, including Members of Parliament who presented the views of their constituents. The ACMD is particularly grateful to those who gave presentations at its evidence gathering meetings in London, Manchester and Cardiff, as well as those who shared their personal views at various community meetings. A list of contributors is at Annex B.
29. The issues which arose in the course of assessing all sources of information and the limitations of the general application of international khat research for the UK are more fully detailed in Annex A⁶.
30. The quality of the available literature was considered to be generally poor so as to preclude meta-analysis. Previous UK reviews on khat, such as those conducted by Anderson (2011)⁷, Sykes (2010)⁸, Warfa (2007)⁹ and their respective colleagues have reached similar conclusions. However, it should be noted that the ACMD sought to identify and extract relevant information from a wide variety of evidence sources, not just those considered 'gold standard' in evidence hierarchies. The usefulness of this evidence in developing the recommendations was assessed by its methodological quality, which was variable.

⁶ Evans D. Hierarchy of evidence: a framework for ranking evidence evaluating healthcare interventions. *Journal of Clinical Nursing* 2003; 12: 77–84

⁷ Anderson & Carrier, *Khat; Social Harms and Legislation – A Literature Review*. Home Office, Occasional Paper 95, July 2011

⁸ Sykes, W., Coleman, N., Desai, P., Groom, C., Gure, M. Howarth, R.

Perceptions of the social harms associated with khat use. Home Office Research Report, 2010

⁹ Warfa N, Klein A, Bhui K, Leavey G, Craig T, Stansfeld SA. Khat use and mental illness: a critical review. *Social Science & Medicine*, 65: 309-318, 2007


2. Khat

31. Khat can currently be imported and used legally in the UK and is not controlled under the Misuse of Drugs Act 1971.
32. Khat grows at an altitude of 5,000 to 8,000 feet and is found throughout Eastern Africa and the Middle East, but also grows in parts of Southern Africa, North Africa, and central Asia. Wild khat trees can grow as high as 80 feet in an equatorial climate, but the farmed variety is kept at around 20 feet with constant pruning. Cultivation of khat has been confined to a narrow geographical area, ranging from Yemen in the Arabian Peninsula to the Meru highlands in Kenya. The only major centres of commercial cultivation are thus found in Yemen, Ethiopia and Kenya¹⁰.
33. The above centres of commercial production are also the main areas of global consumption. In the Arabian Peninsula and eastern Africa khat has traditionally been consumed as an appetite suppressant, and is often taken by persons involved in hard physical labour, and also in a ritual context associated with spiritual contemplation. In modern times, consumption of khat has extended as a leisure pursuit, associated with sociability. These past and present patterns of consumption of khat have been thoroughly studied in the main countries of commercial production¹¹.
34. Khat is a herbal product consisting of the leaves and shoots of the shrub *Catha edulis*. It is chewed to obtain a mild stimulant effect. Khat is a much less potent stimulant than other commonly used drugs, such as amphetamine or cocaine. However, it appears some individuals use it in a dependent manner. When chewing, users of fresh khat report increased levels of energy, alertness, self-esteem, elation, enhanced imaginative ability and capacity to associate ideas. Dried khat and khat juice have significantly lowered levels of active ingredients, if any at all.

¹⁰ Anderson et al, *The Khat Controversy* (Oxford & New York: Berg, 2007), 1-3.

¹¹ Kennedy, *The Flower of Paradise: The Institutionalised use of the drug Qat in Yemen* (London: D. Reidel Publishers, 1987); Weir, *Khat in Yemen: Consumption and Social Change* (London: British Museum, 1985); Gebissa, *Leaf of Allah: Khat and agricultural Transformation in Harerge, Ethiopia, 1875-1991* (London: James Currey, 2004); Carrier, *Kenya Khat: The Social Life of a Stimulant* (Leiden: Brill, 2007).

35. Cathinone and cathine are the main chemical constituents of khat. When isolated in pure form, from synthetic compounds, both substances are stable and are controlled under the Misuse of Drugs Act 1971. This is in direct contrast to the unstable nature of cathinone, which quickly degrades to cathine, as found in the fresh khat plant. Although chewing khat is an efficient method of extracting the active ingredient cathinone it is not extracted rapidly, and does not have a fast onset of action. The bioavailability of the active compounds in khat is low, hence the need for a long period of chewing to elicit an effect. This means the overall intake of the active ingredients is low. The bitter taste and method of consumption make khat unattractive to most potential consumers. Thus the addictive potential of khat is likely to be less than would be the consumption of the pure drug cathinone. It would be easier and less expensive to manufacture synthetic cathinones and cathines than to extract it from fresh khat.

Box 1: Fresh khat¹²															
	<p>Khat may be called –</p> <table> <tr> <td>Mirra</td> <td>Qat Jaad</td> </tr> <tr> <td>Herari Kaad</td> <td>Chat Qaat</td> </tr> <tr> <td>Gat</td> <td>Catha</td> </tr> <tr> <td>Tschat</td> <td>Tohai</td> </tr> <tr> <td>African salad</td> <td>Bushman's tea</td> </tr> <tr> <td>Abyssinian tea</td> <td>Tea of the Arabs</td> </tr> <tr> <td>Flower of paradise</td> <td></td> </tr> </table>	Mirra	Qat Jaad	Herari Kaad	Chat Qaat	Gat	Catha	Tschat	Tohai	African salad	Bushman's tea	Abyssinian tea	Tea of the Arabs	Flower of paradise	
Mirra	Qat Jaad														
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Tschat	Tohai														
African salad	Bushman's tea														
Abyssinian tea	Tea of the Arabs														
Flower of paradise															

¹² D.Anderson, 2012, own private photograph collection, ©.

Khat Use – Global

36. Traditionally khat has been used as a medicine and the leaves have been used for the treatment of depression, gastric ulcers, hunger, obesity, and tiredness. Khat is widely perceived to be a food, not a drug.
37. More recently, Douglas *et al* aimed to identify patterns of khat use among Somali-Australians and explored their views about the perceived links between khat use and personal health¹³. They carried out a qualitative study using semi-structured focus groups among 114 adult members of Somali communities. Khat was widely perceived to be a food and as harmless or even beneficial to the user's health.
38. The EMCDDA briefing note on khat also addresses the environmental and economic issues which arise in regards to its production:
- “In the countries of the khat belt, production, transportation, processing and sales are a major sources of employment . . . unlike coffee, cotton and cocoa, khat prices have shown only modest fluctuations, providing farmers with secure livelihoods. Given its drought resistance and low labour requirements khat is an attractive choice for peasant producers. In the producing countries, intensified khat cash cropping has led to severe environmental consequences and concerns over food security”.
39. Religion is also considered in the social context of khat consumption. The ACMD is aware that some Muslim communities have debated whether khat is halal (that which is permissible and lawful) or haram (anything prohibited by Islamic law). It has been reported that of two mosques in Cardiff one mosque is of the view that khat is halal and the other mosque that it is haram. The debate on khat consumption within some communities may reflect differences in Islamic practices, and views on whether it promotes cultural cohesion. These debates are also found among Muslim communities in eastern Africa¹⁴.

¹³ Douglas H, Boyle M, Lintzeris N. The health impacts of khat: a qualitative study among Somali-Australians. *Med J Aust* 195: 666-9, 2011

¹⁴ Anderson and Carrier, 'Flowers of paradise, or polluting the nation? Contested narratives of khat consumption', in Brewer and Trentmann (eds), *Consuming Cultures, Global Perspectives: Historical trajectories, Transnational Exchanges* (Oxford & New York: Berg, 2006), 145-66.

International Comparisons

Africa and the Middle East

40. There are no internationally comparable prevalence estimates for use of khat.
41. The United Nations Office on Drugs and Crime (UNODC) reported that approximately 72% of Yemeni men and 32.6% of women used khat in 2006, whilst almost a third (31.5%) of Kenyan (Nairobi) school children report use in 2011¹⁵. Analysis of the Yemeni data suggested that use was maintained across the lifespan, with the prevalence in over 61 year olds only 13% lower than in 21 to 30 year olds; this contrasts sharply with age segmented data for other drugs where there is a much greater age disparity. No data was presented for other African and Middle Eastern countries.
42. Amongst the countries in which khat has been historically used are Yemen, Saudi Arabia, Ethiopia, Eritrea, Somalia, Djibouti, Kenya and Uganda. With the exception of Eritrea and Saudi Arabia (where khat is now prohibited), there is a legal trade in the commodity in these regions, where khat chewing is part of the social and cultural fabric in all these countries. There is no reliable population data from these regions to indicate numbers of consumers.
43. A large survey of 10,468 adults in rural Ethiopia reports that 55.7% of the sample had used khat at sometime in their lives, and that 50% were current users¹⁶. Among current chewers 17.4% of this study reported using on a daily basis. About 80% of current chewers in this study reported using it to gain concentration for prayer. Its use was correlated with high educational achievement and tobacco smoking.

¹⁵ UNODC. World Drug Report 2012. UN: New York. 2012

¹⁶ Alem A, Kebede D, Kullgren G. The prevalence and socio- demographic correlates of khat chewing in Butajira, Ethiopia. *Acta Psychiatr Scand Suppl.* 1999;397:84-91.

44. Khat use is also reported in Kenya, a small survey finding it was the third most common drug used after alcohol and tobacco¹⁷. In Kenya, urban khat consumption is strongly associated with poverty¹⁸. Among 90 juveniles attending court in Nairobi it was the fifth most common drug with 5.6% of respondents reporting use¹⁹.
45. A study sampling 181 adults in Uganda found 31.5% lifetime khat use and 20.4% current users, and there was a correlation between khat use and tobacco smoking²⁰.
46. Khat chewing is common in Yemen. A study of 800 adults in an urban setting found lifetime use rates of 81.6% in men and 43.3% in women²¹. Current adult users of khat were estimated at 61.1% in a large survey of 2,500 people in Yemen²².
47. In summary, rates of khat use appear high among the general populous in Somalia, Yemen and Ethiopia. The prevalence of khat use is far less among the Somali community living in the UK than in the population living in Somalia²³.

Europe

48. There is no reliable published evidence as to the rates of khat use in other European countries, although a report from Italy describes khat use as being a common pastime amongst the Somali community in Rome²⁴. It is likely that khat is available in those European cities where there are Yemeni, Ethiopian and Somali communities.

¹⁷ Othieno CJ, Kathuku DM, Ndeti DM. Substance abuse in outpatients attending rural and urban health centres in Kenya. *East Afr Med J*. 2000;77:592-595.

¹⁸ Carrier, Kenya Khat: The Social Life of a Stimulant (Leiden: Brill, 2007), 181-90; Anderson and Carrier, 'Flowers of paradise, or polluting the nation? Contested narratives of khat consumption', in Brewer and Trentmann (eds), *Consuming Cultures, Global Perspectives: Historical trajectories, Transnational Exchanges* (Oxford & New York: Berg, 2006), 162.

¹⁹ Maru HM, Kathuku DM, Ndeti DM. Substance use among children and young persons appearing in the Nairobi Juvenile Court, Kenya. *East Afr Med J*. 2003;80:598-602.

²⁰ Beckerleg, 'What harm? Kenyan and Uganda perspectives on khat', *African affairs*, 104 (2006); Anderson et al, *The Khat Controversy*, 130-43.

²¹ Numan N. Exploration of adverse psychological symptoms in Yemeni khat users by the Symptoms Checklist-90 (SCL-90). *Addiction*. 2004;99:61-65.

²² Ali AA, Al-Sharabi AK, Aguirre JM, Nahas R. A study of 342 oral keratotic white lesions induced by qat chewing among 2500 Yemeni. *J Oral Pathol Med*. 2004;33:368-372.

²³ Anderson et al, *The Khat Controversy*, 77-78, and compare UK rates summarised in Anderson and Carrier, *Khat: Social Harms and Legislation – a literature review* (Home Office Report)

²⁴ Nencini P, Grassi MC, Botan AA, Asseyr AF, Paroli E. Khat chewing spread to the Somali community in Rome. *Drug Alcohol Depend*. 1989;23:255-258.

49. The European Monitoring Centre for Drugs and Drug Addiction (2011)²⁵ reports that EU studies do not provide robust prevalence estimates, but that within Member States khat use is thought to be primarily among immigrants from the Horn of Africa.

Other Countries

50. Chapter six of this report provides details of the legislative status of khat in North America. In Canada, consumption is confined to members of the immigrant communities from eastern Africa and the Arabian Peninsula. There is no epidemiological data on the prevalence of khat use in the United States of America.

²⁵ EMCDDA. Khat use in Europe: implications for European policy. Lisbon: EMCDDA. 2011

Khat Use - UK

Distribution and Prevalence

51. Khat is imported from the main khat growing regions of Kenya, Ethiopia and Yemen. Khat imports arrive primarily to Heathrow airport where direct flights are routed. Some produce transits onward to other countries.
52. Khat is legally imported and liable to VAT before being released for distribution around the UK. Therefore Her Majesty's Revenue and Customs data is a reliable source of information with regard to the amount of khat imported²⁶.
53. From the evidence then available in 2005 the ACMD review calculated that up to 2,800 tonnes a year was imported into the UK.
54. The 2011/12 data confirms that khat had an import value of £13.8 million yielding taxation income of £2.8 million. Volume estimates are based on taxation raised and are reverse calculated. Based on these figures the volume of khat imported in this period was approximately 2,560 tonnes

Year	Volume (tonnes)
2004/5	2,800
2011/12	2,560

55. Thus in summary there has been no increase in importation of khat since 2005: a period of 8 years.
56. Fears of the UK becoming a hub for importation of khat appear not borne out by the VAT figures provided by the HMRC regarding the volume of khat imported into the UK since 2005 or by any evidence suggesting the UK is a landing point for the onward transportation of significant quantities of khat.

²⁶ Email dated 6 September 2012 received from Drugs Legislation, Home Office based on validated figures from CITEK Operations, HMRC.

57. This is notable as the relevant BME population in the UK has increased by 18.4% between mid-2005 and mid-2009, the most recent year for which ONS estimates are currently available. Since the BME population are the main consumers of khat, this strongly indicates that population prevalence of khat use has decreased.
58. Concerns about increased khat usage need to be considered in the context of this reliable data.
59. This data is at odds with media and other reports of what is perceived to be an increase in khat use. This reflects the disparity between fear of crime and reported crime in previous Home Office research. For example the ReDNet Project (an EU funded project monitoring and collecting information on 'legal highs') confirms that searches for sale of khat on the Internet have not increased over the last six years.
60. This discrepancy between perceptions and concerns raised, can potentially be explained by Cohen's concept of 'moral panic' i.e. when "a condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests"²⁷.
61. Police, enforcement agencies and drug services for North and Mid-Wales report no evidence of khat use in these areas. However, in South Wales there has been long established khat use in Cardiff and Newport. Nevertheless, only 6 referrals in total are recorded on the Welsh National Database for Substance Misuse since 2009. It is probable that the historically embedded integration of BME communities in Wales, in particular Somalis with their colonial links to the British navy, result in a different presentation from that of more recent diaspora arrivals as a result of the civil war.
62. There is an efficient distribution network to the khat using communities across the UK. This includes street sales from vehicles, private house parties, local small shops and khat cafes²⁸. The short life span of fresh khat means that distribution needs to be rapid²⁹.

²⁷ Cohen S, *Folk Devils and Moral Panics*, 1973, St Albans, Paladin.

²⁸ Mafreshi, sometimes spelled mugrage or mafrish.

²⁹ Gibbons S., and Arunotayanum, W. (2012). Natural Product "Legal Highs". *Natural Product Reports* 29(11):1304-16.

63. Generally khat chewing is a social event which takes place within family homes, at community parties or at khat cafes. Khat is consumed in the company of others, with solitary use being most uncommon. Khat is purchased in bundles and varies in quantity, quality and country of source. In the UK Kenyan khat retails at about £3 per bundle, with some varieties of Ethiopian khat costing as much as £6 per bundle. Consumers differentiate between types of khat, identifying by quality of taste and freshness, as well as strength. Anecdotal evidence was presented on the different strengths of khat but the ACMD is not aware of any robust scientific evidence to support this³⁰. Whereas most Somali consumers in the UK buy khat for consumption in khat cafes, consumers among the Yemeni community chew in family groups and with friends at home. Most users chew one to two bundles in an average session, perhaps lasting four to six hours.³¹
64. As the trade in khat is a legitimate business, it is distinct from the trade in illegal drugs. Khat cafes are subject to health and safety requirements as they are public areas. Brent local authority's report on khat use confirmed that within its area khat cafes were legitimate businesses, with owners paying their business rates³². In addition khat cafes appear modest enterprises with slim margins of profit from sale of khat. Many cafes are a combination of a business and a meeting place for the community. Khat users at these cafes consider them to be a social resource.³³
65. One of the main epidemiological tools for monitoring drug use is the Crime Survey for England and Wales (the CSEW, previously the British Crime Survey)³⁴. The Survey did not report on khat use until recently. The 2010/11 and 2011/12 surveys reported a level of khat use of 0.2% in the previous year amongst 16 to 59 year olds. However it is important to note this is a general population estimate, which underestimates use in some specific sub-groups. So the figure does not provide a reliable estimate of khat prevalence in BME populations. It was also reported by the NTA that people who completed the survey may have confused khat with 'kat'³⁵ which is a term for mephedrone, an unrelated substance, and this error is echoed in other documentation before the Council.

