Manchester Metropolitan University

- Primary substance
- Younger age of use
- Early onset of harms
- Beyond a '*club drug*'

Manchester Metropolitan University

Self-medication

"I can struggle a bit with anxiety, *so I find it a bit difficult to not be on edge,* ***so I feel like it's very good for that."*** (24-year-old male, Salford)

"I'd say to do with my feelings if you know what I mean? ***Numbness. . . . Less anxious, don't care as much."*** (16-year-old male, Salford)

Manchester Metropolitan University

Trauma

*". . . and I think **a lot have trauma as well,** due to what has happened in their life, so **the kids are just turning to it to cope really."*** (Substance Misuse Advocacy Worker, Trafford & Salford)

Manchester Metropolitan University

Adverse Childhood Experiences

*"A lot of them have had **bereavements or witnessed domestic violence."*** (School Safeguarding Lead, Salford)

***"All of them bar one has been in care,** so there have been **a lot of long-term traumas.** One of them was using it just to have the confidence to participate in daily life."* (Safeguarding Manager, Bury)

Manchester Metropolitan University

The need for earlier engagement

"Often by the time they access our service they are already in need of urological support and intervention. ***We need to be seeing them earlier."*** (Young Person's Substance Use Practitioner, Stockport)

Manchester Metropolitan University

Fear of bladder removal

"To be honest I just didn't want to know. I just kinda [sic] *buried my head in the sand as they say. I knew really that it was the ket that was causing it, so* ***I didn't want to go to the doctors or treatment service and get told I need a [urostomy] bag."*** (22-year-old male, Trafford)

Manchester Metropolitan University

Poor Harm Reduction Information

"Make sure you crush it properly. *I use a rolling pin when it's in the bag.* ***The shards cut the wall of your bladder and that's what cause the problems*** *with your bladder so yeah, make sure you crush it down well, that's my top tip!* [laughs]" (20-year-old male, Trafford)

"I always crush it up really fine. The shards kinda [sic] ***stick to your bladder*** *so you have to make sure you get rid of the shards and crush it to a fine powder."* (21-year-old female, Manchester)

Manchester Metropolitan University

Poor Medical Response & Understanding

". . . when they present at A&E, we have young people that have ***just been provided repeat prescriptions of antibiotics, and they don't get referred into young people drug services****. . . We have to attend GP appointments with the young person and explain about Ketamine cramps and then* ***GPs Google it in front of the young person. They need support and training."*** (Young Person's Substance Use Treatment Service Manager, Trafford and Salford)

Office for Health Improvement & Disparities

Ketamine use- response overview

Pete Burkinshaw

DHSC Alcohol and Drug Treatment and Recovery Lead

Collective Voice ketamine event, 14 October 2025

Treatment

Accessibility, the front door, service promotion, pathways and assessment (as the start of treatment) all key.

Psychosocial support

- Is key, needs to purposeful, person centred and adaptive. Care needs to layered and sequenced. UK Clinical guidelines for Drug Misuse and Dependence (DHSE, 2017) and more in the forthcoming Alcohol Clinical Guideline
- Multi-disciplinary teams are important because of comorbidities and risk
- The intensity of support offered should be based on the severity of the person's dependence and any co-occurring complex needs. Most people can receive appropriate support in the community, but inpatient or residential services may be required for those with the most severe and complex needs.

Pharmacological interventions and health and mental health screening

- Symptomatic management of withdrawal is indicated in some cases, with low-dose benzodiazepine as a starting point. There are no studies to support the use of other pharmaceuticals
- Pain management in partnership with urology, primary care and pain clinics if appropriate
- As part of health checks, routinely ask about urological problems that might come with sustained ketamine use and make supported referrals to urology services, using established pathways.
- Routinely screen for mental health issues and make supported referrals to mental health services, using established pathways

Psychosocial interventions

Evidence suggests:

- Workers who have clear techniques and belief in them achieve better outcomes (goals and structure)
- Supervision and governance are key (active reflection on techniques and maintenance/development of them)
- Outcomes are greatly influenced by the quality of the working alliance

Wampold (2001), Bell (1998), Moos (2003)

Psychosocial interventions

Substance specific:

- specific understanding of the psychopharmacology of the drug (inc alcohol), the associated problems of use and dependence
- relevant harm reduction advice

(all with the additional aim of being credible to the person you are working with)

Formulation – understanding why people use, triggers, context/function and maintaining factors.

