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POSTNOTE

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Minimising the harms of khat

The Government has announced its decision to control the herbal stimulant khat as a Class C drug under the Misuse of Dugs Act 1971. Earlier this year, the Advisory Council on the Misuse of Drugs (ACMD) found insufficient evidence of khat as a cause of harms to justify a ban.[1] This POSTnote summarises the evidence on the impact of khat on health and possible social harms in the UK and comparable international experiences of legislation and control.

Overview

- In the UK khat consumption is largely limited to immigrant communities from the Horn of Africa and the Red Sea Littoral.
- Over the past decade the media, politicians and immigrant communities have expressed concern over the medical and social harms associated with khat consumption.
- In January 2013 the ACMD reported that there is insufficient evidence of harms to justify a ban; instead it recommended the provision of education and therapeutic services amongst relevant UK communities.
- In July 2013 the Government decided to control khat on the grounds that this will protect vulnerable members of communities and send a clear message to international partners that the UK is serious about stopping the illegal trafficking of khat.

Background

Use of Khat in the UK

Khat is a plant product chewed for its mild stimulant effect. The Government has decided to control khat as a Class C drug under the Misuse of Drugs Act 1971 (Box 1). Previously only its active compounds, cathinone and cathine (Box 2), were controlled when isolated (Class C). The Government argues that a ban on the herbal product will "protect vulnerable members of communities and send a clear message to international partners that the UK is serious about stopping the illegal trafficking of khat".[2]

In the UK khat is consumed almost exclusively within communities from East Africa and the southern Arabian Peninsula. It is chewed in family homes, at community events and in khat cafes. Typically chewers consume one or two bundles per session of four to six hours. A bundle costs between £3 and £6 depending on type, quality and freshness. In the original areas of khat production, chewing khat is seen as an aid to religious contemplation and as a medicine. In the UK, although many immigrants see khat as a cultural practice linking them to their country of origin, it often serves a recreational and social function.[3]

The UK Khat Economy

UK khat arrives into Heathrow on chartered flights from Kenya (mostly), Yemen and Ethiopia. After passing Her Majesty's Revenue and Customs (HMRC), khat is transferred to a warehouse in Southall, from where it is distributed to retailers across London and other UK cities. Since February 1998 khat has been classified as a 'stimulant drug' by HMRC and so is standard-rated for VAT at 20%. In 2012/13 HMRC collected £2.5m of an import

Box 1. ACMD, Drugs Policy and Khat Classification

The Advisory Council on the Misuse of Drugs (ACMD) was established as an independent expert advisory body under the 1971 Misuse of Drugs Act. Its remit is to advise Government Ministers on measures to prevent the misuse of drugs or to deal with the social harms connected with their misuse. ACMD has twice (2005 and 2013) 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. The Act classifies drugs as:

- 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

In July 2013 the Government announced khat would be controlled as a Class C drug.

Box 2. The Pharmacology of Khat

The leaves and shoots of khat contain more than 40 complex compounds including the alkaloid stimulants cathinone and cathine. Stored khat leaves lose their stimulatory properties rapidly, becoming physiologically inactive after about 36 hours as the more powerful cathinone decomposes leaving behind the milder, less active, cathine.

Chewing khat is an efficient way of extracting cathinone and cathine by the action of enzymes in saliva. The potential for users to become dependent on khat is limited by two key characteristics. First it takes a long time for the active ingredients to reach maximal levels in the blood. Second the bulky nature of the herbal material limits the maximum dose that can be received. Khat is unlikely to be used to extract pure forms of cathinone and cathine as they are easier and cheaper to manufacture synthetically.

value of £12.4m. HMRC figures show that khat imports have fallen since 2005. This could mean that the formal UK khat economy or its possible role as an international hub is shrinking, or that fewer traders are registering for a licence. Profits from the khat economy contribute to the wider UK economy through the Inland Revenue, and the business represents a means of employment for immigrants otherwise struggling to integrate into UK society.[3]

Community Concerns with Khat

UK Khat-using Communities

Concerns with khat are primarily reported by the UK Somali community. Some members of this community support a ban, claiming that khat is linked with social ills such as unemployment, criminal behaviour, domestic violence, family breakdown, educational underachievement, failed integration and even radicalisation. Women have often led the way in the UK anti-khat campaigns, citing khat as a major cause of divorce.