³⁰ Bundles vary slightly in size, but are each approximately 250g, comprising stalks as well as leaves: see Brent Council Report.

³¹ See Anderson and Carrier, Khat: Social Harms and Legislation, and Anderson et al, The Khat Controversy, especially 175-89, for fuller descriptions of khat consumption in the UK.

³² The health and social impacts of khat use in Brent, January 2012

³³ Anderson et al, The Khat Controversy, 153-63

³⁴ The CSEW does not cover Scotland or Northern Ireland data.

³⁵ Also referred to as M-CAT

66. Currently there are no reliable prevalence estimates of khat use in the general population, as all the epidemiological data relate to communities in which khat use is prevalent e.g. Somali, Ethiopian, Kenyan and Yemeni communities.

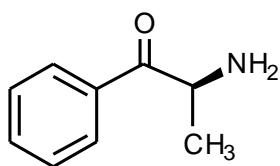
67. In regards to Northern Ireland and Scotland, the devolved administrations do not report returns on prevalence data or treatment data on khat users engaging with the NHS.

3. The Pharmacology of Khat

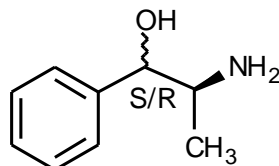
The Active Ingredients

68. Fresh leaves of khat contain the naturally occurring active amphetamine-like stimulants cathinone (S-(-)- α -aminopropiophenone) and cathine (S,S-(+)-norpseudoephedrine)^{36 37} in addition to more than 40 other alkaloids, glycosides, tannins and terpenoids. Cathinone is metabolised into cathine and norephedrine. The amount of cathinone in fresh khat has shown to range from 78-343mg/100g. The stored product loses activity rapidly, becoming physiologically inactive after about 36 hours. When khat leaves dry, the more powerful cathinone decomposes within 48 hours leaving behind the milder less active chemical cathine. Thus khat is transported in plastic bags to preserve its moisture. Dried khat is sometimes used to prepare a “tea” but this is unlikely to possess any significant psychoactive effects unless the plant material is rapidly dried to preserve the cathinone content³⁸. Scientific data confirms effects are significantly diminished if not completely absent if plant material is dried slowly³⁹.

69. Cathinone and cathine are controlled substances, Class C, under the UK Misuse of Drugs Act 1971. These chemicals have a relatively rapid onset of action. However, herbal khat has to be chewed for 1-2h to obtain a delayed psychostimulant effect, and the bulky nature of the herbal material limits the maximum dose⁴⁰.



Cathinone



**1S,2S(+)-norpseudoephedrine
1R,2S(-)-norephedrine**

³⁶ Corkery JM, Schifano F, Oyefeso A, Ghodse AH, Tonia T, Naidoo V, Button J. Overview of literature and information on “khat-related” mortality: a call for recognition of the issue and further research. *Ann 1st Super Sanita* 47: 445-64, 2011a.

³⁷ Cox G. Adverse effects of khat: a review. *Adv Psychiatric Treatment* 9:456-63, 2003.

³⁸ Chappell JS and Lee MM. Cathinone preservation in khat evidence via drying. *Forensic Sci* 195. 108-120.

³⁹ Chappell JS and Lee MM. Cathinone preservation in khat evidence via drying. *Forensic Sci* 195. 108-120.

⁴⁰ Corkery JM, Schifano F, Oyefeso A, Ghodse AH, Tonia T, Naidoo V, Button J. Overview of literature and information on “khat-related” mortality: a call for recognition of the issue and further research. *Ann 1st Super Sanita* 47: 445-64, 2011a.

Pharmacokinetics and Pharmacodynamics

70. Cathinone and cathine are isolated from the leaves of the *catha edulis* plant by the action of enzymes in saliva. When khat leaves are chewed, enzymes in the saliva release cathine and cathinone which are absorbed through the mucous membranes of the mouth and subsequently the lining of the stomach.
71. Although chewing khat is an efficient method of extracting the active ingredient, it is not extracted rapidly, hence the long period of chewing needed to elicit an effect: and it does not have a fast onset of action. Nevertheless, chewing khat extracts much of the available cathinone and cathine from the plant: four non-drug using volunteers chewing an average of 44g of khat for 1 hour managed to extract an average of 90% of the available cathinone and 89% of cathine. The average maximal plasma concentration of cathinone (Tmax) occurred at 2.3h and at 2.6h for cathine⁴¹. A study in six subjects chewing a single amount of khat corresponding to 0.8mg/kg body weight showed maximum plasma concentration of cathinone to be at 2h⁴². Terminal elimination half life for cathinone in the former study was 1.5h and in the latter study 4.3h. The terminal elimination half life for cathine in this study was over 5h.
72. The active ingredient is not extracted rapidly by chewing and thus does not have a fast onset of action. Therefore, the addictive potential of khat is likely to be less than the administration of the pure drug cathinone. It is important to note that it is easier and less expensive to manufacture synthetic cathinones and cathines than it would be to extract it from fresh khat.

⁴¹ Toennes SW, Harder S, Schramm M, Niess C, Kauert GF. Pharmacokinetics of cathinone, cathine and norephedrine after the chewing of khat leaves. Br J Clin Pharmacol. 2003;56:125-130.

⁴² Widler P, Mathys K, Brenneisen R, Kalix P, Fisch HU. Pharmacodynamics and pharmacokinetics of khat: a controlled study. Clin Pharmacol Ther. 1994;55:556-562.

Mechanism of Action

73. Many drugs of abuse are thought to exert their effects by increasing concentrations of stimulant neurotransmitters, such as dopamine, serotonin and/or noradrenaline in specific regions of the brain. Both cathinone and cathine interact with the dopaminergic pathways and prevent the reuptake of noradrenaline and dopamine^{43 44}.
74. There is evidence from animal studies that cathinone causes dopamine release and this is the mechanism underlying khat use⁴⁵; also the release of neurotransmitters at serotonergic (5-HT) synapses and peripheral noradrenergic sites^{46 47}. These biochemical properties are similar to those of amphetamine, especially its sympathomimetic properties. Human volunteers given cathinone in a blind study reported subjective effects similar to those of amphetamine, suggesting that the ability of cathinone to mimic amphetamine represents the key⁴⁸.

⁴³ Pahek EA, Schechter MD, Yamamoto BK. Effects of cathinone and amphetamine on the neurochemistry of dopamine in vivo. *Neuropharmacology* 29: 1171-6 1990.

⁴⁴ Kalix P. Effect of the alkaloid (-) cathinone on the release of radioactivity from rabbit atria prelabelled with 3H-norepinephrine. *Life Sci.* 1983; 32:801-807.

⁴⁵ Brenneisen, R, Frisch HU, Koelbring, U, Geisshjuler, S, Kalix, P Amphetamine-like effects in humans of khat alkaloid cathinone. *Br J Clin Pharmacol.* 2012,30, 825-28

⁴⁶ Kalix P. Effect of the alkaloid (-) cathinone on the release of radioactivity from rabbit atria prelabelled with 3H-norepinephrine. *Life Sci.* 1983; 32:801-807.

⁴⁷ Kalix P. The Pharmacology of khat. *Gen Pharmacol.* 1984;15:179-187.

⁴⁸ Brenneisen R, Frisch HU, Koelbring U, Geisshjuler S, Kalix P. Amphetamine-like effects in humans of khat alkaloid cathinone. *Br J Clin Pharmacol.* 2012,30, 825-28.

4. Medical Harms

75. The quality of the research evidence in this area is generally not strong and conclusive, and it is difficult to differentiate potential adverse medical consequences of khat use from other factors such as poor general health, concurrent smoking of tobacco, low health literacy in some user populations, and lack of access to health services. Moreover, high levels of tobacco smoking are frequently associated with chewing khat and this complicates the interpretation of much of the medical data in this area⁴⁹.
76. The relative paucity of clinical data may represent a lack of adverse outcomes from khat use, or a lack of population-based studies, especially from those countries or communities in which higher prevalence of khat use is reported (including within UK communities). Although anecdotal reports are informative and suggest research priorities, systematic investigations are needed to determine the incidence and prevalence of adverse effects of khat use.
77. Possibly because of the low bio-availability of the cathinones within khat, there is a low risk of acute toxicity associated with khat intake. Excessive khat use, either in terms of amount and/or duration, by vulnerable individuals may be associated with a range of chronic physical and psychological harms, but existing research has not been of sufficiently high quality to allow conclusions to be drawn.
78. Overall, the societal obstacles and problems facing immigrant communities (first and second generations) are complex, multi-factorial and overlaid with a number of concerns and issues, and it is difficult to identify a direct causal factor to khat use from the current research. The ACMD recognises that the primary issue is one of attribution. Many of the issues raised during the evidence gathering meetings, including those around medical harms, were directly attributed to khat use and not to other causes which may have been equally or more applicable.
79. Added to the problems of causality set out above, are the more acute and chronic mental health and physical issues facing first generation settlers who have been subject to adverse historical events in their own home countries, in particular civil war and long term human rights abuses in Somalia^{50,51}.

⁴⁹ Kassim SA, Croucher R. Factors associated with dental and medical care attendance in UK resident Yemeni khat chewers: a cross sectional study. *BMC Public Health* 12:486, 2012.

⁵⁰ Isse H. *Social and health implications of khat usage among Somali refugees in the UK*. [MA dissertation]. University of East London, 1999.

80. A frequently raised concern is that khat consumed may contain high levels of potentially toxic pesticide residues. One recent analysis of khat grown in some parts of Ethiopia found excessive levels of pesticide residues, such as diazinon and dichlorodiphenyl - trichloroethane (DDT)⁵². However, this practice of pesticide use appeared to be time limited, and no equivalent UK data exist so it is not possible to determine the potential risks associated with pesticide exposure in UK khat users. It may prove useful to instigate a monitoring programme for pesticides on khat upon entry into the UK.
81. A small number of studies have examined health perceptions in khat chewers. For example, Douglas *et al* explored the views of users on the links between khat use and personal health⁵³. Khat was widely perceived to be a food, not a drug, and as harmless, or even beneficial, to the user's health. Although khat chewers may experience a sense of wellbeing through their use, it is important that the signs of possible problematic use are brought to the attention of consumers using a variety of media and languages, within culture and gender specific contexts.

Dependence

82. Dependence on drugs or alcohol is defined as a syndrome of symptoms by ICD-10, an international manual for the classification of mental disorders. Diagnosis of dependence can be made if three or more symptoms have been experienced at some time in the year preceding assessment. A person may use a substance for many years without becoming dependent (if use does not result in harm and they are in control of their drug use).

⁵¹ Douglas H, Boyle M, Lintzeris N. The health impacts of khat: a qualitative study among Somali-Australians. *Med J Aust* 195: 666-9, 2011.

⁵² Daba D, Hymete A, Bekhit AA, Mohamed AM, Bekhit Ael-D. Multi residue analysis of pesticides in wheat and khat collected from different regions of Ethiopia. *Bull Environ Contam Toxicol* 86: 336-41, 2011.

⁵³ Douglas H, Boyle M, Lintzeris N. The health impacts of khat: a qualitative study among Somali-Australians. *Med J Aust* 195: 666-9, 2011.

ICD-10 criteria for dependence (simplified):

- i. A strong desire or compulsion to take the substance
- ii. Difficulties in controlling substance-taking behaviour
- iii. Physiological withdrawal state upon cessation of substance use
- iv. Evidence of tolerance to a substance
- v. Neglect of alternative interests due to time spent using the substance
- vi. Persisting with substance use despite evidence of harmful consequences

83. In reviewing khat use and the potential for dependency, the ACMD note that the current literature primarily consists of case reports and relatively poorly controlled surveys that only use self-report methods⁵⁴.

84. Withdrawal symptoms after chronic/long term use of khat have been described and include: lethargy, mild depression, slight trembling and recurrent bad dreams⁵⁵. Although suggestive of dependency, such discontinuation effects do not necessarily imply a withdrawal syndrome and may be comparable to the 'morning after' experience.

⁵⁴ Halbach H. Medical aspects of the chewing of khat leaves. Bull World Health Organ 47:21-9, 1972

⁵⁵ Corkery JM, Schifano F, Oyefeso A, Ghodse AH, Tonia T, Naidoo V, Button J. Overview of literature and information on "khat-related" mortality: a call for recognition of the issue and further research. Ann Ist Super Sanita 47: 445-64, 2011).

85. Reports of prevalence of dependence vary considerably. The issue of physiological and/or psychological dependency is also difficult to clearly ascertain and the research provides variable conclusions. A study in the UK has shown dependence of 6% of khat chewers self administering on a daily basis⁵⁶. A study by Kassim has recently presented self-report data from a non-random sample of 204 Yemeni khat chewers resident in the UK and found that 61 (30%) satisfied the DSM-IV criteria (another international manual for the classification of mental disorders) for substance dependence syndrome⁵⁷. However, in these studies the diagnosis of dependence was not validated through structured clinical interview. Conversely, in one study only 0.6 percent of khat chewers reported that they continued to use in order to prevent withdrawal symptoms⁵⁸. The assessment of khat by the World Health Organisation (WHO) concluded that the abuse potential of khat was low and that khat dependence was mild and associated with consuming khat on a daily basis⁵⁹.

86. Nevertheless, regardless of the robustness of these findings on dependence, higher levels of khat use appear to be a risk factor for poor general health and hence for symptomatic medical attendance⁶⁰. In addition the ACMD are cognisant of the concerns of communities and groups set out in detail in chapter 9, which may create a context within which risk of use and possible dependency may occur. This issue is addressed in the Department of Health's report, which states:

“Deprivation, disadvantage and discrimination in the context of drug use are themes that are raised repeatedly by respondents. This remains true even in areas that are less strongly identified with disadvantage. The risk factors for drug use and disadvantage are established and are particularly relevant to Black and minority ethnic communities. In addition, these communities may face a number of stresses such as racial discrimination, language barriers, immigration status and

⁵⁶ Griffiths P, Gossop M, Wickenden S, Dunworth J, Harris K, Lloyd C. A transcultural patterned drug use: qat (khat) in the UK. *Brit J Psychiatry* 170: 281-4, 1997

⁵⁷ Kassim SA, Croucher R. Factors associated with dental and medical care attendance in UK resident Yemeni khat chewers: a cross sectional study. *BMC Public Health* 12:486, 2012.

⁵⁸ Alem A & Shibre T 1997. Khat induced psychosis and its medico-legal implication: A case report. *Ethiopian Medical Journal*. 35(2): 137-9

⁵⁹ World Health Organization (WHO) 2006. WHO Expert Committee on Drug Dependence—34th Report. WHO technical report series 942-46

⁶⁰ Kassim S. An Exploration of the Association between Khat Chewing and Health Outcomes in UK-resident Male Yemeni Khat Chewers. Thesis submitted to the University of London for the degree of Doctor of Philosophy; Barts and The London School of Medicine and Dentistry, 2010.

displacement. All of these may further increase the risk of developing drug problems.”⁶¹

87. Tolerance to khat i.e. the need to self administer increasing dosages to achieve the same desired psychoactive effects, does not typically occur and if it does seems to take a long time to develop⁶². However, there is evidence that tolerance develops to the khat-associated acute sympathomimetic effects in chronic users. Acute sympathomimetic effects include increasing levels in blood pressure, heart rate, respiratory rate and body temperature⁶³.
88. Although some people who are dependent may require treatment from the evidence presented to the ACMD these numbers are likely to be few.
89. This is confirmed by the NHS data for England for 2010/11 shows that only 112 clients began treatment for the first time citing involvement with khat at any point in their past.
90. For example, Brent Council’s report refers to 14 khat users making use of its drug outreach service provider for the year 2010/11, although this was in addition to using other substances. For the first quarter of 2011/12 only 1 khat user accessed these services. Brent’s pilot to set up a khat outreach service specifically to target khat users has yet to produce data.

Cardiovascular effects

91. There is some weak evidence that khat use may be associated with acute myocardial infarction, but other evidence does not support this.

