Check Delivery

Khat Facts Launch

Speech Made During National Tackling Drugs Week

By Dr Brian Iddon
Member of Parliament for Bolton South East

At the Bolton Science and Technology Centre, Farnworth

Friday 12 June 2009

CHAIRMAN, LADIES AND GENTLEMEN:

I Thank the Bolton Solidarity Community Association for inviting me to address this gathering during 'National Tackling Drugs Week', and I congratulate all the agencies in Bolton for working so well together in partnership to deal with one of the greatest social problems that has faced our developed society, namely the misuse of substances, and I include all drugs under that heading, controlled and legal drugs alike, including alcohol and tobacco.

First I want to say something about '**khat**' and then I want to say something about the classification of drugs and 'substance displacement'. My speech is in two parts with a bridge in the middle linking the two parts.

I am presently Chairman of the All-Party Parliamentary Drugs Misuse Group (APPDMG) and have been for the past 10 years, although I will resign from this post on 16 June at the next meeting of the APPDMPG. Dai Davies, Independent Member of Parliament (MP) for Blaenau Gwent, will hopefully be elected in my place. Therefore, perhaps this is my valedictory address?

I first took an interest in khat in 2005 when my Parliamentary colleague Keith Hill, MP for Streatham, who was Tony Blair's Private Parliamentary Secretary at that time, was anxious that a report published by Drugscope might lead to the classification of this substance, thereby making its sale illegal. After reading that report, I advised Keith Hill in a letter, dated 30 December 2005, as follows:

> *Dear Keith*
>
> *"I received the copy of the report on 'Khat in Streatham: Formulating a Community Response', thanks.....*
>
> *....the problems being experienced by a minority of residents in your Constituency through older Somali men chewing khat do not appear to me to warrant making khat a proscribed drug under the Misuse of*

Drugs Act 1971. It is more of a community nuisance (blocking the footpath and spitting out the debris onto the pavement) in one small area - The Dip (more specifically a small section of Gleneagle Road).

The call for help to provide a community centre is the key recommendation to focus on, in my opinion.

There is no evidence in the report that khat is either addictive or damaging to health if used in moderation, including its capacity to cause mental disease problems. As the report points out, the people using it are already traumatised by their situation in many cases. Obviously, obsessive use of khat creates problems just as misuse of any psychoactive substance does, including tobacco and alcohol, and a route to treatment should be made available.

There doesn't appear to be any connection either between criminality and khat use.

There does, however, appear to be a problem with illegal street traders who should (apparently are being) dealt with."

I haven't changed my opinion about khat since that date, and I was interested to receive a copy of the 'Khat Conference Report' following a conference promoted by the then New Bolton Somali Community Association and held at the Reebok Stadium on 9 November 2007. I noted that the report is not calling for khat to be classified either. I sent copies of that report to our Ministers responsible for substance misuse at that time both in the Home Department (Vernon Coaker MP) and in the Department of Health (Dawn Primarolo MP). The report contains an excellent introduction to the origins of this stimulant drug and its biological effects, if you want to learn more about khat.

Nevertheless, there is a strong Parliamentary lobby at present to classify this substance. Calls are being made in both Houses of Parliament, and the Advisory Council on the Misuse of Drugs (ACMD) is looking at khat at present with a view to classifying it.

When I sat on the Standing Committee of the Drugs Act 2005, just before the 2005 General Election, there was an attempt by Conservative MP Cheryl Gillan to classify khat as a Class A drug through an amendment to the Bill. The Government rejected the amendment.

If it is to be classified in future, which is highly likely in the current climate, my guess is that it will accompany cannabis in Class B, but Class C would be more appropriate in my opinion, although I don't believe that it should be classified at all.

The khat plant, *Catha edulis*, contains over 400 chemicals but the principal psychoactive components are cathinone and cathine, both in there own right Class C drugs. The leaves of the plant have been chewed, mainly by males, for over

1,000 years in the Horn of Africa and down through the countries of East Africa, particularly in Somalia, Ethiopia and the Yemen.