Islamic teaching on the use of khat varies. Some mosques support the ban because they consider khat as *haram* (forbidden) in Sharia (Islamic) law. However, other Islamic teaching – particularly in traditional areas of khat culture and consumption – does not consider the plant as forbidden.[4] In contrast to concerns expressed by some in the Somali community, a Government-commissioned report of 2010 found that within the UK Yemeni community khat is seen as unproblematic as it occurs in a family setting and is integrated into other domestic events.[5] Kenyan and Ethiopian attitudes towards khat are less well researched.

Wider UK Public Concerns

The consumption of khat first came to wider public attention in the UK in the late 1980s. Initial concerns focused on a possible link between khat use and psychosis. The attention of media, academic research and politicians has since grown in scope and volume as the size and visibility of the relevant immigrant communities has increased. In some areas, non-user populations living side-by-side with immigrant communities view the sale and use of khat as a source of public nuisance and crime. Khat is entangled with wider debates and social tensions related to immigration, integration and marginalisation (discussed below).

The ACMD Reviews

The ACMD reviews of khat (2005[6] and 2013) focused on the prevalence of use and possible medical and social harms. ACMD stressed the comprehensiveness and inclusivity of its investigations in order to ensure that concerns raised about the social harms of khat were properly investigated. It considered peer reviewed articles, surveys and data from government bodies and conducted community visits and discussions with council leaders to inform its inquiries.

Prevalence of Use in the UK

There is a strong consensus that khat consumption in the UK is limited to Somali, Ethiopian, Yemeni and Kenyan communities. Very limited population data are available for khat consumption among such communities in the UK. The Crime Survey of England and Wales first asked questions about khat use in October 2009 (it was then the British Crime Survey). The 2011/12 survey recorded that across the whole UK population 0.2% of 16 to 59 year olds reported the use of khat.

NHS data on treatment of khat users suggest that few people seek help because of the drug. For instance, Northern Ireland and Scotland do not report any figures on treatment of khat users through NHS services, and the Welsh National Database for Substance Misuse reports only six referrals since 2009. In England in 2011/12, 112 people who began drug treatment cited involvement with khat as a factor.

A reported concern in the relevant UK communities is of increasing khat use among young people. However, most research among UK Somali communities suggests that khat use is more popular in older, first generation immigrant males. It is less popular among second and later generation immigrants, especially in comparison to other recreational intoxicants. A Home Office commissioned literature review identified a need for rigorous monitoring of consumption patterns in the UK to generate an evidence base for policy.[3]

Medical Harms

Khat is often reported as a direct cause of medical harms by members of the UK Somali community. While anecdotal evidence is useful in establishing research priorities, the overall evidence on khat use and medical harms is inconclusive. This is partly due to the confounding factors present in the communities studied (see later).

ACMD has noted that khat use has the potential to develop into dependency. But it concluded that this is much less likely than dependency on stimulants like amphetamine and more like the type of dependency seen with caffeine.[6] Withdrawal symptoms are reported, but do not necessarily imply a withdrawal syndrome and are more comparable to a 'morning after' experience. The Department of Health has reported that khat users may have a greater risk of dependency if displaced, disadvantaged or discriminated against.[7] However the plant stimulant has a number of properties that limit its potential for addiction (Box 2). In 2006 the World Health Organization (WHO) concluded that the abuse potential of khat was mild.[8]

The ACMD report reviewed research related to potential medical harms from khat consumption under a number of headings: cardiovascular, respiratory, oral and gastrointestinal, liver, pregnancy, psychiatric, cognitive impairment and morality. It concluded that "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". It also highlighted a number of confounding factors from associated activities and the wider social context (see below). ACMD concluded that "clinicians should consider khat as a potential cause of liver disease" in cases of "otherwise unexplained liver injury" in patients "from ethnic communities where khat use is prevalent".[9]