⁶¹ Bashford B et al, The Department of Health’s Black and Minority Ethnic, Drug Misuse Needs Assessment Project, University of Central Lancashire, Centre of Ethnicity & Health, 2003

⁶² Halbach H. Medical aspects of the chewing of khat leaves. *Bull World Health Organ* 47:21-9, 1972

⁶³ Nencini P, Ahmed AM, Amiconi G, Elmi AS. Tolerance develops to sympathetic effects of khat in humans. *Pharmacology*. 1984;28:150- 154

92. Ali *et al* recently reported data from the 9-month prospective, multicentre Gulf RACE-2 study, which recruited 7,399 consecutive patients with 'acute coronary syndrome' (ACS) from 6 Middle Eastern Gulf countries⁶⁴. Patients diagnosed with ACS were recruited from 65 hospitals. 1,408 patients (19%) were khat users, mainly of Yemeni origin (75.5%). Khat users were more likely to present with myocardial infarction followed by unstable angina. However, khat chewers were less likely to have a history of diabetes mellitus, metabolic dysfunction/obesity, hypertension and renal impairment.
93. Overall Ali's study suggests there might be a potential link between khat use and an increased risk of myocardial ischaemia. However, there is missing data regarding whether or not the khat users continued to use upon admission and at follow up; and the increased prevalence of smoking in khat users and differences in the prevalence of other risk factors for coronary artery disease such as diabetes and hypertension make it difficult to determine how much of this effect is due to khat. The issue of chronic use appears to be entangled with associated and related complications in individuals with pre-existing or underlying medical conditions. The differences in health and lifestyle events of a Middle Eastern population compared to a UK based population has also not been captured in this study, in particular the potential differences in primary and secondary health care provision and facilities in these countries. This may mean that the findings are not generally applicable to a UK population, which has access to earlier medical interventions, such as primary percutaneous coronary intervention.
94. A recently published study by the same group (Al Suwaidi *et al* 2012) has looked at the impact of smoking and in particular different smoking modalities, suggesting that there are other factors that are important which may explain the differences within this cohort⁶⁵.

⁶⁴ Ali WM, Al Habib KF, Al-Motarreb A, Singh R, Hersi A, Al Faleh H, Asaad N, Al Saif S, Almahmeed W, Sulaiman K, Amin H, Al-Lawati J, Al Bustani N, Al-Sagheer NQ, Al-Qahtani A, Al Suwaidi J. Acute coronary syndrome and khat herbal amphetamine use: an observational report. *Circulation* 124: 2681-9, 2011.

⁶⁵ Al Suwaidi J, Al Habib K, Singh R, Hersi A, Al Nemer K, Asaad N, Al Saif S, Al-Motarreb A, Almahmeed W, Sulaiman K, Amin H, Al-Lawati J, Al Bustani N, Al-Sagheer NQ, Ali WM. Tobacco modalities used and outcome in patients with acute coronary syndrome: an observational report. *Postgrad Med J* 88:566-74, 2012

Respiratory System Effects

95. Many khat users smoke tobacco during chewing sessions, which may contribute to the increased prevalence of respiratory problems in male khat users. Tobacco smoking or exposure to second hand smoke is one of the established determinants of respiratory/cardiovascular disease thus the data of such research cause difficulties of interpretation⁶⁶.
96. It has been suggested that some khat cafes in the UK are not adequately ventilated, resulting in a potential risk of hazards in terms of both active and passive smoking. Claimed potential respiratory system issues of bronchitis, tachypnoea and dyspnoea may be more related to issues of the khat using environment and smoking rather than khat use itself.
97. Disentangling the primary causes of health related harms, argued to be due to khat, is complicated by, for instance, the use of water pipes⁶⁷ and the sale of cigarettes at these cafes. A 2005 WHO report states that smoking using a water pipe poses a serious potential health hazard and is not a safe alternative to cigarette smoking. Smoke from a waterpipe contains high levels of toxic chemicals, including high levels of carbon monoxide, metals and cancer-causing chemicals⁶⁸.

Oral and Gastrointestinal System Pathologies

98. Al-Hebshi *et al* assessed the effect of khat chewing on major periodontal pathogens in subgingival plaque samples from subjects with chronic periodontitis comparing 10 khat chewers with 10 non-chewers. Overall, there was a lower burden of pathogens in plaque samples of khat users⁶⁹. It was concluded that the lower pathogen burdens were due to a potential probiotic effect of khat on periodontal microbiota.

⁶⁶ Birru RL, Di YP. Pathogenic mechanism of second hand smoke induced inflammation and COPD. *Front Physiol.* 2012;3:348.

⁶⁷ Also known as a hookah, narghile or qalyan which is an instrument for smoking tobacco where the smokes passes through a water basin before inhalation.

⁶⁸ WHO Study Group on Tobacco Product Regulation (TobReg) an advisory note Waterpipe tobacco smoking:health effects, research needs and recommended actions by regulators, 2005

⁶⁹ Al-Hebshi NN, Al-Sharabi AK, Shuga-Aldin HM, Al-Haroni M, Ghandour I. Effect of khat chewing on periodontal pathogens in subgingival biofilm from chronic periodontitis patients. *J Ethnopharmacol* 132: 564-9, 2010.

99. The ACMD is not aware of any robust evidence reporting increased oral cancer in khat users. Anecdotal concerns relating to oral cancer raised by some health professionals could be associated with alcohol or tobacco intake and not directly linked to khat use. These findings should also be placed in the context of those individuals from BME groups who may experience poor health and lack of access to health services, and also the lack of or limited levels of NHS provision for immigrants whose status has not been regularised and asylum seekers.
100. It has also been suggested that gastrointestinal side effects may be encountered with khat use, including: stomatitis, oesophagitis, and gastritis. Evidence however is based on a limited number of case reports⁷⁰.
101. Some research has suggested that khat is a potential contributory factor to prevalence of head/neck/lip squamous cell carcinoma in the population of Yemen. However, it is difficult to understand the potential contribution of khat toxicity, if at all, in regards to the occurrence of these medical issues taking into account the risks associated with specific contributory factors e.g. regular/intense exposure to ultra-violet radiations in Yemen⁷¹. Moreover, there is a lack of detailed data collection from population-based cancer registries.

Liver

102. Research has suggested an association between khat consumption and liver problems. Some of these patients with severe liver toxicity problems required transplants^{72,73,74}.

⁷⁰ Al-Motarreb A, Al-Habori M, Broadley KJ. Khat chewing, cardiovascular diseases and other internal medical problems: the current situation and directions for future research. *J Ethnopharmacol.* 2010;132:540-8.

⁷¹ Nasr AH, Khatri ML. Head and neck squamous cell carcinoma in Hajjah, Yemen. *Saudi Med J* 21: 565-8, 2000.

⁷² Brostoff JM, Plymen C, Birns J. Khat - a novel cause of drug-induced hepatitis. *Eur J Intern Med* 2006;17(5):383

⁷³ Roelandt P, George C, d'Heygere F et al. Acute liver failure secondary to khat (*Catha edulis*)-induced necrotic hepatitis requiring liver transplantation: case report. *Transplant Proc* 2011;43(9):3493-54.

⁷⁴ Stuyt RJ, Willems SM, Wagtmans MJ et al. Chewing khat and chronic liver disease. *Liver Int* 2011;31(3):434-6

103. Both Chapman *et al*⁷⁵ and Morgan⁷⁶ described a series of patients living in the UK who had a history of previous unexplained hepatitis. Khat was believed to be the cause of the liver disease in all six cases. A thorough review was undertaken to rule out other causes of liver injury. The Chapman patients had similar histopathological findings and two of them had a background of chronic liver disease. Five of the patients underwent liver transplantation over this 5 year period.
104. Evidence of chronic liver disease in khat users suggests that its long-term use may be associated with repeated episodes of subclinical hepatitis, with evolution to chronic liver disease over time.
105. The mechanisms of khat-related liver toxicity are unknown, but drug accumulation may be important. Animal studies have demonstrated that khat exposure can cause acute hepatitis and that long-term khat exposure in rats is associated with chronic active hepatitis^{77,78}. It is considered unlikely that the liver injury is related to contaminants such as herbicides, pesticides, heavy metals or toxigenic fungi.
106. Similar observations were made by Peevers *et al*⁷⁹ who identified a number of cases of 'cryptogenic' liver disease in 7 young UK Somali male Khat chewers, some with unexplained cirrhosis, in whom a drug-related injury was suspected. Most of these patients were successfully treated conservatively, with resolution of jaundice and liver function abnormalities following khat withdrawal.
107. Although there are only a relatively small number of reports of liver toxicity related to khat, there is the potential for severe and potentially life threatening liver toxicity related to khat use. The factors which may make an individual more susceptible to liver toxicity (such as genetics, polydrug use, duration of use and amount of khat used) are currently not known. Both Chapman *et al* and Morgan suggest a high degree of suspicion is warranted when patients from ethnic communities where khat use is prevalent present with otherwise unexplained liver injury. Thus clinicians should consider khat as a potential cause of liver disease in this context.

⁷⁵ Chapman MH. Severe, Acute Liver Injury and Khat Leaves. *N Engl J Med* 2010; 362:1642-1644

⁷⁶ Morgan M. Khat-related hepato-toxicity. Presentation given at the 'ACMD: Khat Evidence-Gathering'. London, September 12th, 2012

⁷⁷ Al Mamry, Al-Habori M, Al-Aghbari AA et al. Investigation into the toxicological effects of *Catha edulis* leaves: a short term study in animals. *Phytother Res* 2002; 16:127–32.

⁷⁸ Al-Habori M, Al-Aghbari A, Al-Mamary M et al. Toxicological evaluation of *Catha edulis* leaves: a long term feeding experiment in animals. *J Ethnopharmacol* 2002; 83:209–17.

⁷⁹ Peevers CG, Moorghen M, Collins PL, Gordon FH, McCune CA. Liver disease and cirrhosis because of Khat chewing in UK Somali men: a case series. *Liver Int* 30: 1242-43, 2010

Pregnancy

108. Lactating women who chew khat have been found to excrete norpseudoephedrine in their breast milk. Although the implications of this finding for the child remain to be identified, it may be advisable that khat use in lactating mothers should be discouraged. Observational studies in Yemen have not identified any excess of congenital malformations in babies born from khat using mothers⁸⁰. Although the evidence is limited to animal studies, it has been suggested that if regularly consumed, khat may have teratogenic effects on the foetus⁸¹. It is recognised that neonates may present with low birth weight, a risk factor for peri-natal and young infant death in low income countries. Since the effects were not identified through prospective studies, one cannot rule out the possible confounding role of general poor health/nutrition and smoking as possible causal factors in such countries.

Psychiatric Effects

109. Case reports have described the occurrence of khat induced acute psychotic episodes in a small number of cases⁸².

110. Presentations by Odenwald⁸³ and the systematic review by Warfa *et al*⁸⁴ suggest that whilst khat-induced psychiatric problems are frequently reported in case studies, the balance of evidence suggests that khat alone does not directly cause mental disorders. Nevertheless, khat use complicates the treatment of existing mental health problems.

111. The ACMD finds that the research on khat does not show a direct link between khat and psychosis.

⁸⁰ Eriksson et al (Eriksson M, Ghani NA, Kristiansson B. Khat-chewing during pregnancy-effect upon the off-spring and some characteristics of the chewers. East Afr Med J. 1991;68:106-11, 1991)

⁸¹ Mwenda JM, Arimi MM, Kyama MC, Langat DC, Effects of Khat consumption on reproductive functions: a review, East Afr Med J 80: 318-23, 2003.

⁸² Nielen RJ, van der Heijden FM, Tuinier S, Verhoeven WM. Khat and mushrooms associated with psychosis. World J Biol Psychiatry. 2004 Jan;5(1):49-53

⁸³ Odenwald M. Khat mental and physical harms. Presentation given at the 'ACMD: Khat Evidence-Gathering'. London, September 12th, 2012

⁸⁴ Warfa N, Klein A, Bhui K, Leavey G, Craig T, Stansfeld SA. Khat use and mental illness: a critical review. Social Science & Medicine, 65: 309-318, 2007

112. The further research of Bhui *et al* (2010) suggests that severe mental health problems such as psychosis, depression or Post Traumatic Stress Disorder in khat using UK Somali immigrants are not associated with frequency of khat use but rather were linked to earlier traumatic events^{85,86,87}.

“Somali and non-Somali patients were diagnosed according to DSM-IV-R criteria . . . patterns of illness and adjustment varied significantly by age and gender cohorts, reflecting the relevance of age and gender at time of trauma on different trauma and loss experiences and cultural and religious shaping of subsequent adjustment and symptoms. The study confirmed that almost half of the Somali male patients are under age 30, 80% of whom presented with psychoses, compared with the rate of psychosis (13.7%) in the non-Somali control group of same-aged males at the clinic. The older male, and the majority of Somali female patients, show predominantly depressive and PTSD symptomatology. War trauma experienced in childhood, early malnutrition from famines, head trauma, and excess Khat use in male adolescents provide partial explanations for the large number of young psychotic Somali men seen in the clinic from 2001 to 2009”.

113. It was concluded that more research was required using larger samples to explore the relationship between common psychotic symptoms and the propensity to developing psychotic disorders and whether this differs by migrant status, ethnicity, and other demographics as well as environmental risk factors⁸⁸.

114. To give an indication of the potential numbers of khat users in psychiatric treatment Tulloch *et al*⁸⁹ reviewed the registers of 150,000 UK mental health patients of whom 240 were Somali patients. Of these Somali patients 172 (71.7%) reported a life time use of khat and 80 (33.3%) were current users of khat.

⁸⁵ Douglas H, Boyle M, Lintzeris N. The health impacts of khat: a qualitative study among Somali-Australians. *Med J Aust* 195: 666-9, 2011.

⁸⁶ Odenwald M, Hinkel H, Schauer E, Neuner F, Schauer M, Elbert TR, Rockstroh B. The consumption of khat and other drugs in Somali combatants: a cross-sectional study. *PLoS Med* 4: e341, 2007.

⁸⁷ Odenwald M. Khat mental and physical harms. Presentation given at the 'ACMD: Khat Evidence-Gathering'. London, September 12th, 2012

⁸⁸ Bhui K, Warfa N (2010) . Trauma, khat and common psychotic symptoms among Somali immigrants: a quantitative study. *J Ethnopharmacol* vol. 132, (3) 549-553.

⁸⁹ Tulloch AD, Frayn E, Craig TK, Nicholson TR. Khat use among Somali mental health service users in South London. *Soc Psychiatry Psychiatr Epidemiol* 2012 Jan 15. [Epub ahead of print]

115. More recent research which moved from adverse pre-migration experiences to a comparative cross-national small sample study of Somali refugees in London UK and Minneapolis USA, and how different country experiences may impact on such groups, suggests that “challenges to masculinity, thwarted aspirations, devalued refugee identity, unemployment, legal uncertainties and longer duration of stay in the host country account for poor psychological well-being and psychiatric disorders among this group”⁹⁰.
116. In summation whilst there is evidence to suggest that khat could complicate treatment of existing mental health problems, there is no good evidence to suggest a direct link between khat use and psychosis^{91,92}.
117. Historically, psycho-stimulants have been used in the treatment of depression, as well as to address issues of fatigue, often through ‘self medication’. However further research is required to identify whether depression prefigures khat use or arises as a result of its use, or its withdrawal.

Cognitive impairment

118. Acute khat use may, under some circumstances, impair driving ability. However, this has not been systematically investigated and khat is not included in the Government’s Drug Driving Panel review⁹³. Nevertheless, sub-clinical impairments in cognitive function in association with khat misuse have been noted⁹⁴.

⁹⁰ Nasir Warfa, Sarah Curtis, Charles Watters, Ken Carswell, David Ingleby and Kamaldeep Bhui (2012). Migration experiences, employment status and psychological distress among Somali immigrants: a mixed-method international study. BMC Public Health 2012

⁹¹ Warfa N, Bhui K. Presentation given before the ACMD khat working group, London (UK). July 17th, 2012

⁹² Kroll J, Yusuf AI, Fujiwara K. Psychoses, PTSD, and depression in Somali refugees in Minnesota. Soc Psychiatry Psychiatr Epidemiol. 2011;46:481-93

⁹³ The Drug Driving Expert Technical Panel, presentation by the Chair to the ACMD October 2012.

⁹⁴ Colzato LS, Ruiz MJ, van den Wildenberg WP, Hommel B. Khat use is associated with impaired working memory and cognitive flexibility. PLoS One 6:e20602, 2011.

