Appendix 1

Khat in Brent – what are the health and social consequences of Khat use and how can the council and partners work with users and affected communities to limit any negative impacts of Khat use?

1. What are the main issues? *what is the policy background, how does it link to the council's corporate priorities?*

1.1 Members have been concerned about Khat use in Brent for some time. In recent years there have been two reports presented to the Health Select / Health Partnerships Overview and Scrutiny Committee on the issue. Members have decided that this subject warrants more in-depth investigation and have decided to establish a task group to look at the following issues:

- The perceived impacts of Khat use on the community in Brent, particularly the health and social consequences of Khat use.
- Whether anything can be done to address the problems associated with Khat cafes
- Whether more effective treatment services and diversionary activities can be put in place in Brent aimed specifically at Khat users.

1.2 Background – what is Khat?

1.3 Khat is a herbal product consisting of the leaves and shoots of the shrub *Catha edulis*. It is cultivated primarily in East Africa and the Arabian Peninsula, harvested and then chewed to obtain a stimulant effect. There are many different varieties of *Catha edulis* depending upon the area in which it is cultivated.

1.4 Khat is currently imported and used legally in the UK. In February 2005 the Minister Responsible for Drugs asked the Advisory Council on the Misuse of Drugs (ACMD) to advise the government as to the current situation in the UK and the risks associated with Khat use. At that time the ACMD decided that it would be inappropriate to classify Khat under the Misuse of Drugs Act 1971. They reported that the prevalence of Khat in the UK is relatively low and isolated to the Somali and Yemeni communities. They found there was no evidence of Khat use in the general population. Furthermore, the evidence of harm resulting from Khat use was not sufficient to recommend its control. However, in 2010 the ACMD was asked again to review the available evidence on Khat. It agreed to do this and that review is currently in progress.

1.5 Khat is not currently controlled under the Misuse of Drugs Act 1971 but the two main psychoactive component chemicals, cathinone and cathine, are classified as Class C drugs under the Act. An offence is committed if cathinone or cathine are extracted from the plant. This offence has been identified but there have been no successful prosecutions to date.

1.6 There is evidence of widespread Khat use in the Somali, Ethiopian, Kenyan and Yemeni communities in the UK. Brent has a significant Somali population and it is use of Khat amongst this group that has been of concern to members and also to members of the Somali community.

1.7 Khat imports arrive in the UK daily and there is an efficient distribution network to the Khat using communities. In the first 6 months of 2005 there were imports each day of approximately 5-7 tonnes from Kenya, 500kg from Ethiopia and 175 kg from Yemen (equates to roughly 25000 bundles or doses), the bulk of which was held in transit for export to the USA. Most users buy Khat at the *mafresh* a meeting place where Khat is bought and chewed. As the trade in Khat is a legitimate business, it is quite distinct from the trade in illegal drugs.

1.8 *Mafreshi* are subject to health and safety requirements as they are public areas where Khat is sold but many are unknown to the local authorities. Khat can also be bought at small shops within the ethnic community to be used alone at home or with friends. An alternative supply of Khat is via 'mobile traders', these people sell Khat from the back of a car or van on the street.

1.9 There is no specific evidence linking Khat use, distribution or selling networks to serious organised crime in the UK from published media or any of the law enforcement agencies that presented information to the ACMD Khat Working Group. It is clear that Khat dealing in the UK is a low profit business. The ACMD believes that if Khat were to become more expensive due to criminalisation there is the potential for exploitation by organised criminal gangs already involved in the trade of illegal drug.

1.10 Drugs that have a fast onset of action have a high addictive potential. Although chewing Khat is an efficient way to extract the active ingredients, it takes a long time to reach maximal plasma levels (around 2 to 2 ½ hours) and hence Khat has less reinforcing properties than other stimulants such as amphetamine and cocaine. That said, heavy users do display the symptoms of addiction.

2. Why are we looking at this area? Have there been recent legislation/policy changes? Are there any performance or budgetary issues?