Social Harms

Among the social harms most commonly linked to khat are:

- Khat may be a **barrier to employment** when used as a recreational drug. While there are problem users who experience difficulties, there is no clear evidence of a causal link and the majority of khat chewers appear able to moderate their consumption around work patterns.
- **Excessive expenditure** on khat and the diversion of household income is often cited by UK Somali women as a cause of marital tension and family breakdown, and has been central to the calls for a ban on khat. However, it is difficult to distinguish such claims from confounding factors amongst the UK Somali population (next section).
- Claims linking khat use with **criminal behaviour**. In countries where khat is illegal, khat-related crime is confined to the drug's importation, distribution and use. ACMD also found no evidence supporting media[10] and other[11] reports linking UK khat use and the UK khat economy to gang violence, serious and organised crime, radicalisation and international terrorist groups.
- Community concerns with perceived **low level public disorder** associated with khat in the UK and elsewhere. This includes congregation of Somali men in the streets, loud and unusual behaviour and spitting. Such behaviour can be successfully tackled by local police teams working with local government agencies and community members.[12]

Confounding Factors

Research has struggled to differentiate between potential medical harms of khat use and other factors such as poor general health and health literacy, problems with integration into UK life (Box 3), lack of access to health services and high levels of tobacco smoking in khat-using populations. Moreover, research on the medical harms of khat is further confounded by the acute and chronic mental health and physical issues facing first generation settlers, many of whom were traumatised by civil war and human rights abuses in Somalia. Such factors mean that research has not been able to establish a direct link between khat use and psychosis. However, it does appear that khat use can complicate existing treatment of mental health problems and trigger such problems in vulnerable individuals. Some khat users report experiencing a sense of well-being in their consumption and believe that khat is beneficial to health.

Box 3. Problems with integration

Those seeking to explain the difficult experience of integration for many men among the UK Somali population highlight what they describe as a 'gender crisis' in the community. Most Somalis arriving in the 1990s were women and children who were often successful in establishing themselves and adjusting to UK law and language. Men arrived later and struggled more to integrate into the economy and wider UK society. There is concern that the difficulties of integration, unemployment and changed social status may have contributed to a change in the nature of khat consumption that is excessive and detrimental to physical well-being, family and community at large. The impact of khat on integration is a particular concern in Scandinavia and in the UK among the Somali community. However there is no evidence that khat itself impedes integration.

There is no evidence to support these claims and the ACMD report (2013) highlighted the importance of informing users of the potential for harms of khat in ways sensitive to their cultural, linguistic and community contexts.[1]

ACMD Recommendations

ACMD (see Box 1) reviewed the harms of khat in 2005. The Council wrote to the Home Secretary in December 2005 that: "Use of the substance is very limited to specific communities within the UK, and has not, nor does it appear likely to, spread to the wider community".[6] It recommended that khat not be controlled under the Misuse of Drugs Act 1971, but suggested that the "use of khat had detrimental effects" and "should be discouraged". It recommended the provision of education and information to users and potential users of the harms associated with khat, of effective advice and treatment and the restriction of supply to children. The Government accepted the ACMD's recommendations. However, up-take of education and treatment services implemented since the report has been limited.

In 2010, the Government asked ACMD for further advice on the "harms caused to individuals and the societal harms in the affected UK" communities. In January 2013 ACMD wrote to the Home Secretary "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 social indicators, it is not possible to conclude there is a causal link". ACMD concluded "the evidence of harms associated with the use of khat is insufficient to justify control and it would be disproportionate to classify khat".[1] It recommended "communities be supported and given the appropriate resource and environment within which they can manage issues" such as integration and inequalities of health".

