

Ketamine Use & Harm Reduction: Key Takeaways for Frontline Healthcare Professionals

This webinar—hosted by **Dr Martyn Hull**, Turning Point—addressed the rapid rise in ketamine use across the UK and the increasing burden of ketamine related harm presenting in primary and secondary care. Speakers included **Consultant Urologist Alison Downey**, **BDP CEO Lydia Plant**, and lived experience testimony from Donnie, a Turning Point recovery connector.

1. Why This Matters Now – You Gov Poll results overview

- **One in ten (10%)** young adults have used ketamine, with **3% currently using** and **1% using daily** - a clinically high-risk group.
- **Perceived norms exceed reality:** 35% believe ketamine use is common among their peers (rising to 39% in the North), which may drive risk taking and earlier experimentation.
- **Use is highest in London**, which also reports **3% daily use** and the **lowest perceived risk**, signalling a hotspot for targeted intervention.
- **Social motivations dominate:** Enhancing parties (52%), curiosity (50%), fun (49%) and peer influence (up to 49%) are primary drivers - reinforcing ketamine's normalisation in youth culture.
- **Psychological factors are significant:**
 - 41% cite escapism
 - 25% cite stress/mental health management
- This rises to **30% in London** and **27% among 18–24s**, pointing to self-medication trends.
- **Risk perception gap:** 65% view ketamine as dangerous, but **25–30-year-olds are least concerned**, despite being more likely to use frequently.
- **Regional variation matters:**
 - North: highest “enhancing parties” driver
 - Midlands: strongest peer pressure & curiosity drivers
 - London: most fun driven and stress linked motivations
- **Daily use is a red flag** due to rapid tolerance, dependence risk, and significantly increased likelihood of bladder injury (KIU).

2. Clinical Harms: What GPs Should Look For

Ketamine-Induced Uropathy (KIU)

Common presenting features:

- Severe frequency (every 10–15 min)
- Urgency ± urge incontinence
- Pelvic/bladder pain (“like a mini heart attack each time they void”)
- Visible or microscopic haematuria
- Extremely reduced bladder capacity (50–70 mL vs normal 500–600 mL)

Progression can include:

- **Fibrotic ‘contracted’ bladder**
- **Hydronephrosis** from high bladder pressure
- **Ureteric strictures** → risk of obstruction
- **Renal impairment/failure**, sometimes requiring nephrostomies
- Associated issues: sexual dysfunction, GI problems, rectal prolapse, cardiotoxicity, cognitive issues, cholangiopathy and even cirrhosis. Emerging reports of cardiac failure

Critical point: Frequency of use - not just dose - is the strongest predictor of harm.

Assessment Recommendations

- **Renal ultrasound** to rule out hydronephrosis/obstruction
- Consider cystoscopy **only where indicated** (e.g., unexplained persistent haematuria)
- Consider discussing with your local urology unit to the **best referral pathway for patients** with visible haematuria - flexible cystoscopy can be extremely painful and cystoscopy is better done under GA if needed: flexible cystoscopy is extremely painful and not helpful in KIU
- Evaluate for coexisting liver abnormalities; cholangiopathy is well recognised

Management Principles

- **Cessation of ketamine is the single most effective intervention.**

- Stage 1–2 disease often improves significantly with abstinence.
- Neuropathic pain regimens (e.g., amitriptyline, pregabalin) may help—discuss addiction risks.
- Prepare patients that **symptoms may worsen for 2 weeks post cessation** as ketamine is a potent analgesic.
- Severe cases may require Botox, bladder stretching, or reconstructive surgery.

3. Recognising Ketamine Use in Primary Care

- Young people with **unexplained urinary symptoms**
- Patients presenting with **recurrent anxiety, depression, social withdrawal or pain**
- People whose only effective pain relief appears to be ketamine (a red flag for dependence)
- Nonjudgemental direct questioning is encouraged, given high prevalence

4. Harm Reduction & Engagement Strategies

Why People Don't Seek Help Earlier

- Lack of confidence in traditional drug services
- Fear of judgement
- Belief that services are only for heroin/crack users
- Scare stories or misinformation

Effective Ways to Engage Ketamine Users

- **Outreach in familiar environments:** festivals, nightlife spaces, universities
- **Pleasure-based AND harm-based messaging:**
 - E.g., “chop powder finely to protect your nose *and* make it go further”
- **Provide nasal care advice:** avoid shared snorting equipment, rotate nostrils, rinse afterwards

- **Drug-checking conversations:** nitazenes, xylazine and other adulterants increasingly found
- Use **non-judgemental, curious, evidence-based communication**
- Target messaging to **stage of use:** occasional, frequent, or dependent
- Avoid scaremongering—users know when information doesn't match their lived experience

“Set, Setting, Sitter” Principles (for clients who will continue using)

- **Set:** emotional state (avoid using when distressed)
- **Setting:** safe physical environment
- **Sitter:** a trusted person, ideally not drinking or taking drugs, present to prevent harm

5. Lived Experience: Insights from Donnie

- Many dependent users started ketamine use to manage **mental health challenges**.
- Long-term use led to severe physical harm and psychosocial impacts.
- Early, non-stigmatising engagement is vital to avoid people reaching crisis.
- **Watch Donnie's story:** <https://mytp.me/donnies-story>

6. Key Risks of Occasional vs Frequent Use

Occasional Binge Use:

- Risk of **intoxication, K-holes, unconsciousness**
- Increased vulnerability to **accidents, assault, drowning, falls**
- Rapidly increasing **tolerance**, which can escalate use
- Stronger risks when combined with **alcohol or benzodiazepines**

Frequent Use:

- High risk of **significant bladder injury**, renal damage, and liver issues
- Likelihood of developing **dependence**
- Severe **withdrawal discomfort**, though withdrawal is not medically dangerous

7. Practical Guidance for GPs & Frontline Teams

Do

- Ask directly and sensitively about ketamine use
- Consider ketamine in young patients with chronic urinary symptoms
- Arrange **renal ultrasound** promptly
- Refer to specialist urology **without 2WW unless cancer is suspected**
- Connect early with local drug & alcohol services (Turning Point, BDP etc.)
- Provide brief harm reduction advice

Don't

- Report use or supply information to police unless there is an immediate safeguarding risk
- Use scaremongering approaches
- Assume ketamine withdrawal is medically dangerous—it isn't, but it **can be painful and difficult**

8. Overall Conclusion

Ketamine-related harm is **common, increasing, and often severe**, but **early detection and compassionate engagement in primary care makes a significant difference**.

Most early-stage uropathy **can improve dramatically with cessation**, and embedding harm reduction, education, and effective referral pathways across healthcare systems is critical.

9. Resources

Know Your K Campaign: <https://mytp.me/know-you-k>

Turning Point's national harm reduction campaign focused on early intervention. The goal is to help people understand the risks, recognise early warning signs and seek support sooner.



View Webinar Recording: <https://mytp.me/ketamine-webinar-for-professionals>

Download Ketamine Briefing Note: <https://mytp.me/ketamine-briefing-note>

Visit Turning Point's Ketamine Harm Reduction Page: <https://mytp.me/ketamine-and-your-health>

Know its effects, the risks, and harm reduction advice for staying safe if you use it. This page gives you clear and honest information so you can make informed choices.