✅ 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 – YouGov 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

A. Ketamine-Induced Uropathy (KIU)

(From **Alison Downey**, Consultant Urologist)

Common presenting features:

- Severe urinary 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, and emerging reports of **cholangiopathy and even cirrhosis**.

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)
- Avoid routine 2-week-wait cancer pathways unless red flags exist: flexible cystoscopy is extremely painful and not helpful in KIU
- Evaluate for co-existing liver abnormalities; cholangiopathy is increasingly 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

Dr Hull highlighted key opportunities:

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

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✅ 4. Harm Reduction & Engagement Strategies

(From **Lydia Plant**, Bristol Drugs Project)

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 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.

✅ 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

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✅ 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.