2.1 There are three main issues associated with Khat use that have been of concern to members. The first is the perceived health and social impacts of Khat use on the community in Brent. The ACMD report into Khat set out a number of possible harmful effects of Khat. In summary, these were:

- It has been linked to family breakdown and violent behaviour
- It can effect users employment prospects if they spend too much time taking Khat
- Spending on Khat can mean that money needed for other essential household items isn't available

- Extensive Khat use prevents immigrant communities from integrating with wider society
- Khat users report increased levels of energy, alertness, self esteem and sensations of elation. However, over stimulation of the central nervous system can lead to psychiatric disorders and there are reports of people developing psychosis after Khat use. There are, as yet, no studies that prove this link.
- Khat use can lead to sleeping problems, loss of appetite, tiredness and a depressed feeling the day after use.

2.2 The link with psychosis is an interesting one. The ACMD reports that many of those people who have settled in the UK from Khat using communities may be more susceptible to psychosis because of trauma suffered in their home country or in getting to the UK and dealing with the subsequent immigration process. What is less clear is whether Khat the cause of psychosis or a convenient scapegoat. Anecdotal evidence suggests a link between Khat use and psychosis, but it is not a proven link.

2.3 Despite the harmful side effects Khat is said to be an important part of the culture of user communities, particularly at social occasions such as weddings, funerals, parties and religious ceremonies. But it was not clear to the ACMD whether a person's Khat use is the cause of family disruption or again, the scapegoat for it. There is little evidence that Khat fuels acquisitive crime in the way that other drugs do, nor does it appear that Khat users abuse other drugs. This maybe because Khat users do not have to come into contact with dealers who sell a range of illicit drugs.

2.4 The task group will explore these issues with the community in Brent, and gather together evidence of real life experiences of Khat use and the impact that it has had on family and social networks. In particular the group will consider the impact that khat use has on women and children, if their husband / father is a persistent khat user. The group will also explore how younger users are getting into khat and the efforts that are being made to stop this from happening.

2.5 The second issue is the proliferation of Mafreshi, or Khat cafes in the borough. These are now in many of the borough's wards and may be operating under the radar of the local authority, in poor conditions and without the proper licensing and health and safety arrangements in place. There is also concern that the cafes are magnets for antisocial behaviour. The group will focus on specific areas of the borough, such as Church Road to look at the consequences of a concentration of khat cafes and shops selling khat in one area. The Task Group will find out whether there is anything that can be done to address the problems associated with Khat cafes.

2.6 Finally, a report to Health Partnerships Overview and Scrutiny Committee in February 2011 outlined the services available for Khat users in Brent. They are:

- The DAAT will improve access to services for those affected by Khat through the development of the Cobbold Road Treatment and Recovery Service which will offer a range of treatment interventions including assessment and triage services, structured day programmes, one to one

working, counselling services and onward referral to clinical and residential services.

- A Khat support group is already offered through Addaction via Cobbold Road with outreach and engagement services to be undertaken by CRI Brent Outreach and Engagement Team (BOET).
- Counselling Services for BAME communities are already provided through EACH. In 2011-12, these will be provided through two sites (Wembley Centre for Health and Care and the Cobbold Road Treatment and Recovery Service) will further provide support and counselling for Khat users and their families.
- Funding will be sought in partnership with Brent Council Community Safety Unit to develop a work programme with the Help Somalia Foundation for a Peer Mentoring Project with Somalian youth in the Church End area to raise awareness of Khat misuse and to work with outreach and engagement services to improve awareness of local treatment provision and access to GP practices.

2.7 It is acknowledged that services for Khat users are underdeveloped. Users themselves are said to be reluctant to use mainstream addiction services as they do not feel Khat addiction warrants the interventions associated with other substance addiction. They also do not wish to be stigmatised within the community for using mainstream addiction services. The task group will consider what alternative treatment options are available in the borough, including alternatives to "traditional" drug treatment services, such as diversionary activities, employment and volunteering opportunities and ways to empower khat users in order for them to make more positive choices about their lifestyle and they way they spend their time.

