Summary of Home Office report ‘Perceptions of the social harms associated with khat use’ and media/policy update

Anthony Thickett

A.Thickett@mdx.ac.uk

Research Report 44 The report

Perceptions of the social harms associated with khat use

Wendy Sykes, Nick Coleman, Philly Desai, Carola Groom, Mohamud Gure, Radhika Howarth
Independent Social Research

1. Introduction

This is the report of research into perceptions of social harms associated with the use of khat in Somali, Yemeni and Ethiopian communities in England and Wales. Views were sought from within these key communities, from professionals and practitioners directly involved with them, from mainstream drug and alcohol service providers and from members of the wider UK population. The research was carried out in London, Sheffield and Cardiff with fieldwork conducted during May and June 2009.

Research objectives

The research was to:

- explore the perceived social harms associated with khat affecting the user, his/her family and the wider community;
- explore differences in perceptions of harms by age group, country of origin and gender;
- investigate the level and type of service available to khat users and their families, and the expectations and needs of khat users from services;
- investigate views on the appropriate Government response to khat.

Background

Khat (quat, qat, chat) has been described as 'the most recent plant-based psychoactive substance to spread across global markets' (Anderson *et al.*, 2007) and is grown and consumed mainly in East Africa and the Middle East. Users chew the leaves and stems over several hours to allow the active components to be isolated by enzymes in saliva and absorbed through the oral mucosa.

The alkaloid stimulant components of khat (cathine and cathinone) are Class C controlled substances[2] if extracted in their chemical form. However, it is legal to import, sell and consume khat itself in the UK.[3] A distribution network ensures it reaches customers as soon as possible after harvesting. Freshness is important because the strength of khat starts to degrade 36 hours after picking.

In February 2005, the Government invited the Advisory Council on the Misuse of Drugs (ACMD) to advise on the use of khat in the UK and associated risks (ACMD, 2005). The ACMD report compared the pharmacology of khat with that of amphetamines but with effects that were much less dramatic (in this study, users reported that khat helped keep them alert and also relaxed and talkative.) The report confirmed the main khat chewing communities in the UK are Somali, Ethiopian and Yemeni and also Kenyan. The ACMD found no information on prevalence in the general population. They reported various studies, but none using random sampling techniques, that had found high levels of occasional use of khat in the three main communities. Levels were highest among males and among Somalis. Among male Somalis, levels of well over 50 per cent were reported but again not through large-scale random sampling methods. The same studies found that percentages reporting they chew every day were much lower, in single figures.

2 Misuse of Drugs Act 1971.
3 Khat is banned in the US and Canada, as well as in a number of European countries.

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

The Research, Development and Statistics Directorate exists to improve policy making, decision taking and practice in support of the Home Office purpose and aims, to provide the public and Parliament with information necessary for informed debate and to publish information for future use.

© Crown copyright 2010 ISSN 1756-3666 ISBN 978 1 84987 360 4 October 2010

Home Office

Issues addressed

- Practices and consumption trends
- Cultural attitudes
- Health and social harms
- Attitudes towards possible government intervention
- Review of treatment and support services

Practices and trends

- Khat used by 0.2% of UK population but 50%+ of Somali males
- Market said to have ‘increased significantly’ in recent years
- Use ‘widespread’ across the UK Somali, Yemeni and Ethiopian communities
- Connection with countries of origin
- ‘Culturally specific alternative to alcohol’
- ‘Typical’ user might chew once or twice a week
- Few participants thought khat use would spread to the wider community

Social and health impacts

- Positive and negative social impacts
- Negative impact on family life and a barrier to integration
- Few reports of khat-related anti-social behaviour
- Physical health impacts perceived to include heart and liver problems, cancers related to the use of chemicals and tooth loss
- Mental health impacts – paranoia, depression and mood swings

Attitudes to government intervention

- Range of perspectives with views ranging from support for a complete ban to those advocating quality control and/or sale restrictions
- Gendered issue
- Concerns expressed about criminalising large numbers of law-abiding citizens, possible increase in cost and the creation of criminal markets

Treatment and support services

- Only 15 of the 121 DATs that responded to the a request for information from the research team reported offering services for khat users/their families
- Of those, only 7 offered khat-specific services
- Low demand for services, lack of funding, difficulties engaging communities and questions about the cultural appropriateness of existing service delivery models all cited
- Acknowledged need to get more information to users

Khat in the media

- ‘Khat use spreads to British youth’ (bbc.co.uk)
- ‘Drug could cause anti-social behaviour in Slough’ (bbc.co.uk)

Policy context evolution

- ‘a future Conservative government would legislate to make khat a classified drug’ (Sayeeda Warsi, 2008)
- October 2010: announced that the ACMD to undertake a further review of the available evidence on khat to update its assessment and provide the government with advice both in relation to control under the 1971 Misuse of Drugs Act and a wider response