Sierra Leone's Kush crisis: A socio-economic emergency hiding in plain sight

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- Kush does not prey on the already impoverished — it creates impoverishment: two-thirds of active users were employed before first use, yet nearly two-thirds now report unstable or very unstable income.
- Social networks, not desperation, drive initiation: peer pressure is cited by over 60% of users as their primary motivation for first use, with one in six starting before age 18.
- The government's rehabilitation programme shows promise but has not been rigorously evaluated: six batches have been completed without a robust assessment of what works, for whom, and why.
- Recovery requires social and economic reintegration: 91% of users report serious damage to family and social relationships, and 88% of programme graduates were unemployed at the time of interview.

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Introduction

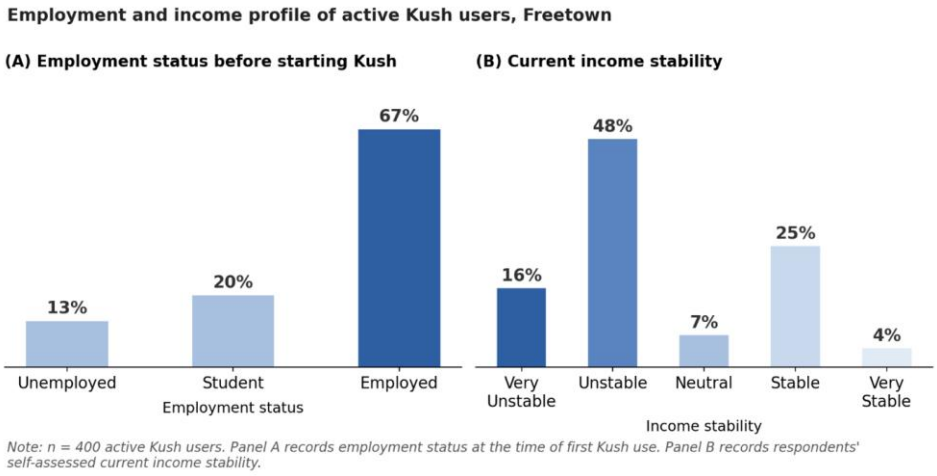
Sierra Leone's Kush epidemic was declared a national emergency by President Julius Maada Bio. The synthetic drug — a cocktail of synthetic opioids and cannabinoids (Bird Ruiz Benitez de Lugo and de Bruijne, 2025) — has taken hold among young people in Freetown with devastating speed, contributing to rising rates of homelessness, crime, and premature death, and a near 4,000% surge in admissions at Sierra Leone's only psychiatric hospital since 2020 (Baldeh et al., 2024). Yet despite its visibility on the streets, little systematic evidence exists on who uses Kush, why they start, and what it takes to help them stop.

To fill this gap, we conducted a mixed-methods study of 400 active Kush users in Freetown, complemented by qualitative interviews with Kush dealers, policymakers, and users' families, and focus groups with 50 graduates of the government's rehabilitation programme ("ambassadors"). This policy brief presents our key findings and draws out three urgent policy priorities: community-based prevention, rigorous evaluation of the flagship rehabilitation programme, and serious investment in social and economic reintegration.

Findings

1. Kush creates impoverishment — it does not target people who already have low incomes. The popular image of a Kush user as someone with nothing to lose is misleading in an important way. Two-thirds of users in our survey (67%) were employed before they started using, and another 20% were in school. Only 13% were unemployed at the time of first use. Kush is overwhelmingly a young man's crisis: 84% of surveyed users were male, with a mean age of 27. The current situation of active users is dire: 52% are homeless, and a further 21% live in squatter settlements. The picture that emerges is not one of pre-existing destitution— it is one of economic descent.

FIGURE 1: Employment and income profile of active Kush users, Freetown.