The Government's response in July 2013 noted that "the whole of northern Europe... have controlled khat" and that failure to "change the UK's legislative position on khat would place the UK at a serious risk of becoming a single, regional hub for the illegal onward trafficking of khat to these countries". On harms, the response noted that "the Government are concerned that we risk underestimating the actual harms of khat in our communities owing to the limitations of the evidence base available to the ACMD". It concluded that to "ensure a proportionate and robust

Table 1. International Laws on Khat

Country	Legislation
Australia	Review 2009 advised against further legislation. Some restrictions but laws vary between states.
Canada	No review of harms. Possession legal but import and trade prohibited in 1997.
Denmark	No review of harms. Import, trade and consumption prohibited in 1993.
Netherlands	Reviews in 2008 and 2011 concluded no need for prohibition. Khat included in List 2 of the Opium Act in 2013 making trade and possession punishable.
Norway	No review of harms. Import, trade and consumption prohibited in 1989.
Sweden	No review of harms. Import, trade and consumption prohibited in 1989.
USA	Restricted by federal law but state law varies.

policing response, the Government will introduce an escalation framework for the possession of khat for personal use, similar to that in place for cannabis".[2]

The Control of Khat

International Regulation of Khat

The WHO has conducted two reviews – in 1964 and 2006 – of khat; neither recommended prohibition of the plant. However, concerns over the abuse potential of the pure forms of khat's active ingredients cathinone and cathine led to them being scheduled as psychotropic substances in 1988. This prompted legal prohibitions of the plant khat in North America and Europe (Table 1). Justifications for these prohibitions varied and included references to khat's abuse potential, public nuisance, links to organised crime and acting as a barrier to integration of immigrant communities into wider economy and society. In one case – the Netherlands – reviews of harms were commissioned prior to introducing national legislation; neither recommended prohibition or further legislation.[13,14]

Prohibition, Crime and International Trafficking

In general, the potential for the international trafficking of khat is limited by the short shelf-life of the plant product (see Box 2). Where khat has been banned elsewhere in Europe and North America there is no evidence that demand has been reduced. For instance when Norway introduced a ban on khat in January 1989, Gothenburg became a major entrepot for Norway-bound khat until Sweden introduced its ban later the same year. Following Sweden's ban, Denmark became a major destination for Swedish consumers of khat until the Danish ban was introduced in 1993. Since the ban in Sweden, official figures show that Swedish seizures of khat have risen.[15]

In Canada, there has been exploitation by criminal elements of the underground market created by the ban. In 2009 the police reported the first case of the use of marine transport to smuggle freeze-dried khat into Canada as an alternative to smuggling by air.[16] The police see enforcement of the ban as a nuisance and low priority. Local Somalis feel police target them fuelling an existing sense of discrimination.[17]

Australia's regulatory framework has been cited as a middle ground between a free-market approach and an outright ban. Regulation is through a regime of overlapping and differing Commonwealth, state and territory laws. Victoria State where most Australian East African immigrants live has no restrictions on consumption but importers must hold a licence and permit issued by the Office of Chemical Safety and Environmental Health. A review in 2009 found no substantive evidence of medical and social harms and recommended no change to Australian legislation. A further review in 2012 saw no need for a ban, but did recommend that the law be made clear in each state.[18]

Protecting Vulnerable Members of Communities

The ethnic specificity of khat consumers means that there is a risk that the prohibition of khat could result in a worsening of the relationship between these ethnic communities and the police. This could add to a sense of discrimination in an already economically and socially marginalised population.[9] Community groups that provided evidence to the ACMD highlighted a lack of ethnically-sensitive service provision – for example on the potential harms of khat use – and the need for further involvement of ethnic minority groups in drugs control. This chimes with studies for the UK Government[19] and the EU[20] that have highlighted the need "to develop more accessible and appropriate [drug] services" for ethnic minority communities. The Government recently announced a review of some policing tools used to combat drugs offences recognising that they have been used disproportionately against ethnic minority communities.[21]

Endnotes

1 *Khat: A review of its potential harms to the individual and communities in the UK (2013)*, ACMD, 2013
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3 *Khat:-social harms and legislation. A literature review.* HO OP95, 2011
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21 *Home Secretary launches consultation into stop and search*, HO press release 2 July 2013

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