3. Methodology for the Review

3.1 The task group's work will focus on a number of issues:

(i). Consider the social implications of Khat use to determine whether there are significant problems within user communities, especially Brent's Somali community.
(ii). Consider whether the health of Khat users in Brent has suffered as a result of their use of the drug.
(iii). Consider the impact that Khat use has had on families in Brent, particularly for women and children.
(iv). Determine whether the Khat cafes in Brent are the cause or contributor to antisocial behaviour and health problems and whether there is any steps that can be taken to address these issues.
(v). Consider whether more effective treatment services can be put in place in Brent aimed specifically at Khat use.
(vi). Identify good practice already happening in Brent (such as the Help Somalia Foundations khat outreach work) and see what can be done to assist community organisations working with khat users.
(vii). Work with the local community to develop possible recommendations and solutions that can be implemented and lead by the Somali community in Brent.

3.2 In order to start this work the task group is keen to meet with people from the Somali community in Brent in order to get community buy in to the task group. Although a broad set of terms of reference have been drafted, community

involvement in this work is crucial, particularly if the recommendations are to have any impact on local people and services. A task group launch event with community representatives was held on the 19th May and this scope has been developed to reflect the views put forward at that meeting.

3.3 The task group will also:

- Interview members of the Somali community in Brent about their experiences of Khat use within the community and consider the work that is already taking place to tackle the problems associated with khat in Brent.
- Carry out site visits to Khat cafes and the surrounding localities to give members an opportunity to see how they operate, consider the immediate environment around the cafes and also (if possible) to speak to owners and customers about the use of Khat.
- Consider the powers that the council has to license Khat cafes to ensure that they are operating legally, and if they're not, to see what steps can be taken to close them. Contact will be made with Environmental Health, Licensing and Trading Standards on this issue.
- Consider why people are using cafes beyond chewing khat. Is it for social reasons, or to get their news or information on events in Brent or Somalia? If so, is there an alternative to the cafes, where khat isn't chewed?
- Meet with officers from local housing associations, Brent Community Safety Team, the Safer Neighbourhood Teams and the DAAT to assess the problems associated with Khat use, especially around the Khat cafes and treatment available for Khat users in Brent.
- Consider best practice in other boroughs in dealing with problems associated with Khat (for instance, Tower Hamlets has produced a Mental Health Needs Assessment for its Somali community, and Hillingdon has just completed a Khat Scrutiny Review) and see what good practice can be applied in Brent.
- Engage with the Advisory Council on the Misuse of Drugs to see how Brent can assist in their ongoing review into Khat.
- Map the location of Khat cafes and vendors in Brent to show which areas are most affected by Khat use.

3.4 The review will begin in April 2011, with an intention to report to the Health Partnerships Overview and Scrutiny Committee on the 20th September 2011.

4. What could the review achieve? Influence policy change, improvement to service delivery, budget savings, develop partnerships etc

4.1 The review will provide a comprehensive report on the use of Khat in Brent and the consequences this has for users and their communities. Ultimately the review report will be sent to the Advisory Council on the Misuse of Drugs to inform their review, and will influence policy and services in Brent.

4.2 The task group will ensure that any recommendations are agreed with the local community who will need to help implement and drive forward work to tackle problems associated with khat. The council will not be able to tell people to stop using khat – this has to be an individual choice, but one supported by people within the local community. The task group is realistic

about the impact it can have on khat use and will be pragmatic about the outcomes it is seeking to achieve and the recommendations it makes.

4.3 Potential outcomes will include:

- Clarity on the impact that Khat has on users and their families in the borough
- Evidence as to whether Khat use leads to use of other drugs or alcohol, particularly for young people
- Evidence, or not, of antisocial behaviour associated with Khat use, especially at Khat cafes. The task group will take a broad view of the situation in Brent, but will also focus specifically on smaller areas where there are concentrations of cafes, such as Church Road.
- Recommendations about Khat cafes, and whether there are any licensing implications
- Recommendations for treatment services for Khat users, that do not include mainstream addiction services and encourage the use of diversionary activities
- Information on the health impacts of Khat use, and possible ways to address these with users.
- A campaign with community groups in Brent to raise awareness of the consequences of taking Khat. The task group will also approach Somali TV and radio stations to see what support they can offer, if it is felt that this is appropriate.
- Contribute to the Advisory Council on the Misuse of Drugs review into Khat that is currently underway.