119. Furthermore, Colzato *et al* assessed whether khat use was associated with changes in the emergence and resolution of response conflict⁹⁵. Khat users (n=16) and khat-free controls (n=16) were matched and tested and it was concluded that khat use is associated with specific impairments in behavioural control, in terms of general slowing and less efficient resolution of response conflicts, which is likely to impair decision making in everyday life⁹⁶.
120. In a recent Australian report the apparent variable impact of khat use on cognitive skills were pointed out as well as the potential negative behaviours exhibited in the context of its use⁹⁷:

“Psychological effects are enhanced concentration, increased alertness, enhanced mood, talkative, increased self-confidence. Vulnerable individuals can experience toxic effects, such as hypervigilance, anxiety, agitation, and features of psychosis (perceptual disturbances, paranoia). Toxic effects may also be a consequence of extended periods (e.g. days) with little or no sleep and poor hydration and nutrition.”

Links to mortality

121. Corkery *et al*⁶⁸ described in detail 14 deaths occurring in the UK in the time frame 2004–2009 which had a potential link with khat consumption, after reviewing data back to 1997. In most of these cases the role of khat was unclear. In fact, concurrent presence of other drugs/alcohol; and/or the presence of medical/psychiatric predisposing factors, as well as the context of the fatality make it difficult to interpret the data. On balance it is not likely that khat was responsible for death in these cases, although as a scoping exercise it may have value.

⁹⁵ Colzato LS, Ruiz MJ, van den Wildenberg WP, Hommel B. Khat use is associated with increased response conflict in humans. *Hum Psychopharmacol Clin Experimental* 27: 315-21, 2012.

⁹⁶ Colzato LS, Ruiz MJ, van den Wildenberg WP, Hommel B. Khat use is associated with impaired working memory and cognitive flexibility. *PLoS One* 6:e20602, 2011.

⁹⁷ National Drug Law Enforcement Research Fund, Law Enforcement and Khat, No. 40, 2012

Summary on Medical Harms

122. In summary, with the exception of a small risk of significant liver disease there is no strong or conclusive evidence of the above medical effects having a direct causal link to the chewing of khat. The confounding role of general poor health, smoking and genetics are not known. A number of the concerns raised may be due to other factors and contributory associations, which should be placed within the wider context of obstacles and lack of opportunities facing overseas nationals and those seeking asylum within society.

5. Overview of the Societal Harms associated with khat use

123. The ACMD convened a number of evidence gathering meetings for contributions from experts, stakeholders, community groups and other individuals (details of contributors are at Annex B).
124. Anecdotal evidence reported from communities in several UK cities links khat consumption with a wide range of social harms. Research into these concerns has been undertaken, but no robust evidence has been reported to demonstrate a causal link between khat consumption and the harms described⁹⁸.
125. Several studies have been undertaken looking at khat use in the UK since the 1990s, all of which have looked at the issue of social harms⁹⁹. The reports clearly establish that consumption in the UK is limited to Diaspora communities: primarily Ethiopians, Somalis, Yemenis and some Kenyans. Among Somali khat users tend to be older than non-users and are predominantly male. All reports concur that the majority of consumers chew khat moderately, though there is evidence of heavy use by some. Unfortunately data on the prevalence and patterns of khat chewing in the UK among Ethiopian, Kenyan and Yemeni consumers are meagre as most of the literature concentrates on Somali consumption¹⁰⁰.
126. This section gives a summary of the research findings available on social harms related to khat, assessing the evidence cited in the literature. Its main focus is on the UK literature, but also includes global evidence in regard to relevant communities. The section addresses the evidence related to the issues that most commonly arise from concerns expressed by the diaspora communities.

⁹⁸ Anderson and Carrier, *Khat; Social Harms and Legislation – A Literature Review*. Home Office, Occasional Paper 95, July 2011.

⁹⁹ National Drugs Intelligence Unit, 'Khat misuse in the United Kingdom', *Drugs Arena*, 10 (1990); Griffiths, *Qat Use in London: A Study of Qat use Among a Sample of Somalis Living in London* (Drugs Prevention Initiative, Paper 26, 1998. London; Home Office); Turning Point, *Khat Use in Somali, Ethiopian and Yemeni Communities in England; Issues and Solutions* (London: Home Office, 2004); Patel *et al*, *Khat Use Among Somalis in Four English Cities* (London; Home Office, 2005)

¹⁰⁰ Anderson and Carrier, *Khat; Social Harms and Legislation – A Literature Review*. Home Office, Occasional Paper 95, July 2011.

Unemployment

127. In khat producing countries khat use is seen as functional; farmers, night watchmen, labourers, lorry drivers and students chew khat in order to prolong periods of physical labour, wakefulness and to suppress appetite¹⁰¹. For the Somali community, this functional use is qualitatively different from that experienced in the khat cafes of the UK, where consumption is considered recreational. Long hours spent chewing, and then in the recovery phase, can become a barrier to obtaining employment. Many commentators identify this as a key problem with khat use in the diaspora¹⁰².
128. The quantitative evidence on khat consumption and Somali employment in the UK gives an unclear picture. In 1998, Griffiths reported 47% of the sample (n=207) as unemployed, with only 17% in formal employment¹⁰³. In 2005, Patel *et al.* 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 sample (n=602) 38% were in employment and 68% of those who were unemployed did not chew khat¹⁰⁴. A study by Warfa *et al.*, comparing Somali migrants in London and Minneapolis, identified higher employment levels as a key determinant of well-being among migrants in Minneapolis, where only 26% of the respondents in their survey were unemployed compared with 90% in the London sample. The authors identified higher employment levels as a key determinant of well-being among migrants in Minneapolis. The study reported that Somalis in the US were more likely have organised support on arrival and for a period of up to five years. They proposed that adaptation and integration can best be achieved through policies which seek to enhance employment opportunities, and thus reduce psychological problems.
129. Recent research shows that the majority of users moderate their consumption to fit in with work patterns, although for some who are ‘heavy users’ consumption does adversely compromise their lifestyles¹⁰⁵.

¹⁰¹ Carrier, *Kenya Khat: the Social Life of a Stimulant* (Lieden: Brill, 2007a); Almedon and Abraham, ‘Women, moral virtue and tchat chewing’. In *Gender, Drink and Drugs*, M. MacDonald (ed) (Oxford: Berg, 1994).

¹⁰² Turning Point, *Khat Use in Somali, Ethiopian and Yemeni Communities in England; Issues and Solutions* (London: Home Office, 2004)

¹⁰³ Griffiths, *Qat Use in London: A Study of Qat use Among a Sample of Somalis Living in London* (Drugs Prevention Initiative, Paper 26, 1998. London; Home Office).

¹⁰⁴ Patel *et al.*, *Khat Use Among Somalis in Four English Cities* (London; Home Office, 2005)

¹⁰⁵ Anderson and Carrier, *Khat; Social Harms and Legislation – A Literature Review*. Home Office, Occasional Paper 95, July 2011.

130. No evidence is available to support a causal link between khat as a cause for unemployment status¹⁰⁶.

Family breakdown

131. Much anecdotal evidence describes the stresses placed upon family life by khat consumption, and it is clear that the absence of Somali men from the household in order to spend many hours at khat cafes is a concern for many. In contrast, consumption among users in the Yemeni community is most commonly in a domestic setting, with friends gathering together at the home. It is therefore unsurprising that the evidence regarding khat's association with family breakdown is contradictory.

132. UK Somali women report family breakdown "as probably the most serious consequence of khat use"¹⁰⁷. Anecdotal evidence suggests that the behavior and mood swings associated with heavy consumption leads to quarrels and disputes within the family, but this is not supported by other studies. Patel for example found that 13% of respondents reported being personally affected by another person's khat chewing. However, 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"¹⁰⁸.

133. Evidence from Denmark does associate heavy khat use with marital breakdown reporting that two-thirds of male "*heavy khat users*" in one study were divorced, which is double the number among other males in the sample¹⁰⁹. However, this Danish study acknowledges that heavy khat use might be an effect of divorce as much as a cause and it is difficult to judge the significance of such a statistic without more information. There is no comparable data for the UK on khat use and marital breakdown.

¹⁰⁶ Klein, 'Khat in the neighbourhood – local government responses to khat use in a London community', *Substance Use & Misuse* 43 (6) (2008b), 819-831.

¹⁰⁷ Turning Point, *Khat Use in Somali, Ethiopian and Yemeni Communities in England; Issues and Solutions* (London: Home Office, 2004)

¹⁰⁸ Patel et al, *Khat Use Among Somalis in Four English Cities* (London; Home Office, 2005)

¹⁰⁹ Sundhedsstryelsen, *Brug Af Khat Blandt Personer Med Somalisk Baggrund* (Department of Health: Copenhagen, 2009)

134. Other researchers indicate that the perceived link of khat with family breakdown should be seen in the context of what has been termed a 'gender crisis' faced by Somalis in the diaspora. This observation has arisen from reports on users in Australia¹¹⁰ and the UK¹¹¹. As Harris explains, from the mid-1990s most Somalis arriving in the UK were mothers and their children and were only joined later by their partners. By that time the women had already become established, learned English and were aware of the different gender politics in the UK compared to their home countries¹¹². By the time partners settled in the UK their integration fell behind the women; who had already established a high degree of economic and social independence. This pattern is identical to that reported from Australia, where Stephenson and Fitzgerald see the gender conflict regarding khat consumption within the family – between women and men - to be a reflection of wider issues of integration and household management.¹¹³

¹¹⁰ Stevenson et al, 'Chewing as a social act: cultural displacement and khat consumption in the East African communities of Melbourne', *Drug and Alcohol Review* 15 (1996), 73-82; Fitzgerald, *Khat: A Literature Review* (Melbourne, 2009)

http://www.ceh.org.au/downloads/khat_report_FINAL.pdf.

¹¹¹ Anderson et al, *The Khat Controversy: Stimulating the Debate in Drugs* (Oxford: Berg, 2007)

¹¹² Harris, *The Somali community in the UK: what we know and how we know it* (London: Information centre for Asylum and refugees in the UK, 2004).

¹¹³ Stevenson et al, 'Chewing as a social act: cultural displacement and khat consumption in the East African communities of Melbourne', *Drug and Alcohol Review* 15 (1996), 73-82; Fitzgerald, *Khat: A Literature Review* (Melbourne, 2009)

http://www.ceh.org.au/downloads/khat_report_FINAL.pdf.

Income diversion

135. The proportion of income spent on purchase of khat by users was a commonly expressed concern¹¹⁴. In the UK this concern is reinforced by relatively high levels of unemployment among the Somali community, with income diversion often mentioned as a source of tension between khat-using Somali men and their wives, especially when those chewing are on a low income¹¹⁵. The majority of young Somalis in a survey by Nabuzoka and Badhadhe's (2000, n=94) reported that using khat caused them financial problems¹¹⁶, while a substantial proportion of khat users in Griffiths' (1998) sample saw their spending as problematic: 33% of all users often worried about how much they spent on khat¹¹⁷. A moderate UK consumer, using two bundles of khat twice a week, would spend a maximum of £24. However, users interviewed in the Patel study, when asked what they do when they cannot afford khat, most frequently responded that they would go without (37%)¹¹⁸.

Consumption by Young Persons

136. Several community members giving evidence to the ACMD expressed their concerns about a perceived increase in the consumption of khat amongst Somali young people. Although there is no prohibition in eastern Africa or Yemen on youths consuming khat, consumption is more commonly restricted there to male adults¹¹⁹.

¹¹⁴ Milanovic, 'Qat expenditures in Yemen and Djibouti: an empirical analysis', *Journal of African Economies* 17(5) (2008), 661-687.

¹¹⁵ Turning Point, *Khat Use in Somali, Ethiopian and Yemeni Communities in England; Issues and Solutions* (London: Home Office, 2004)

¹¹⁶ Nabuzoka and Badhadhe, 'Use and perceptions of khat among young Somalis in a UK city', *Addiction Research* 8(1) (2000), 5-26

¹¹⁷ Griffiths, *Qat Use in London: A Study of Qat use Among a Sample of Somalis Living in London* (Drugs Prevention Initiative, Paper 26, 1998. London: Home Office)

¹¹⁸ Patel et al, *Khat Use Among Somalis in Four English Cities* (London: Home Office, 2005)

¹¹⁹ Anderson et al, *The Khat Controversy: Stimulating the Debate in Drugs* (Oxford: Berg, 2007)

137. In seeking to test the validity of these concerns, the ACMD requested evidence that khat consumption is increasing among young people, or even that it is prevalent among this age group. No substantive evidence has been presented to the ACMD on this issue. The one exception to this statement comes from the Cardiff Bay Neighbourhood Policing Team from South Wales Police, who confirmed that in the historically more established Somali community areas in Wales incidents of anti-social behaviour by teenagers using khat in public places (similar to the previous glue sniffing phenomena) were of sufficient frequency and degree to initiate a multi-agency approach over a period of two years. This problem was satisfactorily tackled through a community-focused approach, as described elsewhere in this report, which included meeting with BME community elders. This work built on previous anti-social behavior work referred to under the Public Protection umbrella in 2011 where under 18 year olds were to be referred for child protection assessment as vulnerable individuals and parental visits protocol.
138. The spread of khat use to teenagers was regularly mentioned by Somalis opposed to the use of khat. Although there was anecdotal evidence for such claims only Cardiff figured in confirmed reports, despite requests for written representations and further information from others. For example Brent Council in its study in London did not find any evidence of use by young people: a concern raised which the Council specifically sought to address.

Cardiff Bay – South Wales Police and Cardiff Council

<p>Residents' concerns regarding youths congregating in public places and communal residential areas leaving litter, causing noise nuisance and low level anti-social behaviour was addressed by community meetings with Council representatives and Police neighbourhood teams. Steps were taken to address these concerns, for example: litter fines were issued; council waste personnel increased visits to problem areas; street trading laws were applied; PCSO and other workers targeted the areas and advice was given to youths; and regular community meetings were held. As a result, when the situation was reviewed after two years the local problem had been resolved through the successful joint partnership working of relevant community groups and authorities using existing legislation and powers.</p>
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Consumption by Women

139. Many of the community groups who gave evidence to the ACMD on khat expressed concerns about the use of khat by women. The ACMD consider that this reflects normative assumptions that prevail in the countries of origin. Earlier studies have reported very low levels of khat use by women¹²⁰. The ACMD found no evidence to suggest that consumption by women is increasing, or that it implies any particular social harm.
140. On the contrary evidence of female users tended to be anecdotal and involve single figures based on perceptions. Although Brent Council held a women only focus group all attendees were non-users and only one female figured in the drug support services provided, and that was not for use of khat. However it has also been suggested that cultural pressures and gender politics in such BME communities may mask female use of khat through stigmatisation, rendering it 'invisible' to official figures. This concern may be ameliorated through positive steps to address cultural sensitivities in recruitment of drug support workers to reflect local community needs and to ensure treatment models address gender politics.

Brent Council Report - January 2012

Job Centre Plus in Brent work with the Somali community to help them into employment. For example, in partnership with the Help Somalia Foundation, Job Centre Plus organised a jobs fair at Brent Town Hall in 2010 aimed at the community. This was attended by about 400 people. Courses are run from the College of North West London and BACES in subjects related to industries where there are vacancies in Brent's "travel to work area". ESOL courses are provided, which are accessible to people from the Somali community (or any other individual wanting to take English lessons). The task group was informed that Somali women often seek jobs in the care industry. Free courses in this sector are currently running at CNWL, with guaranteed interviews at the end of the course.

¹²⁰ Patel et al, *Khat Use Among Somalis in Four English Cities* (London; Home Office, 2005); Turning Point, *Khat Use in Somali, Ethiopian and Yemeni Communities in England; Issues and Solutions* (London: Home Office, 2004)

Anti-Social Behaviour

141. There is some evidence linking khat with antisocial behaviour in the UK and elsewhere in the diaspora communities, concerning public nuisance caused at sites of khat sale and consumption. Klein, for example, describes concerns about khat among residents of Streatham focused on the associated spitting of chewers and the congregation of Somali men on streets¹²¹. There were reports of similar concerns in one of the areas studied in the Sykes *et al.* (2010) report where there had also been complaints about Somali khat users “*hanging around, spitting of khat leaves on the street, yelling, fighting*”¹²². In places where consumers congregate to purchase or chew, problems of littering commonly arise, as has also been recently reported for the Netherlands and in the Hillingdon and Brent Council reports¹²³.
142. Despite such widely reported concerns of such incidents related to khat e.g. those in Cardiff and outside khat houses in Bristol, matters have been successfully dealt with by community-level action working in partnership with the police and local authorities.
143. It is evident that the use of tenant groups and community meetings to listen to concerns regarding litter, graffiti, noise pollution and vehicle obstructions associated with the selling of khat can be successfully addressed with effective partnership working of community, non-statutory organisations and statutory bodies using a range of existing legislation and policies, including: housing, public health, trading standards and environment, as well as police powers. Such approaches rely on the need to mediate neighbourhood disputes and resolve potential conflicts at an early stage¹²⁴.