Fast air transport means that it can be flown fresh into our major air hubs and sold, actually quite cheaply, throughout these communities in Britain. About 7 tonnes arrive at Heathrow Airport every week from Ethiopia, Kenya and the Yemen.

It is sold in grocers shops amongst the vegetables and from car boots in the street in some areas. The detritus on the streets of some areas is found to be objectionable by non-using residents.

Men tend to chew it for longer in Britain because unemployment is a serious problem in the recently arrived immigrant communities that use it. Of course, even though it is cheap to buy, it can be a drain on a limited family budget. The men often visit dens, called mafreshi, to chew it with their friends, although it is available in coffee shops too in the communities who use it.

Slowly its use is spreading to other communities. Students have found that it helps them to stay awake to study longer at night. Khat is a stimulant that prevents fatigue and depresses appetite. In this respect its pharmacological properties are rather like those of the amphetamine class of drugs.

However, heavy use can lead to insomnia, high blood pressure, heart problems and impotence. Cancer of the mouth is a long-term risk, and it is now recognised to produce liver disease in vulnerable individuals. It can produce feelings of anxiety and lead to aggression. Paranoia and psychoses can be induced by chronic use of khat.

The plain fact is that not enough research has been done on khat in this country. When Norman Lamb MP asked the Secretary of State for the Home Department "What her estimate is of the number of people who have used khat in the last 10 years?", the answer given on 1 June 2009 was "No annual estimates are currently made of the number of people who have used khat. The Home Office is planning to add questions to the British Crime Survey from October 2009 to ask respondents about self-reported use of khat, ever, in the last year and in the last month.

When Sir Peter Soulsby MP asked the Secretary for the Home Department "What assessment she has made of research commissioned by her Department on the individual and social effects of the use of khat in the UK?", the response given on 1 June 2009 referred to the ACMD recommendation published in March 2005 that there wasn't enough evidence to classify khat at that time but that they (the ACMD) would continue to monitor khat usage.

The Home Secretary also pointed to the fact that the Government's 2008 Drug Strategy Action Plan set out the intention to consider further the social harms created by khat use and to improve our understanding of the needs of khat users and their families. She also reported that her Department has now commissioned research on khat. Focus groups are planned for the Somali, Yemeni, and Ethiopian

communities.

Interest in Parliament in khat took off in 2005. On 8 June that year, Mike Gapes MP held a 30 minute Adjournment Debate on khat in which he referred to earlier Parliamentary activity.

The Home Office Minister responsible for drugs, Caroline Flint MP, told David Davies MP in a written Parliamentary answer on 27 February 2006, "....that the national drug treatment monitoring system shows that 141 people in England reported to treatment services with khat as their main drug of use, and 9 persons reported with it as their secondary drug of use between April 2004 and December 2005", which makes khat of minor importance in the drug treatment area.

Conservative Peer Baroness Warsi initiated a short debate in the House of Lords on 24 June 2008 and, on 1 June 2009, she raised the issue again. She wants the drug to be made illegal.

My view is that khat is more of a public health issue than a criminality issue, and any problems arising in the communities that use it should be treated as such. This requires the involvement of the host community which has begun to happen in Bolton. The user communities need to be advised of the health problems that will arise from chronic and long-term use of khat and they need to be provided with all the skills that will help them to be assimilated into the host communities with whom they live. That is why I welcome events such as this one.

What would the classification of khat mean? Sales of khat would not be halted; they would go underground. It could not arrive legally on flights to Britain, so a smuggling route would have to be established. Its distribution and sales would end up in the hands of the criminal drug dealers and, of course, it would cost an awful lot more than at present, meaning an even bigger drain on family economies.

There would be more violence in the user communities too and those who use it now and continue to use it in future would be criminalised, with all the consequences that that involves with respect to free travel and job hunting. The penalties for its use would depend on its classification, A, B or C, with higher penalties going up from Class B to Class A.

The communities must ask themselves - is that what they really want or can we control the use of khat to such a degree that the calls to make it illegal go away?

Now, let me explain the meaning of the term 'substance displacement', which will enable me to move on to the second part of my contribution today.

One of the problems created by making drugs illegal is that users look for something else - a 'legal high', for example. The substance the user is displaced to may be far more dangerous to use than the one they used perfectly legally earlier.

