Home Office

Professor Les Iversen
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Dear Professor Iversen

I wish to thank the ACMD for its extensive report and in particular its efforts to engage with affected community groups in order to give due consideration to public concerns. The ACMD's thorough assessment and my own considerations underline the complexity of this issue.

As the ACMD report acknowledges, whilst the evidence base has developed since its previous review, aspects of it continue to be limited. Based on ACMD's advice, I recognise that current evidence shows no direct causal link to medical harms, though it does point to a small risk of serious liver disease amongst long term users.

Khat use continues to feature prominently among the health and social issues (such as low attainment and family breakdown) cited by the khat-using communities and the police and local agencies working with them. This is despite continuing local efforts to address these issues. ACMD's advice makes clear the difficulty in disentangling whether khat is the cause or a symptom of these social harms. The ACMD has come to a reasonable conclusion based on the available evidence on harms, but I remain concerned that there is an absence of robust evidence in a number of areas, as also acknowledged by the ACMD.

I also have to consider the UK's role in the international community. The UK is one of the few Western countries not to have controlled khat. The whole of northern Europe, the majority of EU member states as well as most of the G8 countries (including the US and Canada) control khat. The ACMD has been made aware of concerns that khat is being re-exported to countries where it is illegal and that the UK is a transport hub. The ACMD acknowledged that this activity was likely to occur though it was not presented with any evidence of the scale of this activity. There are certainly reports, which the ACMD is also

aware of, of khat being smuggled through our borders to countries where it is illegal including Scandinavia, the US and Canada. This indicates that criminal elements already operate under cover of the UK's khat trade, taking advantage of the UK's position being out of step with those receiving countries.

I have looked at this issue particularly in the context of introduction of a full ban on khat in The Netherlands in January. I am concerned that this places the UK at serious risk of becoming a single, regional hub for the onward illegal trafficking of khat. Border Force report increasing seizures, in terms of both quantity and volume (in two cases in excess of one tonne) by EU law enforcement partners of khat in transit from the UK to The Netherlands in recent months. The seizures, within French and Dutch borders and at exit points from the UK, provide evidence that the UK is already becoming a transit point for khat supply to the Dutch market in addition to those other countries where it is banned. It is clear to me that the UK's responsibilities to the international community in tackling drug trafficking with its wider implications for the UK will go unabated if we do not take action.

The Government is entitled and expected to take a broader view, taking into account other factors relevant to the issue at hand. In this case, I have taken account of the risks arising from the limitations concerning the available evidence base on health and social harms, the community concerns, the UK's national interest and our international responsibilities.

I have therefore made the decision to control khat under the Misuse of Drugs Act 1971– as a Class C drug, in line with the current control of its active ingredients. This is not a decision which I have taken lightly. It is not, nor should it be perceived to be, a rejection of the ACMD's assessment of the available evidence at the time of its review. On this occasion, with the broader role I have under the Misuse of Drugs Act 1971, I have come to a different view to that of the Council. I will be working with our partners to ensure that we have robust yet proportionate policing of possession cases by introducing an escalation framework for the possession of khat for personal use, similar to that in place for cannabis**.**

I am very mindful that the ACMD's report gave us more insight into the issues affecting these communities and made a number of other recommendations for community-based interventions to address health and social issues and a multi-agency approach to address wider community issues.

I am supportive of these. They can inform how we approach and respond to the needs of individuals and local communities affected by khat use. Through initial consultation with other departments, who have key interests that are engaged here, it has become clear that their responses would be significantly influenced by the decision I have now made on control. It is important that we act in concert across government to ensure that our policies and those of local organisations involved in local delivery are reviewed in the lead up to, and following, the control of khat. For that reason and to ensure that we take full advantage of the ACMD's findings and recommendations, we will now consult further across Government. I aim to provide a further response to the ACMD soon.

I am copying this letter to the Secretary of State for Health and the Secretary of State for Communities and Local Government.

The Rt Hon Theresa May MP