¹²¹ Klein, ‘Khat in the neighbourhood – local government responses to khat use in a London community’, *Substance Use & Misuse* 43 (6) (2008b), 819-831. See also Anderson et al, *The Khat Controversy: Stimulating the Debate in Drugs* (Oxford: Berg, 2007).

¹²² Pennings et al, ‘Risk assessment of khat use in the Netherlands: a review based on adverse health health effects, prevalence, criminal involvement and public order’, *Regulatory Toxicology and Pharmacology*, 52(3) (2008), 199-207

¹²³ M. de Jonge and C. van der Venn, *Qatgebruik onder Somaliërs in Nederland* (Utrecht: Trimbos Instituut, 2011); The Hillingdon Khat Repot: a call for action, (2011) Hillingdon Council; Brent Council, *The Health and Social Impacts of khat use in Brent*, 2012.

¹²⁴ Anderson et al, *The Khat Controversy: Stimulating the Debate in Drugs* (Oxford: Berg, 2007) for a discussion of these points.

144. The joint evidence gathering ACMD meetings themselves proved of value. During the course of the Welsh meeting representatives of BME communities, housing, charities, NGOs, Police and NHS shared their concerns and their different approaches to resolve matters. During this process positive networks were forged with the intention to work together in the future to address these specific concerns of the community. As a result of the meeting consideration of whether any specific actions on khat should be addressed in the substance misuse strategy implementation plan are being reviewed.

Bristol – Avon and Somerset Constabulary and Bristol Somali Resource Centre

Residents' reported their concerns about groups of customers congregating outside private houses and khat cafes leading to obstruction of roads, litter, traffic jams and noise pollution. Bristol police issued letters of advice under the first stage step of their anti-social behaviour process to all local residents pointing out the problems and future potential action if matters were not resolved. As a result the community groups confirmed that the adverse events were resolved within a short period of time.

Violence

145. Since the collapse of the Somali state in the late 1980s, media reports have crudely correlated the use of khat with violence, due to its consumption by militia¹²⁵. This association with violence exists in the diaspora too, mainly in connection with domestic violence. However the available evidence does not support a link between violence and khat use.

¹²⁵ Anderson and Carrier, 'Flowers of Paradise, or polluting the nation? Contested narrative of khat consumption'. In *Consuming Cultures, Global Perspectives; Historical Trajectories, transnational Exchanges*, Brewer and Trentmann (eds) (Oxford: Berg, 2006)

146. The Turning Point (2004) report commented, “*violent behaviour was seen by many women as directly caused by khat chewing*”¹²⁶. However, this assertion is not supported by any reported cases. Patel reported six respondents (out of a sample of 602) being victims of domestic violence perceived to be related to khat¹²⁷. No more recent evidence of violence was brought to the Council’s attention.

NOTE ON EFFECTIVE PRACTICE

Good inter-agency partnership working with the third sector to address specific concerns of communities could include: issuing letters of advice and use of staged anti-social behaviour measures, including social contracts through to more formal action, by neighbourhood police and police community support officers; litter prevention by refuse/recycling providers and issuing of fixed penalty tickets for littering; removal of vehicular obstructions; enforcement of street trading licensing and trading standards; and tenant and neighbourhood disputes resolved through use of local conflict mediation schemes.

Crime and Criminal Networks

147. There has been some media coverage and assertions regarding links of khat production with serious organised crime, or even terrorist groups. This concern was specifically addressed in the ACMD review.

148. The Serious Organised Crime Agency defines organised crime as: “those involved, normally working with others, in continuing serious criminal activities for substantial profit, whether based in the UK or elsewhere”. As stated in this report the profit margins of local businesses involved in khat use are slim, limited by the low price of khat and the inelasticity of price (where UK prices have remained largely unchanged despite the imposition of VAT on importers). Based on this definition there is no evidence of khat consumption being directly linked with such criminal behavior and little to no evidence of its use being tangentially linked to distribution or selling networks to

¹²⁶ Turning Point, *Khat Use in Somali, Ethiopian and Yemeni Communities in England; Issues and Solutions* (London: Home Office, 2004)

¹²⁷ Patel et al, *Khat Use Among Somalis in Four English Cities* (London; Home Office, 2005)

serious organised crime. This view accords with restricted information received from two other countries.

149. Having consulted with representatives from UK Law Enforcement on the potential links of khat with organised crime there is no evidence to support the theory that khat is either funding or fuelling organised crime in the UK. This is unsurprising given khat is not an illegal drug and is not a high value substance and therefore attracts very little profit from the UK market.
150. It is clear that currently the sale of khat in the UK is a low profit business.
151. The ACMD has not fully explored the positive or negative affects of criminalisation of khat. However, it can be assumed that if the price of khat increases, for example due to criminalisation, there is the potential for exploitation by organised criminal gangs already involved in the illegal drug trade and this would arguably increase funds available to such networks and groups if khat use went 'underground'.
152. In regard to international crime, it is known the Al Shabaab militia, which control parts of southern Somalia, tax sales of khat as all retail transactions of any product are taxed. However, in countries beyond the UK where khat has been prohibited it enters the illegal market through smuggling and illicit sale, and so becomes criminal activity by definition. To clarify, the ACMD has not been provided with any evidence of Al Shabaab or any other terrorist groups' involvement in khat export/sale, despite repeated requests for this informaton from a number of national and international official sources, including various Government bodies.
153. Although generic anecdotal claims of a small number of fatalities by those involved in khat supply in the UK was presented to the ACMD by a London local authority, upon further investigation these comments were not borne out by the evidence.
154. Evidence presented to the ACMD by practitioners and researchers found no link between gang crime and khat use; although concerns were raised that if khat were criminalised this profile could change.¹²⁸

¹²⁸ Aldridge, Judith et al (2008). Youth Gangs in an English City: Social Exclusion, Drugs and Violence: Full Research Report ESRC End of Award Report, RES-000-23-0615. Swindon: ESRC; Manchester community presentation to ACMD 2012; and Aldridge, Judith (2012) email to ACMD.

155. In regards to generic crime the Patel 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”¹²⁹.

Integration

156. The notion that khat consumption prevents migrants from integrating into the wider society is a key issue in the Scandinavian literature¹³⁰. This issue is frequently expressed by members of the UK Somali community. In Denmark, it is reported 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. However, other factors affecting integration are also relevant. Language skills in particular are seen as a key integration factor in the UK (and reflected in the more recent requirements of the Immigration Rules for settlement), with younger Somalis fluent in English regarded as better able to integrate than older Somalis with less fluency¹³¹. It is also not clear whether the use of khat is symptomatic of non-integration as opposed to the view that khat is a barrier to integration.¹³² The comparative research undertaken by Warfa et al in London and Minneapolis draws attention to the ongoing support upon arrival provided to those arriving in the USA, and how this enhanced employment opportunities, where employment was a key determination for social well being.

¹²⁹ Patel et al, *Khat Use Among Somalis in Four English Cities* (London; Home Office, 2005)

¹³⁰ De Cal et al., *Kat I Sverige: Kartlaggning av katanvandning I Goteberg, Stockholm och Malmo* (Goteberg, 2009); Sundhedsstyrelsen, *Brug Af Khat Blandt Personer Med Somalisk Baggrund* (Department of Health: Copenhagen, 2009); Omar and Besseling, *Khat: a drug of growing abuse* (Lund: EURAD Sweden, 2008); Tollefsen, 'Khatbruk - et onde eller et gode?', *Rus & Avhengighet* 5 (2006),

http://www.idunn.no/file/ci/2913138/rus_2006_05_khatbruk_et_ond_eller_et_gode_.pdf

¹³¹ Patel et al, *Khat Use Among Somalis in Four English Cities* (London; Home Office, 2005)

¹³² Perouse de Montclos, 'A refugee diaspora: when Somalis go west'. In *New African Diasporas*, Koser, K. (ed) (London: Routledge, 2002); McGowan, *Muslims in the Diaspora: The Somali Communities of London and Toronto* (Toronto; university press, 1999).

Summary on Social Harms

157. There are two key conclusions on societal harms:

- There is a general lack of robust evidence on the link between khat use and societal harms. Reported societal harms associated with khat remain a concern among the UK's Somali community, yet beyond contradictory anecdotal statements no credible evidence has been found to show a direct causal relationship between khat and the various harms for which its consumption is claimed to be responsible.
- 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 present as unproblematic consumers of khat. As well as khat, many other socio-economic variables and societal inequalities might contribute to the social problems confronting the UK Somali community e.g. potential lack of support in integration, the damaging effects of civil war, family fragmentation, displacement in seeking settlement outside home countries and evolving gender relations through the diaspora. These factors need to be considered and weighed in an holistic manner disentangling potential factors without isolating khat as the only causal agent.

6. International Issues

Legislation

158. The World Health Organisation first undertook research into the pharmacology and health implications of khat in the 1950s. 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 consumers¹³³.
159. 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 i.e. 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.
160. This initiative applied only to the isolated compounds, and was not intended to subject khat itself to international control. Despite this, some countries have applied the scheduling of cathine and cathinone as a reason to prohibit khat. 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"¹³⁴. 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*"¹³⁵.

¹³³ UN Economic and Social Council, 'Resolutions Adopted by the Economic and Social Council', 11 August 1964.

¹³⁴ WHO, *Assessment of Khat (Catha edulis Forsk)*, WHO Critical review, 34th ECDD (World Health Organisation Technical Report series, no.942: Geneva, 2006)

¹³⁵ WHO, *Assessment of Khat (Catha edulis Forsk)*, WHO Critical review, 34th ECDD (World Health Organisation Technical Report series, no.942: Geneva, 2006)

161. With regard to specific national legislations, in 1981, following publicity given to investigations by the WHO, Finland, Germany and New Zealand legislated against khat. However, the ACMD did not find evidence that these decisions were based on a thorough assessment into khat use or its potential harms. Norway and Sweden acted in 1989, followed by Italy in 1990, and Denmark and Ireland in 1993. None of these countries conducted studies into khat consumption or potential harms studies before legislating. Thus decisions appear not to be driven by evidence. The USA brought measures against khat's compounds in 1988 (cathine), and 1993 (cathinone), but without any review of khat consumption or trade. Switzerland and Canada acted against both compounds in 1996 and 1997 respectively.
162. In Europe, Cyprus, the Czech Republic, Greece, Malta, the Netherlands, and Portugal had not legislated by 2005.¹³⁶ Khat has, until recently, been 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. However there was a subsequent report in 2011, post dating the analysis of Anderson and Carrier. Although this report did not recommend controls or prohibition, the government of the Netherlands is moving to bring in restrictions, anticipated for 2013 (see table below).
163. Cathine and cathinone are controlled under Australian law, but khat imports are allowed under licence. Khat is regulated in Australia through a complex regime of overlapping and differing Commonwealth, state and territory laws. In some states possession of khat is strictly prohibited and carries heavy penalties, whereas in others possession of khat appears to be legal (at least for personal use). A review conducted in 2009 found no substantive evidence of social or medical harms and recommended no change to Australian legislation¹³⁷. A recently published Australian review of 2012 recommends the law in relation to khat should be made as clear as possible in each state, especially given that many khat users speak English as a second language¹³⁸.

¹³⁶ ACMD, *Khat (Qat): Assessment of Risk to the Individual and Communities in the UK*. (London; Advisory council on the Misuse of Drugs, 2005).

¹³⁷ Fitzgerald, *Khat: A Literature Review* (Melbourne, 2009)
http://www.ceh.org.au/downloads/khat_report_FINAL.pdf.

¹³⁸ National Drug Law Enforcement Research Fund, *Law enforcement and khat: an analysis of current issues*, Monograph series No.40, 2012

Legislation by Country¹³⁹

Country	Legislation
Australia	Reviews of khat in 1996 and 2009. 20 tonnes imported in 2008. Law varies by state, but not prohibited. For example khat can be imported under license in Victoria where permit holders are allowed to import 5kg per month. A 2012 review recommends clarification of the law.
Canada	Import and trade prohibited in 1997, but possession technically legal. No review of khat conducted prior to ban. 28 tonnes seized in 2007.
Denmark	Import, trade and consumption prohibited 1993. No review of harms. No available data on seizures, but review in 2009 revealed trade and consumption on-going.
Netherlands	Unrestricted after review in 2008. Imported four days a week from Kenya, however restrictions on imports now planned. Anticipated implementation 2013.
Norway	Import, trade and consumption prohibited 1989. No review of harms. 3.7 tonnes seized in 2007.
Sweden	Import, trade and consumption prohibited 1989. No review of harms. 9 tonnes seized in 2007.
USA	Khat's alkaloids (cathine, cathinone) restricted under Federal Law, effectively prohibiting khat, but law inconsistent between states. No review of harms has been conducted. Khat smuggled into country by couriers and mail services. 40 tonnes seized in 2006.

¹³⁹ This section draws upon the research reported in Anderson & Carrier, *Khat; Social Harms and Legislation – A Literature Review*. Home Office, Occasional Paper 95, July 2011

Australia

164. Khat's active constituent compounds (cathine and cathinone) are controlled in Australia but the treatment of khat varies by State. 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 importation of 5 kg of khat per month.
165. Khat use has been known since the mid-1990s¹⁴⁰. Imports have grown markedly from 70 kg in 1997 to 20,130 kg in 2008. 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 fresh khat is increasing in supply¹⁴¹. 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 legislation¹⁴².

Canada

166. Canada lists khat itself as a controlled substance of Schedule IV, making it illegal to import, export or traffic in the plant¹⁴³. While it is not illegal to possess a Schedule IV substance, it is illegal to seek to obtain one. It has been reported that this creates confusion even for the police, who seem unsure as to the precise status of khat¹⁴⁴. However, it has been reported that there is a market for khat which is being exploited by some criminal elements.

¹⁴⁰ Stevenson et al, 'Chewing as a social act: cultural displacement and khat consumption in the East African communities of Melbourne', *Drug and Alcohol Review* 15 (1996), 73-82

¹⁴¹ Fitzgerald, *Khat: A Literature Review* (Melbourne, 2009)

http://www.ceh.org.au/downloads/khat_report_FINAL.pdf.

¹⁴² Fitzgerald, *Khat: A Literature Review* (Melbourne, 2009)

http://www.ceh.org.au/downloads/khat_report_FINAL.pdf.

¹⁴³ INCB, *Report of the International Narcotics Control Board for 2006* (Vienna: United Nations International Narcotics Control Board, 2006)

¹⁴⁴ *National Post* (Canada), Friday 28 September 2007.

167. There are no published reports on prevalence or patterns of khat use in Canada. Khat continues to be used despite occasional seizures. In 2007, 23 tonnes of khat were seized in Canada¹⁴⁵. Police officers reportedly see khat as low priority and even a nuisance. However, local Somalis feel that police now target them because of the khat ban. Politicians in Canada have called for a scientific review of khat to consider decriminalisation, suggesting that a multicultural society should tolerate such practices as khat chewing¹⁴⁶.

Denmark

168. Soon after the banning of khat in Norway and Sweden, Denmark became the major *entrepôt* for khat smuggling i.e. where goods can be imported and exported without payment of duties. 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 kg¹⁴⁷.

169. In 2009 smuggled khat was reported to sell at 100 kroner (£12) per bundle¹⁴⁸ whilst the same study revealed that only 15% of 15 to 50 year old Somalis (within a sample of 848), chewed khat. More restrictive legislation in Sweden makes Denmark an attractive destination for Swedish-based consumers¹⁴⁹. Community anxieties about increasing khat use and adverse effects upon Somali youth are not supported by recent research, which suggests a “*new attitude to khat among the young*” with the great majority of youth not chewing khat and expressing disapproval against its use¹⁵⁰.

¹⁴⁵ Royal Canadian Mounted Police, *Report on the illicit drug Situation in Canada* (National intelligence analysis: Criminal intelligence, RCMP, 2008).

¹⁴⁶ Anderson et al, *The Khat Controversy: Stimulating the Debate in Drugs* (Oxford: Berg, 2007), 195-99.

¹⁴⁷ Anderson & Carrier, *Khat; Social Harms and Legislation – A Literature Review*. Home Office, Occasional Paper 95, July 2011

¹⁴⁸ Sundhedsstyrelsen, *Brug Af Khat Blandt Personer Med Somalisk Baggrund* (Department of Health: Copenhagen, 2009)

¹⁴⁹ Anderson et al, *The Khat Controversy: Stimulating the Debate in Drugs* (Oxford: Berg, 2007), 199-201.