The ‘War on Drugs’ causes displacement - substance displacement, geographical displacement and policy displacement, for example.

Let me quote from page 11 of the Press Kit to the UN 2006 International Narcotics Control Board Annual Report:

> *“The abuse and trafficking of prescription drugs is set to exceed illicit drug abuse, warned the International Narcotics Board in its Annual Report released today (1March 2007). The Board added that medication containing narcotic drugs and/or psychotropic substances is even a drug of first choice in many cases, and not abused as a substitute. Such prescription drugs have effects similar to illicit drugs when taken in inappropriate quantities and without medical supervision. The ‘high’ they provide is comparable to practically every illicitly manufactured drug.”*

Why would a person risk a fine or even a prison sentence when perfectly legal substances are able to give them a ‘buzz’? As we increase the penalties for those using controlled drugs, as we have done again for UK cannabis users, or increase the numbers of classified substances - whether it be khat or ‘legal highs’ next - people will seek alternative substances to give them a ‘buzz’. Enforcement leads to substance displacement.

Concerns have been rising in recent years about the numbers of people who have been physically dependent on or addicted to legal substances, and even overdosing on these substances, in some cases resulting in a tragic death. The high-profile death of Heath Leger was only one example of many.

Soon after my election to Parliament in 1997 I came across a former policeman, David Grieve, who had been addicted to cough mixture containing codeine - he had been drinking litres of it every day. David Grieve started up a small charity called Over-Count which he still runs today to give on-line advice to those who have become addicted to over-the-counter medication.

The All-Party Parliamentary Dugs Misuse Group (APPDMG) decided to launch an inquiry in the 2007-08 Parliamentary session into “Physical Dependence and Addiction to Prescription and Over-the-Counter Medication”. We published our report in January this year and it has attracted a lot of media attention. During our research we came across two other reports - one published in the State of Victoria in Australia and the other in Scotland - whose findings are similar to our own.

Our inquiry was carried out along the lines of a Parliamentary Select Committee inquiry. First, we issued a ‘call for evidence’ through a Press Release then, based on the over 100 pieces of written evidence that we received, we invited two groups of witnesses to give oral evidence.

One group represented organisations, such as the Royal Colleges, trade associations, and regulators, such as the Medicines and Healthcare products

Regulatory Agency (MHRA), as well as the pharmaceutical companies, whilst the other group were patients who had been affected, or organisations representing them.

My researcher, Gemma Reay, organised the inquiry and wrote the final report, which can be accessed through a link from my web site at www.brianiddon.org, or through the DrugScope web site.

The evidence that we received suggests that there are two main groups of legal substances that are causing significant problems, the benzodiazepine tranquillisers and their successor drugs, the so-called 'Zed-drugs', and products containing codeine.

Of course, benzodiazepines are also Class C drugs in the UK. They are popularly used as 'downers' by those who use street drugs. Evidence suggests that they are being smuggled into the UK now in considerable quantities.

The ready availability of drugs on the largely unregulated internet has exacerbated drug abuse problems in my opinion. At least 10% of the drugs sold on the internet are counterfeit, which adds to the complexity of the problem.

The benzodiazepine class of drugs - Valium and Librium came first - were introduced in the 1960's, and were welcomed by clinicians to treat anxiety and insomnia in place of the much more toxic barbiturate drugs that had resulted in far too many overdose deaths. At first they were seen to be quite safe, and their addictive properties were overlooked for some time.

By the 1970's benzodiazepines were the most widely prescribed of all prescription medicines. However, many of those who tried to stop taking them experienced severe withdrawal symptoms as a result of their involuntary addiction to them.

I remember Esther Rantzen and her "That's Life" team highlighting these problems in the early 1980's, and a book was published as a result of her campaign in 1984.

In 1988, the Committee on the Safety of Medicines issued clinical guidelines recommending that the drugs not be used for more than 4 weeks at a time, and that patients on these drugs be closely monitored. Sadly, many of our General Practitioners have ignored this advice and, as a result, an estimated 1.5-2 million of our citizens are addicted to these drugs today. We came across patients who have been prescribed
benzodiazepines for over 30 years. Our evidence suggests that repeat prescriptions handed out by doctors without monitoring their patients is a common cause of involuntary addiction.