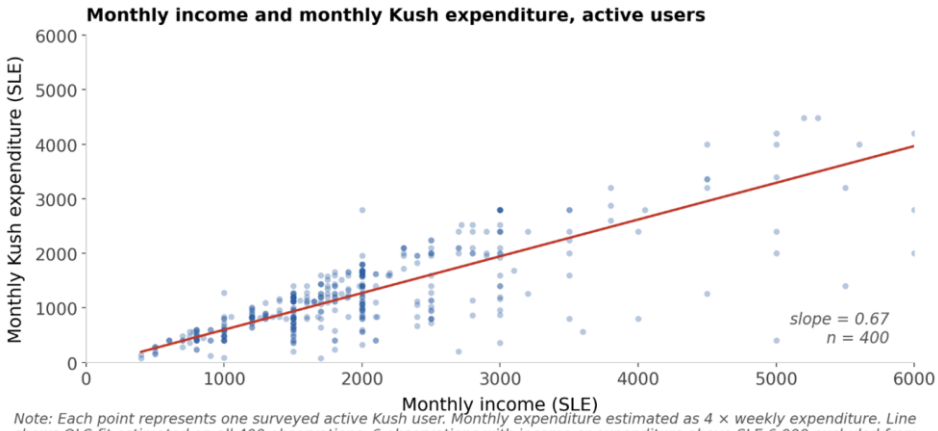


Two-thirds of users were employed before starting Kush, and a further 20% were in school — yet nearly two-thirds now report unstable or very unstable income. Source: Authors' survey of 400 active Kush users, Freetown.

2. Social networks, not desperation, drive initiation. Peer pressure is the most commonly cited reason for first use, reported by over 60% of respondents. Only about a quarter reported that coping with personal problems motivated their first use; curiosity and the pursuit of happiness together accounted for less than 12%. One in six users in our sample started before age 18, and one in three before age 20. As the drug becomes more entrenched and normalised, initiation among school-age youth is likely to begin earlier still. Schools are not just a natural entry point for prevention — they may soon become the frontline.

3. The financial and social costs spread far beyond the user. The median user spends SLE 1,120 per week on Kush — more than the weekly minimum wage. Kush expenditure rises consistently with income: higher earners are not immune; they simply spend more. For those without a stable income, focus group participants described a familiar trajectory: selling personal possessions, then stealing from family, then petty theft. Ninety-one per cent of users agreed or strongly agreed that Kush had negatively affected their relationships with family or friends. Recovery from Kush is not just a medical challenge — it requires rebuilding the social and economic foundations that addiction destroys.

FIGURE 2: Monthly income and monthly Kush expenditure, active users.



Note: Each point represents one surveyed active Kush user. Monthly expenditure estimated as 4 × weekly expenditure. Line shows OLS fit estimated on all 400 observations. 6 observations with income or expenditure above SLE 6,000 excluded from plot.

Kush spending rises consistently with income. Higher earners are not immune — they simply spend more. Source: Authors' survey of 400 active Kush users, Freetown.

4. The government's rehabilitation programme is promising but unproven. The Ministry of Social Welfare (MoSW) has run six batches of a programme combining medical care, secure isolation, counselling, and faith-based activities. Graduates become "ambassadors", conducting community sensitisation and supporting reintegration. The ambassadors we spoke with were largely able to remain drug-free post-rehabilitation, which is encouraging. But in the absence of a rigorous evaluation, it is difficult to assess with confidence. Ambassadors reported in focus groups that many of their fellow graduates had relapsed or fallen out of contact. The true success rate remains unknown.

5. Reintegration remains the missing piece. Even among ambassadors — the programme's visible successes — life after rehabilitation is deeply difficult. At the time of interview, 88% were not working, and half reported that stigma makes finding employment difficult. Nearly half still felt distrusted by their neighbours. Kush does not just damage users economically: rebuilding social ties is as important as rebuilding economic footing.

Discussion and policy recommendations

1. Prioritise community and peer-level prevention. Information campaigns alone are unlikely to stem initiation that is driven primarily by peer pressure and social networks. Prevention efforts should target schools and youth

communities, and be designed to reach young people before they first encounter the drug. Given that one in six users in our survey started before age 18 — and that Kush use is becoming more entrenched and normalised — waiting until adulthood to intervene is not a viable strategy.

2. Commission a rigorous evaluation of the rehabilitation programme. Six cohorts have completed the government's flagship programme without a robust independent assessment of what works, for whom, and why. Commissioning such an evaluation should be treated as urgent. Any evaluation will require investment in robust tracking and follow-up systems, given that many graduates fall out of contact post-discharge. If effectiveness is confirmed, scaling cohort sizes and programme frequency should follow as a matter of priority. The programme has received remarkably little attention from the donor community, given the scale of the crisis; this gap needs to be closed.

3. Treat reintegration as a core component of recovery, not an add-on. Social and economic reintegration must not be an afterthought to medical rehabilitation. Given that 91% of users report serious damage to family and social relationships, rebuilding those ties is as important as rebuilding economic footing. Half of programme graduates report that stigma makes finding employment difficult, and nearly half still feel distrusted by their neighbours — pointing to the need for community-level efforts alongside individual support. Programmes that address both the social and economic dimensions of reintegration together need to be developed, piloted, and rigorously evaluated.

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