¹⁵⁰ Sundhedsstyrelsen, *Brug Af Khat Blandt Personer Med Somalisk Baggrund* (Department of Health: Copenhagen, 2009)

The Netherlands

170. The Netherlands is a major destination for khat for internal consumption by local Somalis and there is some re-export. There are no available data on quantities imported, or on prevalence, patterns or trends. Concern over use has resulted in minor measures being taken against khat. Pennings *et al.* report that one Dutch town has prohibited khat use within 500 m of the distribution point, a measure designed to prevent potential anti-social behaviour. This same government report found the harm potential of khat to be low¹⁵¹. As in the UK, import taxes are imposed on khat in the Netherlands.
171. A further investigation into the consumption of khat by Somalis in the Netherlands was carried out by researchers from the Trimbos Institute and published at the end of 2011. This study reported stable and relatively low levels of khat use among Somalis in the Netherlands, but reported some instances of public nuisance being caused by khat cafes and retail outlets. The study found no significant social harms associated with khat, and the authors did not recommend the need for any legislative action regarding khat use¹⁵². Nonetheless, following the publication of the Trimbos Institute report the Government of the Netherlands has announced its intention to issue legislation prohibiting the trading of khat. The implementation of this directive is still pending as at January 2013.

Norway

172. When adding cathinone and cathine to the list of controlled substances, Norway also prohibited khat in January 1989. However, according to Tollefsen, at that time “there were no studies conducted to show whether criminalisation was a good idea or not”¹⁵³. Gunderson, the author of the most recent larger study of khat in Norway, also confirms that there is nothing to indicate that the impact of khat use was assessed at the time of the decision to prohibit¹⁵⁴.

¹⁵¹ Pennings *et al.*, ‘Risk assessment of khat use in the Netherlands: a review based on adverse health health effects, prevalence, criminal involvement and public order’, *Regulatory Toxicology and Pharmacology*, 52(3) (2008), 199-207

¹⁵² M. de Jonge and C. van der Venn, *Qatgebruik onder Somaliërs in Nederland* (Utrecht: Trimbos Instituut, 2011)

¹⁵³ Tollefsen, ‘Khatbruk - et onde eller et gode?’, *Rus & Avhengighet* 5 (2006).

http://www.idunn.no/file/ci/2913138/rus_2006_05_khatbruk_et_ond_eller_et_gode_.pdf

¹⁵⁴ Gunderson, *Bruk Av Khat I Norge* [Khat Use in Norway]. NOVA Occasional Paper, Oslo, 2006. http://www.nova.no/asset/2396/1/2396_1.pdf

173. Price in Norway is now high compared with the UK (a bundle costs around 180 krone/£17)¹⁵⁵ compared with £3 to £6 in the UK and has remained at this level since¹⁵⁶. Despite this high price, 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) and the upward trend continues. In 2006, 3.7 tonnes were seized, rising to 11 tonnes in 2010¹⁵⁷.
174. Opinions about khat are divided among Somalis in Norway, some call for tougher restrictions while others argue for tougher legalisation. Women are among the more vocal anti-khat campaigners and the time men spend away from families chewing is seen as a factor in divorce¹⁵⁸. Tollefsen (2006) has called for a re-evaluation of khat's status¹⁵⁹.

Sweden

175. 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 khat¹⁶⁰. Khat was not then viewed as a social problem by the Swedish authorities given the small population of East Africans¹⁶¹.

¹⁵⁵ Gunderson, *Bruk Av Khat I Norge* [Khat Use in Norway]. NOVA Occasional Paper, Oslo, 2006. http://www.nova.no/asset/2396/1/2396_1.pdf

¹⁵⁶ Personal communication, T. Gunderson, Oslo, November 2012.

¹⁵⁷ Norwegian Customs & Excise, http://www.toll.no/templates_TAD/Topic.aspx?id=2189952epslanguage=no

¹⁵⁸ Gunderson, *Bruk Av Khat I Norge* [Khat Use in Norway]. NOVA Occasional Paper, Oslo, 2006. http://www.nova.no/asset/2396/1/2396_1.pdf, p45.

¹⁵⁹ Tollefsen, 'Khatbruk - et onde eller et gode?', *Rus & Avhengighet* 5 (2006).

http://www.idunn.no/file/ci/2913138/rus_2006_05_khatbruk_et_ond_eller_et_gode_.pdf

¹⁶⁰ Hartelius, *Kat: Carnegie Mini-Series* 3 (Stockholm: Svenska Carnegie Institutet, 2a tryckningen, 1995)

¹⁶¹ Socialstyrelsen, *Narkotikaboken: historic, preparat, missbrukare och missbruksorsaker, forebyggande insatser, lagstiftning, vard.* (Stockholm: Socialstyrelsen redovisar, 1988)

176. Estimates suggest that khat is still used by 30% of Somali men in Sweden¹⁶². A bundle was reported to sell for between 200 to 400 krona (between £18 and £36 in 2008)¹⁶³. Smuggling remains prevalent with seizures of around 9 tonnes each year since 2006. However, 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 quantities 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 khat¹⁶⁴.

United States of America

177. The Drug Enforcement Administration (DEA) define 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.

178. There are no published data on khat consumption from either before or after the legislation. DEA officials say that khat is “low on their radar”¹⁶⁵, although seizures appear to be rising: 40 tonnes of khat were seized in 2006, 33 tonnes in 2007, and 74 tonnes in 2008. 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. It is believed that much of the khat smuggled into the USA comes there via the UK. However, the ACMD has not received any substantive evidence to support this claim.

179. Prohibition appears to have raised prices: it is reported that a £3 bundle in the UK sells for ten times that price in the USA¹⁶⁶. Lawyers report 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 with two

¹⁶² Anderson et al, *The Khat Controversy: Stimulating the Debate in Drugs* (Oxford: Berg, 2007).

¹⁶³ Omar & Besseling, *Khat: a drug of growing abuse* (Lund: EURAD Sweden, 2008)

¹⁶⁴ De Cal et al., *Kat I Sverige: Kartlaggning av katanvandning I Goteberg, Stockholm och Malmo* (Goteberg, 2009); Omar and Besseling, *Khat: a drug of growing abuse* (Lund: EURAD Sweden, 2008). See also, Anderson et al, *The Khat Controversy: Stimulating the Debate in Drugs* (Oxford: Berg, 2007).

¹⁶⁵ Carrier, *Kenya Khat: the Social Life of a Stimulant* (Lieden: Brill, 2007a)

¹⁶⁶ Anderson et al, *The Khat Controversy: Stimulating the Debate in Drugs* (Oxford: Berg, 2007).

receiving custodial sentences of 21 months and the third a sentence of 12 months.¹⁶⁷

180. Commentary on khat in the US media is bounded by associations with conflict in Africa and the Middle East, especially a supposed link to the funding of terrorism, although ACMD has seen no evidence to support this claim¹⁶⁸. No research has been reported on attitudes towards khat among immigrant communities in the USA.

Summary on international issues

181. There are three principal conclusions from the evidence on the international responses to khat:

- Legislation regarding khat in Europe and North America has been widely introduced. However, there is a general lack of quality studies that consider the harms of khat to support the controls imposed. It appears that decisions to control khat are likely not to have been based on robust evidence of either physical or societal harms, but other factors.
- The impact of legislation is difficult to measure, however, it is clear that there is still a demand for khat even in those countries where it is prohibited. The outcomes of enforcement are mixed and appear fragmentary in some cases.
- It is not known if the issues facing those communities where khat is more prevalent, such as Integration, have been resolved in countries where it has been controlled.

¹⁶⁷ Anderson & Carrier, *Khat: Social Harms and Legislation – A Literature Review*. Home Office, Occasional Paper 95, July 2011

¹⁶⁸ For example, Kushner and Davis, *Holy War on the Home Front: The Secret Islamic terror Network in the United States* (New York: Sentinel, 2005).

7. Education and Prevention

182. The FRANK, Know the Score, and DAN 24/7 websites provide basic information on khat, such as a description of the plant, its effects, risks, and the law.
183. The risks published seem to be more related to those of psychostimulant drugs in general, rather than specifically for khat. The harmful effects listed include insomnia and 'confusion'; high blood pressure and heart palpitations; increased libido leading to the risk of unsafe sex, oral inflammation; anorexia; anxiety and aggression; and worsening of pre-existing mental health problems - albeit there are no references to support these claims. The ACMD did not find evidence to support all of these statements.
184. The FRANK website also suggests the potential for dependence, although this is scientifically controversial due to the lack of evidence as set out in this report. The DAN 24/7 website also includes information on cathinone and refers to injection. Whilst cathinone injection is plausible, we are unaware of any reports of khat injection. Linking the two drugs creates the wrong impression that cathinone obtained in pure/powdered or injectable form is directly related to khat.
185. It is therefore important that UK information websites review the accuracy of information that they present in order to remain useful and credible to (potential) khat users.
186. The ACMD is not aware of any evidence based khat education or prevention resources currently available in the UK. According to one Home Office funded study, 15 out of 191 English Drug Action teams (DAT) provided specific or generic khat services in 2009/10¹⁶⁹. Activities included funding of a dedicated khat worker, community volunteer training, production of information resources and community drug education projects. However, this evidence was reported two years ago.
187. In an accompanying piece of qualitative research, demand for support services by Somali, Yemeni, and Ethiopian communities was perceived to be low. This was confirmed by, for example, the Brent Council study.

¹⁶⁹ Sykes, W., Coleman, N., Desai, P., Groom, C., Gure, M. Howarth, R. *Perceptions of the social harms associated with khat use*. Home Office Research Report, 2010

188. A consultation (primarily with Somalis) conducted by the National Drugs and Race Equality Coalition (NDREC) indicated that existing information on khat was not reaching community members¹⁷⁰. It was suggested that 'good practice' should include the provision of culturally appropriate services which would provide specific information on khat as part of wider social, educational, and health support.
189. The BME community groups which provided evidence to ACMD highlighted the problems of the lack of an ethnically sensitive service provision and the need of further involvement of the community groups in the service for the delivery of such support. This was reiterated by contributors to the Department of Health commissioned report of 2003¹⁷¹:

“Services need to have workers from different communities and not treat everyone the same, but according to the needs they are presenting with...black staff would be culturally appropriate, as they would be able to break down the language barriers...”

190. The report goes on to state: “the general impression from interviews with service providers is that they would struggle to meet the needs of those Black and minority ethnic communities that are not currently accessing services . . . Some service providers appeared sensitive to the suggestion that they could not meet the needs of Black and minority ethnic clients, with many reporting that the service is open to all people regardless of ethnicity”.
191. These views were echoed by the work of Brent Council which found BME support workers who matched the ethnicity of the community were more successful in entering the local community to identify people who needed and would accept the support offered. The ACMD is cognisant that NHS data may not fully represent the treatments needs of khat users due to the difficulties in engaging with all groups within communities.

¹⁷⁰ Buffin, J., Mir, Y. and Mirza, I. Khat: current views from the community around the UK. Preston: National Drug & Race Equality Coalition, University of Central Lancaster. 2009

¹⁷¹ Bashford B et al, The Department of Health's Black and Minority Ethnic, Drug Misuse Needs Assessment Project, University of Central Lancashire, Centre of Ethnicity & Health, 2003

192. This above research supports the experience and views of Brent and Hillingdon Councils and BME groups that cultural and ethnic sensitivities in selection of staff and approach to the local community ensures an increased demand for services; not least as the BME groups are not heterogeneous and some community groups are separated along clan lines, and where clan politics may intervene. This point also relates to the perhaps tautological conclusion drawn by service providers that lack of engagement equates to lack of need, which in consequence would undermine any evidence based budget requirements to commission such BME workers. The positive outcome of the Welsh experience of partnership working 'hand in hand' with the community confirms such steps can be effective.
193. The NHS service providers which presented to the ACMD reported that a lack of information and reliable evidence regarding the potential negative health impact on khat users meant that there was little upon which to base service provision and to advise clients/patients. In order to avoid stigmatisation (particularly amongst female users), it was believed important that services for khat users were not presented as 'drug services' and might be best delivered as part of general community health services. In considering research priorities it is therefore important to promote those which are embedded in health services research (particularly with regards to the implementation and configuration of services) and to identify, if any, the most common and burdensome health effects of use.
194. In the absence of effective interventions that might prevent khat related potential harms, general health promotion, education and prevention principles may be useful. It is important to note that these will need to be adapted to meet the needs of particular communities, their cultural sensitivities and be based on local needs, which include gender issues.
195. According to the Drug Education Forum¹⁷² school based drug prevention education should be developed in accordance with the principles in Annex D. It is recognised that most community based substance use work takes place outside the school environment, often with populations who are not engaged with formal education. The principles that concern planning, content development, and the role of the educator/facilitator are relevant to all settings (including non-school settings) and groups. These principles provide useful guidance that would help in the development of khat specific approaches, or to address khat use as part of universal activities, particularly with respect to skills development, a focus on risk and protective factors, and exploration of attitudes to khat and khat users.

¹⁷² <http://www.drugeducationforum.com>

196. A basic template of the overview of approach to be used in regards to education and prevention is set out in Annex D.

8. Treatment of Khat Use

197. Under the NHS strategy local drug partnerships identify and address the needs of their communities. Support has been provided to communities affected by substance misuse directly, supporting effective commissioning in all areas of the country, through systematic local substance misuse assessment of need and partnership working.
198. In England Primary Care Trusts are responsible for local needs assessments. From April 2013 this responsibility passes to Local Authority Directors of Public Health. The commissioning of substance misuse services are based on local needs assessments following a process of prioritisation of actions agreed through local strategic partnerships to co-ordinate strategies across health, social care and the criminal justice system. In most areas in England there is a dedicated NHS substantive misuse commissioner or commissioning team with links to the PCTs and local authorities.
199. Currently, local drug partnerships are responsible for providing (either directly or by commissioning them) drug services that meet the needs of their communities. The role of the DH and National Treatment Agency for Substance Misuse (NTA) is to support local drug partnerships in achieving this. This includes the NTA supplying partnerships with data and tools to support the Joint Strategic Needs Assessment process (a comprehensive analysis of health and social care needs in a local area) and the DH providing information to professionals and supporting professional development in the area of substance misuse for doctors and those working in primary care. This is achieved through a range of initiatives that impact on basic knowledge and understanding, including primary care, and will underpin any work with communities affected by substance misuse, including khat use.

200. Sykes' research referred to 15 DAT initiatives that provided khat specific services, however this was in 2010 some two years ago. Currently the National Treatment Agency for Substance Misuse reports two examples of khat specific initiatives: a project in Haringey, North London which engages with the Somali community about khat use and a research report commission by Mersey Care NHS Trust in Liverpool to find out about levels of khat use amongst East African communities in the city. The ACMD understands that the former service has now closed. More recent data from the Department of Health confirms only 6 khat projects are run in England. The ACMD was also informed that one London khat service had been shut down in 2011 and another was in operation in West London by EACH¹⁷³. The data on the proposed khat initiatives of Brent Council are not yet available.
201. In Wales the Community Safety Partnerships (Area Planning Boards from April 2013) Public Health Department commissions services based on identified need according to the collation of data. As there were few users of khat identified as engaging with the health system in Wales, there are insufficient numbers to warrant the commission of bespoke services; a consideration in the current financial climate at a time when spending restraints are required. There could be a number of reasons for the 'invisibility' of users, as addressed elsewhere in this report, including that data is not collated for a product which is not illegal (although a 'khat' field is included in the Welsh National Database for Substance Misuse dataset), khat is not itemised in the checklist of drugs by agencies, or there is a failure to engage by khat users. The lack of khat users presenting with an apparent need for NHS khat services in Wales contrasts with its local partnership initiatives in regard to the anti-social aspects of khat use.
202. No evidence was received by the ACMD in regard to support groups or aid specifically offered to carers and family members of khat users.

¹⁷³ EACH report to NTA London providers group July 2012

Treatment of Dependence

203. UK clinical guidelines for the treatment of drug dependence state the mainstay for treatment for stimulant dependence is psychosocial interventions¹⁷⁴. There is research evidence that psychosocial interventions are effective in treating dependence on a range of stimulant drugs. These guidelines recognise a range of severities of stimulant dependence exists and recommends those with short histories of use may benefit from brief motivational interventions, whilst those with more entrenched dependence or poly substance misuse may benefit from a longer period of care planned treatment consisting of psychosocial 'key working' plus contingency management. Key working is a basic mechanism where a professional develops a therapeutic relationship with a client and they jointly develop a treatment and recovery plan. Key working components can include: drug-related advice and information; interventions to reduce use and decrease harm and interventions to increase motivation to change and prevent relapse. Keyworking can also help promote recovery by helping address social problems such as housing, relationship issues, and unemployment, co-ordinating health care and encouraging well-being and social integration. The role of mutual aid (such as Narcotics Anonymous) or self help groups of people wanting to recover from substance dependence is also recognised as being effective for stimulant misusers¹⁷⁵.