Just as ceasing to use controlled drugs, such as heroin and cocaine, results in severe withdrawal symptoms, the same symptoms will be felt by a patient who ceases to take benzodiazepines, if they have become addicted to them. Professor Heather Ashton of the University of Newcastle has developed a withdrawal protocol

for these patients.

Patients are commonly incapacitated through their dependence on or addiction to benzodiazepines, or through their self withdrawal from these medicines. Some are left with long-term health problems even after withdrawal.

It is more difficult to estimate the number of people addicted to products containing codeine, but estimates suggest that the figure stands at at least 20-30,000 and may be as high as 150-200,000. The products that cause the most problems contain higher than usual doses of codeine, at 12.5 mg per tablet, and usually contain the codeine admixed with another drug such as ibuprofen or paracetamol.

We have received evidence to suggest that those addicted to these products are taking between 30 and as many as 70 tablets per day. Unless the codeine is separated from the co-medication, such as ibuprofen, these dose levels can cause medical complications such as serious internal bleeding, often resulting in death. The codeine can be easily separated from the co-medication, and the methods to achieve this separation are described on internet web sites.

The stereotypical addict is a middle aged female user of these products. However, more and more people are becoming addicted to these products through treatment of chronic pain by codeine-containing drugs in the absence of an adequate pain management strategy. It would appear that a significant number of codeine addicts also have a co-morbid mental health problem. Some addicts have a polydrug problem involving alcohol and prescription drugs.

Where people suffer headaches on a regular basis and self medicate with codeine-containing products, they develop a symptom that has been termed “medication overuse headache”. When these people are enabled to give up the products the headaches disappear. Overuse of codeine desensitises the pain receptors.

People who become addicted to over-the-counter medicines believe the products that they are buying without prescription are safe and do not believe that they can become addicted to them. Similarly, patients who receive prescriptions from their doctors believe that they will be protected from side effects and cannot believe that addiction or physical dependence can be an outcome.

With both tranquilliser and codeine addiction we have found that most General Practitioners either do not recognise the problem their patients have or are at a loss to know how to deal with it. The plain fact is that, today, it is probably easier for an illegal drug user to get a referral to a Drug and Alcohol Addiction Team (DAAT) than it is for those having problems with legal drugs (other than alcohol) to get treatment.

Our report contains 24 recommendations. They refer to adequate training of medical professionals, raising awareness of the problem, proper prescribing to and monitoring of patients, more research to establish the scale of the problem and, most importantly, recognition of the patients with problems and the ability to refer them to an appropriate treatment centre.

Both the pharmaceutical industry and the patient have responsibilities, the former to make patients available of the potential problems associated with their products, including physical dependence or addiction, in the Patient Information Leaflet (PIL), and the latter to ensure that they do read the PIL or listen to the advice given by their doctor.

In some countries the advertising of codeine-containing products has been banned and, in others - the USA, for example - they have been made prescription only medicines (POMS). We would not wish to burden doctors any more than they are already and, in any case, there is a move to self medication, with a greater role for the pharmacists in advising patients, which is to be welcomed.

The National Treatment Agency (NTA) was set up in 2000 and has been very successful in treating those referred to it who are addicted to controlled drugs. However, we believe that it is not geared up to treating those whom I have been describing in this part of my contribution. The stigma associated with controlled drug addiction and the shame associated with those who have become involuntarily addicted to prescription and over-the-counter medicines means that these patients are hardly likely to volunteer to be referred to the facilities provided by DAATs.

Therefore, we have recommended that the DoH provide centres for treatment within the NHS. Throughout our report we have stressed the importance of the voluntary sector in helping these patients but their resources have become stretched in recent years and, in any case, they have not been listened to by our Government.

Next, I want to raise awareness of our report in Parliament through an Adjournment Debate and by arranging an appointment to see the Minister of State responsible for drugs misuse at the DoH. The Adjournment Debate is next Tuesday at 11.00 a.m. to 12.30 p.m.

Thank you for listening.

END