Implications for khat treatment and recovery interventions

204. Currently, local drug partnerships are responsible for providing (either directly or by commissioning them) drug services that meet the needs of their communities. The role of the DH and National Treatment Agency for Substance Misuse (NTA) is to support local drug partnerships in achieving this. This includes the NTA supplying partnerships with data and tools to support the Joint Strategic Needs Assessment process (a comprehensive analysis of health and social care needs in a local area) and the DH providing information to professionals and supporting professional development in the area of substance misuse for doctors and those working in primary care. This is achieved through a range of initiatives that impact on basic knowledge and understanding, including in primary care, and will underpin any work with communities affected by substance misuse, including Khat use.

¹⁷⁴ Drug misuse and dependence: UK guidelines on clinical management (Department of Health and devolved administrations 2007)

¹⁷⁵ Psychosocial interventions for drug misuse (NICE, 2007)

205. The UK Clinical guidelines¹⁷⁶, NICE guidelines¹⁷⁷ and the Drug Strategy 2010 provide some basic building blocks of evidence-based stimulant (and therefore khat) treatment and recovery interventions. It is essential that interventions are tailored to the cultural and religious norms and needs of those communities and delivered in such a way that respects those cultures i.e. have cultural competence. This builds on and develops the finding of the Home Office 2010 report regarding the need for dedicated khat workers¹⁷⁸. Although it was suggested there was emerging evidence that highly tailored khat treatment and recovery work is occurring in some areas, it was also confirmed there were no dedicated khat services available¹⁷⁹. Due to the contradictory information before it, the ACMD was unable to clarify the situation.
206. The ACMD is mindful that serious health and social care needs of some of the discrete community groups (particularly those from war torn areas) most impacted by khat use may add to the complexity of achieving recovery social integration, health and wellbeing.
207. This research supports the experience and views of Brent Council and BME groups that cultural and ethnic sensitivities in selection of staff and a similar approach, including gender considerations, in dialogue with the local community ensures an increased demand for services; not least as the BME groups are not heterogeneous and some community groups are separated along clan lines. Nevertheless it is important to note that these will need to be adapted to meet the needs of particular communities, their cultural and sensitivities and be based on local needs.
208. The NHS presenters to the Working Group also claimed a lack of information and reliable evidence regarding the negative health impacts on khat users upon which to base their service provision and to advise clients/patients.
209. There was also voiced by the BME groups a fear of stigmatisation and a wish to avoid services labelled as 'drug addiction'. The groundswell agreed opinion was that any support provided should be through routine NHS services. In the absence of effective interventions that might prevent khat related potential harms, general health promotion, education and prevention principles should be useful.

¹⁷⁶ Drug misuse and dependence: UK guidelines on clinical management (Department of Health and devolved administrations 2007)

¹⁷⁷ Psychosocial interventions for drug misuse (NICE, 2007)

¹⁷⁸ <http://rds.homeoffice.gov.uk/rds/pdfs10/horr44c.pdf> - (HO research 2010 RE perceptions of khat use in UK communities and government/local responses to khat use)

¹⁷⁹ EACH report to NTA London providers group July 2012

9. Concerns: communities and groups

210. The ACMD, in collating the evidence for this report, received representations from a diverse range of communities and groups in the UK.

211. The ACMD is conscious that it is important to contextualise the concerns raised by the BME, NGO and community groups as they have to be viewed within the historical and often complex societal groupings within our diverse UK society. The BME groups are not homogenous entities and distinct nationalities are not internally uniform. For example, the Somali community is formed by numerous different clans with their own distinct tribal rules.

Clans of Somalia



212. The diverse immigration histories of BME groups encompass the well established Somali populations who have a tradition of assimilation in excess of a century whilst retaining their own cultural identities, and recent asylum seekers who have no family or relationship support networks in the UK. Thus integration of a fourth or fifth generation BME group well settled in the UK with those fleeing persecution would have significantly different life experiences and face different challenges. Therefore, the BME reactions to khat use are likely to be similarly disparate, even within same ethnic groups.
213. It was an often repeated claim by the majority of the Somali groups that khat use was a significant problem within their local areas and community. In contrast it was reported that the Yemeni community had no problem with khat use, as it takes place within the family setting and is integrated into other social domestic events. Although Kenyans are the largest relevant BME population in the UK, generally this community does not tend to figure in concerns raised in regards to khat use, even though it is one of the three main production countries.
214. There should be recognition that there is a qualitatively different life experience between a British born and bred Somali and a recent arrival fleeing the civil war and seeking asylum. The independent Country of Origin Reports¹⁸⁰ provides a picture of the adversity facing some asylum seekers from Somalia, where there has been no central Government for two decades in a land riven by civil war and clan rivalries. The report records the indiscriminate violence, violation of human rights, extra-judicial killings, torture, kidnappings, forced recruitment of child soldiers, female genital mutilation and trafficking of adults, as well as issues of famine and drought, and lack of medical care.¹⁸¹
215. The research of Warfa *et al* confirms and reflects the complex multi-factorial issues facing khat using refugees, which suggest that "challenges to masculinity, thwarted aspirations, devalued refugee identity, unemployment, legal uncertainties and longer duration of stay in the host country account for poor psychological well-being and psychiatric disorders among this group"¹⁸².

¹⁸⁰ Produced by the COI Service, UK Border Agency, for use by officials involved in the asylum/human rights determination process and compiled wholly from material produced by a wide range of external information sources attributed to original source material and does not contain any UKBA opinion or policy.

¹⁸¹ Somalia Country of Origin Information Report, COI Service, 17 January 2012 available on <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/coi/somalia/report>

¹⁸² Nasir Warfa, Sarah Curtis, Charles Watters, Ken Carswell, David Ingleby and Kamaldeep Bhui (2012). Migration experiences, employment status and psychological distress among Somali immigrants: a mixed-method international study, BMC Public Health 2012

216. In the UK, there is evidence that those seeking treatment for khat use are from marginalised communities, often displaced from their countries of origin, who also have a range of issues including: trauma (e.g. from war), low trust in authority, social dislocation, unemployment, poor English literacy etc.. Thus support and treatment for khat dependence needs to be culturally competent in the groups affected and be set in the context of improving health and wellbeing and encouraging social integration and recovery.

217. The problems facing a person fleeing Somalia under these circumstances give rise to a number of vulnerabilities, exacerbated by attempts to access the legal advice needed to regularise their stay in the UK and the task of obtaining accommodation and health care service provision, as well as much needed specialist trauma care. The executive summary of the report of the ongoing European funded refugee research project led by Professor Papadopoulos of EVASP states: ¹⁸³

“One of the main arguments that this research advances is that these factors of vulnerability and service provision are inexorably related and one cannot be understood without the other. Indeed, this project claims that vulnerability cannot be understood as a single entity or characteristic that belongs to one dimension of human functioning ‘within’ one individual, but it essentially is a relational phenomenon and can only have meaning in the context of the interaction between the individual (a family, a community) and the services available. In other words, the degree of vulnerability is directly dependent on the extent of available services. Moreover, it is proposed that vulnerability is a complex and composite phenomenon of various ‘external’ and ‘internal’ dimensions and it consists of various clusters (called ‘dimensions’) and each cluster (‘dimension’) includes a number of constituent ‘categories’”.

218. The dimensions that emerged as the most relevant included multi-factorial and multi-layered complex issues of: employment, family support, health needs, not being subject to racial and general discrimination, community and wider society connections, language differences and educational needs.

¹⁸³ Enhancing Vulnerable Asylum Seekers' Protection, Professor R Papadopoulos, www.evasp.eu

219. Evidence submitted to the ACMD confirmed that the integration and intensive support services provided to Somali immigrants in America enabled employment levels to be reached of 74% by the end of 2 years presence and was held up as an example of good practice¹⁸⁴. Whereas the comparative sample of Somali in the UK have an employment level as low as 10% apparently due to the different degree and type of support available in these countries, even though a higher proportion of the UK sample had attended higher education. This is of significance in regards to employment being a potential protective factor in regards to mental well-being, albeit that this is also dependent upon other factors such as recognition of legal status, access to language education and validation of previous professional qualifications¹⁸⁵.

Brent Council Report 2012

The task group has made nine recommendations which can be broadly split into five categories:

- Resolving immigration problems
- Training, employment and diversionary activities
- Treatment services
- Regulation
- Raising awareness of khat, its possible negative side effects, and promoting positive health messages

¹⁸⁴ Nasir Warfa, Sarah Curtis, Charles Watters, Ken Carswell, David Ingleby and Kamaldeep Bhui (2012). Migration experiences, employment status and psychological distress among Somali immigrants: a mixed-method international study. BMC Public Health 2012,

¹⁸⁵ Silove D, Steel Z, Susljik I, Frommer N, Loneragan C, Chey T, Brooks R, le Touze D, Ceollo M, Smith M, Harris E, Bryant R: The Impact of the refugee decision on the trajectory of PTSD, anxiety, and depressive symptoms among asylum seekers: a longitudinal study. Am J Disaster Med 2007, 2(6):321–329.

220. It would be unremarkable that a number of overseas nationals encountering such adverse background circumstances would experience mental health issues. In the report 'Improving mental health services for immigrant, refugee, ethno-cultural and racialised groups: Issues and options for service improvement' it is stated:

“Mental health problems and mental illness: Mental health problems and illnesses are clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering, or impairment in one or more areas such as school, work, social and family interactions, or the ability to live independently. There are many different kinds of mental health problems and illnesses. They range from anxiety and depressive disorders through to schizophrenia and bipolar disorder, and are often associated with a formal medical diagnosis. There is no single cause for most mental health problems and illnesses. They are thought to be the result of a complex interaction among social, economic, psychological, and biological or genetic factors. They may have different causes and treatments which make discussing them as one group problematic at times, but they also have some similarities in their impact on individuals, their families and society.”¹⁸⁶

221. In conclusion it is evident that some asylum seekers of various nationalities would encounter significant and severe obstacles and experience health care problems upon arrival into the UK, which would require specialist support for some time to come. It is within this complex context that the research in the area of khat use should be placed, as an indication of the often apparently intransigent obstacles, which face certain sections of the BME groups and issues of risk of dependency should be approached. Even the most routine of immigration cases would experience fragmentation of families and the problems of relocation to a country with a different culture and language, as well as potential racial discrimination. Thus to suggest that khat use by a minority of the BME groups is a direct cause of the many obstacles and concerning problems facing them in the UK today would be a simplistic and incorrect view.

¹⁸⁶ Mental Health Commission of Canada, Centre for Addiction and Mental Health, 'Improving mental health services for immigrant, refugee, ethno-cultural and racialised groups: Issues and options for service improvement, 12 November 2009

222. To respond to these multi-layered complex problems by criminalising an already disadvantaged group in society deserves serious and careful consideration, especially in light of the limitations of the findings of the research before the ACMD. A didactic approach is supported by the National Federation of Somali Associations in the Netherlands which prefers education and information about the potential risks related to the use of Khat, as well as a coordinated national approach to address the social and economic problems members of the Somali Community are confronted with.

10. Summary and recommendations

223. The ACMD has reviewed the evidence regarding the use of khat and the extent to which it is, or is likely, to be physically harmful to those who use it or to lead to societal harms for themselves and their communities.
224. The limitations in the evidence concerning potential physical harms associated with khat use (fully detailed in the chapter on 'Quality of Research and Hierarchies of Evidence' and at Annex A) does not provide reliable evidence of acute or chronic harms for the reasons herein, other than in regard to the issue of liver toxicity.
225. Nevertheless there is clearly a 'coalescence of concerns' by professionals and communities which is recognised by the ACMD, although further robust research is required. In particular, more evidence needs to be collected in terms of potential association between long term khat consumption and occurrence of acute/chronic liver dysfunction, worsening of cardiovascular issues and impairment of existing psychiatric conditions.
226. While a number of representations were made to the ACMD about potential social harms, most were in the form of opinion rather than evidence and where there was some evidence in support it was not usually robust.
227. We found no evidence of the wide spread and increased use by women, other than a few anecdotal reports. Nor was there evidence of widespread or general use by children. Of the one area minor khat use by teenagers was reported, steps taken resolved matters within a relatively short period of time through the existing legislative framework by joint partnership working with the community.
228. Broadly, the societal harms identified concerned the nuisance caused in places where khat is sold and consumed, and its claimed impact on the lifestyle of those who use it, as well as their families. It has not been possible to disentangle the contribution of the use of khat from the other factors that impact the community, many of whose members have suffered considerable hardship before coming to this country and whose life opportunities may have been significantly compromised.

229. Overall, the societal obstacles and problems facing immigrant communities (first and second generations) are complex, multi-factorial and overlaid with a number of concerns and issues, and it is difficult to identify a direct causal factor to khat use. Many of the issues raised were attributed to khat use and not to other causes which may have been equally or more applicable. Added to such problems of causality are the mental and physical issues facing first generation settlers who have been subject to adverse historical events in their own home countries, in particular civil war and long term human rights abuses in Somalia^{187,188}.
230. Reports from localities indicated that existing legislation and policies of statutory bodies gave a platform for dialogue and were sufficient to effectively address a number of these social harms caused or attributed to khat e.g. anti-social behavior projects set up and working in partnership with BME communities.
231. It has been demonstrated that such concerns raised by communities can be appropriately addressed through the existing legislative framework.
232. The ACMD find that, based upon evidence requested and provided from all of the relevant departments, organisations and agencies in regard to potential links of khat with organised crime, there is no evidence to support the theory that khat is either funding or fuelling organised crime in the UK. This is perhaps not surprising, as it is not an illegal or high value substance and is a low profit business in the UK. However in countries beyond the UK where khat has been prohibited it enters the illegal market through smuggling and illicit sale, and so becomes criminal activity by definition.
233. The ACMD heard concerns that khat is re-exported to countries where it is illegal and the UK is a transport hub. Despite enquiries made, no concrete evidence of the scale of this activity was submitted to support this claim. However it is likely that some khat is re-exported to countries where it is banned. Onward transportation of khat to those countries where possession, supply or use is prohibited is a matter that the UK Government may wish to consider.

¹⁸⁷ Isse H. *Social and health implications of khat usage among Somali refugees in the UK*. [MA dissertation]. University of East London, 1999.

¹⁸⁸ Douglas H, Boyle M, Lintzeris N. The health impacts of khat: a qualitative study among Somali-Australians. *Med J Aust* 195: 666-9, 2011.

234. In the context of those communities where khat is used, consideration of the potential negative impact criminalisation may have should be carefully balanced against the need for support to focus on the concerns raised by communities.
235. The evidence indicates that for most users, the use of khat does not lead to harm. For example there have been no reports of the societal harms of khat from people in the Yemeni community or any request for classification of khat. On the contrary a number of representations made to the ACMD specifically included requests not to classify khat for cultural reasons and to militate against the adverse impact of criminalisation of groups already subject to social exclusion. The evidence collected suggests that the use of khat and inferred harms associated with it, need to be considered in the context of the holistic needs of these communities and their concerns voiced as a 'cri de coeur'.
236. Although the synthesised active ingredients of khat were placed under Schedule B of the Misuse of Drugs Act in 2010 on account of concerns about the increasing use of synthetic cathinones, including mephedrone, nevertheless khat as a natural plant which quickly degrades, is less harmful and its method of consumption means that overall intake of the active ingredient is lower, and less potentially addictive. It is less attractive to consumers and its use appears to be tied to groups where khat use is culturally normative.
237. The best available information is that the amount of khat used in the United Kingdom has reduced since the ACMD's previous khat report produced in 2005. Whilst the 2005 previous figures were estimates and some leeway should be allowed, the current figures based on HMRC taxation returns show a reduction in importation into the UK. Such a reduction appears counter intuitive in the face of the increased population growth by 18.4% of relevant communities in the UK during this period. It can therefore be inferred that proportionate use of khat is falling.
238. The ACMD considers that the evidence of harms associated with the use of khat is insufficient to justify control through classification. The ACMD believes that it would be inappropriate and disproportionate to classify khat under the Misuse of Drugs Act 1971. In summary the ACMD considers that the harms of khat are not commensurate with class C drugs and does not reach the level required for classification.

Recommendation 1

The ACMD recommend that the status of Khat is not changed and is not controlled under the Misuse of Drugs Act 1971.

Physical and Mental Harms

239. The ACMD considered extensive evidence about the harms associated with the consumption of khat, much of which was anecdotal, and there was little quality research based evidence due to the limitations of the methodologies applied. Some of this evidence relates to the use of khat in Africa and other evidence relates to its use, for example, by Somali and Yemeni communities in the United Kingdom. There have also been comments about khat use and its possible association with mental illness. Overall there is presently a lack of evidence to support a direct link between khat use and mental illness. However it is likely that its use could compromise an existing condition and its treatment.
240. There are a relatively small number of reports of significant liver toxicity related to khat use. The factors which may make an individual more susceptible to liver toxicity, such as genetics and duration of khat use, are currently not known.
241. However the lack of robust evidence is a gap in the understanding of the harms of khat.
242. Individuals that use khat are often drawn from communities that are less advantaged and where other generalised health and socio-economic inequalities have been identified. In addition, although tangential to the ACMD's consideration, it should be acknowledged that individuals and families may have undergone fundamental changes to lifestyles (particularly in the case of those living in the Yemen or Somalia) or may have endured considerable hardship as refugees seeking protection (in contrast to well settled second and third generation communities). Both khat users and the health professionals within these communities should be aware of the range of potential physical harms that may be associated with the use of khat, and the need to properly respond to them, as well as the need to consider other potential specialist interventions of previous traumatic experiences¹⁸⁹. At the same time as efforts to improve overall health and welfare of these communities, intervention arrangements should be reviewed to ensure engagement and service provision is undertaken in a culturally appropriate manner tailored to the community to be served.

¹⁸⁹ For example, the services of the Medical Foundation for the Care of Victims of Torture, now known as Freedom from Torture at <http://www.freedomfromtorture.org/>

243. These services should take into account that those presenting with problems associated with their use of khat may have problems with tobacco, alcohol or drugs. In addition, the services should be delivered in a way that makes them accessible to all affected members of the community. Prevalence of tobacco use in khat users suggest that smoking cessation strategies could be targeted at this population.

Recommendation 2

It is recommended that Commissioners and Directors of Public Health from Local Health Boards, NHS Boards, Health and Wellbeing Boards, and Health and Social Care Boards should:

- **Include Khat in local needs assessments, particularly where there are population groups of relevant BME groups;**
- **Where Khat use is found to be present in local communities, this substance should be included in local generic substance misuse education and prevention initiatives;**
- **Where khat use is found, the commissioning of culturally specific and tailored treatment and recovery services incorporating ‘mutual aid’ models of support should be considered;**
- **Consider dialogue and partnership working with appropriate NGO, third sector, voluntary organisations and BME communities, so holistic needs of health and social issues are met.**

Social Harms

244. The ACMD have thoroughly reviewed the available evidence concerning the reported social harms. Some of these societal harms affect the individual, some the family and some the community.

245. The main concerns cited by those presenting to the ACMD were the lack of time heavy khat users spent with their families and the reduced time available for work, with less opportunity to contribute positively to the local and wider community. Family concerns centred on the negative impact on family dynamics and relationships. Other commentators observed that it is difficult to know whether khat use leads to unemployment or vice versa. Moreover khat use is only one factor in the complex multi-layered migration and settlement experience of inter-generational communities.

246. Concerns have been expressed to the ACMD about the nature and location of premises where khat is retailed or consumed. It had been suggested that some khat cafes in the UK were not adequately ventilated. In some areas complaints have been made about nuisance from cars visiting, waste packaging being left on the street and noise pollution around these premises at unsocial hours. The ACMD received successful evidence of effective local community focused partnership approaches to tackle these concerns and problems, using current legislation and applying strategic policies. In the first instance attempts should be made to engage and work with the local community to resolve the identified problems.
247. It has been demonstrated that concerns raised by communities can be appropriately addressed through the existing legislative framework. The remit of the Department of Communities and Local Government may have a role to play.

Recommendation 3

It is recommended that where concerns are expressed about social harms associated with the use of khat, Local Authorities and new Police and Crime Commissioners should address them through engagement and dialogue with the local community and good inter-agency working, supported as necessary by the use of existing measures coordinated through the relevant Community Safety Partnerships and the use of community remedy.

Data and Research

248. During the course of this review the ACMD has received many submissions about the use of khat, however, generally there has been an absence of robust data. To better understand the prevalence of khat, the CSEW should be complemented by the more formal capturing of epidemiological data about khat use among those accessing NHS services for help with drug misuse and related problems. Additionally those entering the Criminal Justice System should also have khat use recorded. The approach of different agencies in collating this information needs to be uniform and agreed and complement the HMRC figures regarding taxation on imports, as well as relevant UKBA statistics.
249. In particular, more evidence needs to be collected in terms of association between long term khat consumption and potential risks of: occurrence of acute/chronic liver dysfunction; emergence/worsening of cardiovascular issues; and worsening of existing psychiatric conditions.

250. It is important that such research incorporates a wide range of health determinants and outcomes, and is not just limited to those communities where khat use is perceived to be problematic.

Recommendation 4

It is recommended that Commissioners of Public Health services, as well as Criminal Justice System bodies and the new Police and Crime Commissioners should include the use of khat in regular monitoring returns required from treatment and enforcement agencies and publish annual figures. This data should form the basis of future research on khat to address the concerns raised in this report.

There is a need for further research on khat to develop the evidence base of any findings. The ACMD echoes the view of the European Monitoring Centre for Drugs and Drug Addiction that “knowledge gaps in this area remain considerable, and little is known about the social or health consequences of [khat] use”¹⁹⁰.

¹⁹⁰ EMCDDA. Khat use in Europe: implications for European policy. Lisbon: EMCDDA. 2011.

Annex A – Quality of Research and Hierarchies of Evidence

Evidence from the scientific literature has provided information on important topics such as the prevalence of khat use, pharmacology and toxicology. In making its recommendations the ACMD has not only considered the key messages drawn from all of these sources of evidence, but more importantly considered the quality of the methodology used to generate the evidence. Not all research designs are structured such that the methodology applied is equal in terms of the potential risk of error and possible bias in their results.

A study which observes people who exhibit the behaviour under examination and measure this over a long period of time, such as khat chewing, and compare them against a carefully selected and matched reference group would be considered to be a relatively high quality research design. In contrast, methodologies such as expert opinion, small scale clinical case reports and surveys which are not considered to be representative of the wider population of interest are considered to be of poorer quality in coming to a rounded consideration and judgement. This is because that there will be many other important factors which may cause or contribute to the effects observed, but these have not been adequately explained ('controlled for') by the methodology used.

The majority of the evidence reviewed or received by the ACMD in writing this report was considered to be of relatively poor quality. Even studies published in the scientific literature generally used methodologies which meant that the risk of bias, or alternatively explanations for the effects seen, could not be discounted. For example, many studies had small sample sizes which meant that any statistical analysis conducted may have produced erroneous results. There were also problems in the use of appropriate comparison groups, and the lack of consideration in analyses of the effects of other factors which may have led to the outcomes observed (e.g. pre-existing cardiovascular problems, smoking, deprivation and social exclusion). Some study authors also over generalised their findings; meaning that results obtained from a small number of individuals, who might have been atypical and at increased risk of harm, were considered to be equivalent to all khat chewers.

Often, and bearing in mind all the above considerations, in writing this report it was only possible to conclude that some adverse outcomes were *associated* with khat use, but not *caused* by khat use. This is an extremely important distinction. *Causation* would suggest that khat directly caused the outcome of interest, whilst *association* means that there would likely to be a complex interaction of khat with other factors in producing the outcome.

In conclusion, this report does not demonstrate a weight of evidence that identifies specific khat-related harms that could be solely attributed to use of the drug, other than the reference to liver toxicity.

This does not mean this evidence was discounted. All evidence received and reviewed was used to inform this report and it is a result of these presentations and research papers that a number of areas of concern which require further exploration, and important research gaps, have been identified. In assessing the medical effects and social harms of khat use the ACMD undertook a detailed and wide ranging literature review (with particular attention to material published since 2005), which included articles written in Arabic. The ACMD also had the opportunity to consider oral and written evidence submitted by organisations and individuals with a special interest in khat.

During the review the ACMD identified a lack of routine data collection on khat by health, social welfare and criminal justice service, partly as a result of its uncontrolled status, but also because of a perceived lack of impact on health and wellbeing. For example, during evidence gathering in Wales it was presented that over a period of about 7 years the problematic use of khat was in single figures. Whether this represented a real lack of problematic khat use or issues regarding identification and collation of data is unknown, but regardless these numbers were so low it was argued that it would be difficult to make a case for a specific khat service provision. Of the patients identified a number had multi-drug use and complex socio-economic needs such that khat use could not be isolated as the direct cause of these health needs. The numbers were so few that in consequence a business argument for funding provision of khat specific services would likely be unsuccessful. NHS and NGO groups providing health services for drug users used different checklists and approaches to identify the drugs used by patients/clients. Some checks specifically referred to khat whereas other checks asked open questions regarding generic drug use, and others targeted illicit drug use alone. This differing approach was also evident in the checks undertaken by police upon arrest, not least as it was known khat was a legal product and not an illegal drug. So possibilities of capturing data on khat use and misuse were not fully utilised as approaches and checklists were not uniform by official bodies and authorities. Overall the lack of evidence of khat use in datasets collected by official bodies was at odds with the voiced concerns of the BME groups in Wales. It would be unusual if such issues regarding data collation were not reflected in similar systems in England.

In addition the concerns voiced by the community groups and NGOs from their subjective experiences have also been taken into account in this report. It is the 'coalescence of concerns' of the BME communities themselves and the disjunction between official statistics which underpin the need to address such research and data collation matters, which is reflected in the ACMD recommendations of this report.

The ACMD is particularly grateful to those who gave presentations at its evidence gathering meetings in London, Manchester and Cardiff, as well as those who shared their personal views at various community meetings.

Annex B – List of Contributors

The following individuals and organisations gave oral evidence, research papers, written representations and shared information with the ACMD.

Presentations to the ACMD at London, Manchester and Cardiff:

Abukar Awale (Somalia Diaspora UK)

Dr David Anderson and Dr Neil Carrier (Oxford University): *A review of the social harms of khat and legislation*

Andy Brown (NHS Brent) *CRI Project*

PC Emma Coombes and PCSO Neil Crawly (Cardiff Bay neighbourhood policing team): *Khat Presentation*

John Corkery (University of Hertfordshire): *Morbidity and mortality associated with khat consumption*

Conrad Eydmann Head of Substance Misuse Strategy and Development Cardiff and Vale University Health Board: *Impact of Khat use - Perspectives from a Local Health Board*

Mohamed Ibrahim (London Somali Youth Forum)

Muna Ismail: *Pharmacology of khat*

Dr. Axel Klein (Kent University): *Links to Organised Crime*

Manchester Drug and Alcohol Strategy Team (DAST): *Khat Usage in Greater Manchester*

Dr. Marsha Morgan (University College London): *Khat as a hepatotoxin - the role of pharmacogenetics*

Dr. Michael Odenwald (Konstanz University): *Mental Health and Physical Harms*

Julia Osmond, Public Health Lead for Substance Misuse in Gwent (ABHB): *Khat in Wales - A Public Health Perspective*

Dr. Saba Salam: *Khat trends among the Yemeni community*

Prof. Fabrizio Schifano (University of Hertfordshire): *Medical effects associated with Catha edulis/khat intake - an overview*

Wendy Sykes, Carola Groom, Nick Coleman, Mohamud Gure (Independent Social Research): *Perceptions of the social harms associated with khat use*

Dr. Nasir Warfa and Professor Kamaldeep Bhui (Queen Mary's University): *Khat use and mental health*

Individuals attended these meetings from the following organisations:

Bristol Resource Centre
Bristol Somali Resource Centre
Cardiff and Vale LHB
Communities First
Hamadryad CMHT
Kaleidoscope
Madadryad CMHT
MEC Newport Communities First
Newlink Axis Project
Public Health Wales
Somali Advice and information Centre,
South Wales Police
Workspring Nilari

Community Meetings were convened with the following organisations:

Brent Council
Hillingdon Council
London Somali Youth Forum
Manchester Drug and Alcohol Strategy Team
Somalia Diaspora UK

Meeting held on 5 September 2012 to gather information from MPs on constituency issues arising from khat use. Attendees:

Jeremy Corbyn MP (Labour, Islington North)
Paul Flynn MP (Labour, Newport West)
Mark Lancaster MP (Conservative, Milton Keynes North)
Fiona MacTaggart (Labour, Slough)
Eric Ollerenshaw OBE MP (Conservative, Lancaster and Fleetwood)
Representative from Sarah Teather's office

MPs correspondence:

Mark Lancaster (Conservative, Milton Keynes North)
Fiona MacTaggart (Labour, Slough)
Paul Flynn (Labour, Newport West)
Sarah Teather (Liberal Democrat, Brent Central)

Documents and Information submitted:

Scott Blinder, Senior Researcher, Migration Observatory, University of Oxford

The Honourable Senator Brett Mason, Shadow Minister for Universities and Research, Liberal National Party, Senator for Queensland, Australia

Professor Renos Papadopoulos, Centre for Trauma, Asylum and Refugees, Essex University

Contributing Officials:

Mr Gareth Hewitt, Head of Substance Misuse Policy and Finance - Wales

Mr John Somers, Head of Strategy, Treatment and Prevention - Drugs Policy Unit Scotland, Scotland

Mr Gary Maxwell, Health Development Policy Branch – Northern Ireland

Mr John McCracken, Drugs Program Manager, Department of Health

Ms Angela Scrutton, Head of Drug Legislation, Home Office

Mr Cyrille Marcel, Drug Legislation Adviser, Home Office

Annex C – ACMD Members

Ms Gillian Arr-Jones	Chief Pharmacist – Care Quality Commission
Mr Martin Barnes	Chief Executive – DrugScope
Commander Simon Bray	Commander – Metropolitan Police
Dr Roger Brimblecombe	Pharmaceutical Industry
Ms Annette Dale- Perera	Strategic Director of Addiction and Offender Care – NHS
Dr Paul Dargan	Consultant Physical and Clinical Toxicologist – Kings College
Professor Simon Gibbons	Professor of Phytochemistry – University of London
Ms Sarah Graham	Director – Sarah Graham Solutions
Dr Linda Harris	General Practitioner Chief Executive of Spectrum Community Health
Professor Raymond Hill	Visiting Professor of Pharmacology Pharmaceutical Industry
Professor Leslie Iversen CBE	Chair of the ACMD. Retired Professor of Pharmacology – Oxford University
Ms Kyrie James	Solicitor-Advocate (non-practising) Member of the International Association of Women Judges Member of the UK Rapporteur’s Working Party on Vulnerable Persons of the International Association of Refugee Law Judges Member of the Council for Immigration Judges Lecturer at Centre for Trauma, Asylum and Refugees, Essex University
Mr Nigel Kirby	Branch Head, Drugs and Firearms - SOCA
Mr David Liddell	Director – Scottish Drugs Forum

Dr Hew Mathewson CBE	Dentist Former President of the General Dental Council
Professor Fiona Measham	Lecturer in Criminology – University of Lancaster
Mrs Jo Melling	Director – Oxfordshire Drug and Alcohol Action Team
Mr Graham Parsons	Pharmacist with Special Interest in Substance Misuse – NHS
Mr Richard Philips	Directors – SMART Recovery UK
Mr Howard Gray Roberts	Retired Deputy Chief Constable
Professor Fabrizio Schifano	Chair of Clinical Pharmacology and Therapeutics – University of Hertfordshire Consultant Psychiatrist (Addictions) – Hertfordshire Partnership NHS Foundation Trust
Professor Harry Sumnall	Professor in Substance Misuse – Liverpool John Moores University
Mr Arthur Wing	Retired Director of Intervention – Surrey and Sussex Probation Trust

Officials

Mr William Reynolds and Miss Rachel Fowler – ACMD Secretariat

Annex D – Education and Prevention Template

Environment: Good drug education is:

- a. Underpinned by a whole school approach
- b. Enhanced by family-based prevention programmes

Planning: An Appropriate Curriculum is:

- Relevant and responsive to the developmental stage and circumstances of the children and young people
- Taught in the context of other personal, social and health issues
- Manageable given available resources
- Informed by programmes that produce achievable outcomes
- Developmental: re-visited, consolidated and extended throughout childhood and youth
- Supported by appropriate training
- Evidence based and/or evaluated

Practice: The Educator:

- Creates a comfortable classroom climate
- Uses interactive teaching styles
- Is responsive to different cultural views and realities
- Includes a normative component

Content: The Selected Materials and Activities:

- Explore attitudes to drugs and drug users
- Provide children and young people with opportunities to develop social skills

- Use credible, reliable and up-to-date sources to explore, contrast, and, where appropriate, support (or challenge) attitudes to self and others, to drugs, to drug use and non-use - and to drug users and non-users
- Strengthen protective factors
- Minimise risk factors

Evaluation: The programme is informed by:

- Assessment
- Monitoring
- Impact evaluation