Intervention common factors (or change mechanisms), include:

- a strong therapeutic alliance
- session structure
- goal direction (incremental)
- interventions to develop alternative, rewards and activities
- engagement with positive social networks (that are recovery focussed)
- building self-efficacy and coping skills to control use or maintain abstinence

Actions for partnerships and services

- **Combating Drugs Partnerships (CDPs):** CDPs bring together a range of partners from across health and social care, criminal justice and education. CDPs tend to have main 'board' style meetings that involve key senior decision-makers, and sub-groups to take forward work in more detail by theme – for example, prevention or treatment. Ketamine should be discussed in both contexts, informed by local data and intelligence.
- **Adult drug treatment services** –Harm reduction, psychosocial and pharmacological interventions.
- **Children and Young People's specialist drug and alcohol services-** as above but also targeted awareness raising, advice and information.
- **Urology services –** Any patient with unexplained symptoms should be screened for ketamine use and referred to treatment if needed. Pathways from D&A treatment services to urology services should also be established.
- **Primary care** – Targeted screening, identification and referral. Pain management and referral to urology and pain clinics as appropriate.

Actions for partnerships and services

- **Sexual health services** –identify people at risk and screen and refer, and provide simple interventions, with clear pathways into drug and alcohol treatment, using established referral pathways.
- **Youth services** – Professionals working with CYP, including complex safeguarding and CYP in the youth justice system, should routinely screen for drug and alcohol use, including ketamine use, and have well established supported referral pathways for specialist interventions/treatment. They should engage with their local authority commissioned D&A treatment services to learn about local patterns of use and harm.
- **Mental health services** – Services should use the ASSIST-Lite to assess drug use problems. MH services should have local pathways to drug treatment in place. Treatment should address the substance use and the mental health issues through effective partnership working. D&A treatment services should strengthen referral pathways into Talking Therapies services.
- **Emergency departments** – Training and awareness of ketamine related bladder damage and targeted screening and referral. On discharge, patients identified as at risk of further ketamine harms should be referred to drug treatment services. In some hospitals, alcohol and drug care teams might be able to directly assess, deliver brief interventions and make supported referrals into treatment.

The landscape of ketamine use disorder: patient experiences and perspectives on current treatment options

Harding, R. E., Barton, T., Niepceron, M., Harris, E., Bennett, E., Gent, E., Fraser, F., & Morgan, C. J. A. (2025). Addiction.

University of Exeter

UCL

Summary

- Total N=274 with a current or previous problematic ketamine use (45% female)
- Majority of sample were current ketamine users (68.7%) and non-treatment seeking (59.82%)
- 73% primary drug of choice was ketamine
- The most common route of administration was insufflation (93%)
- 4 users first sourced ketamine through a clinical prescription
- ~2g per day average
- 34% had sought treatment for physical symptoms via GP or A&E – only 36% were satisfied with treatment
- KUD treatment-seeking participants reported that services had little (31%) or some (31%) awareness of ketamine and that services were not tailored to ketamine use (43%)
- Most participants (86%) felt there was insufficient awareness about ketamine risks in education and peer groups - 59% said "definitely not" and 27% said "probably not"

Conclusions

There is a need for *better education and awareness* about the negative effects of ketamine use for healthcare professionals and the general public

There is a need for improved *evidence-based, tailored* approaches for treatment of KUD

There is a need to *reduce stigma* attached to ketamine addiction

Future research should investigate *new treatment approaches* to better support individuals

South London and Maudsley NHS
NHS Foundation Trust

Addictions Clinical Academic Group (CAG)

Pier Road Ketamine Project: *Characteristics and issues of who we're thinking about.*

Irene Guerrini MD, PhD
Consultant Psychiatrist and Clinical Lead for Bexley Addictions- South London & Maudsley NHS Trust
Visiting Senior Clinical Lecturer Institute of Psychiatry, Psychology & Neuroscience, King's College London

KING'S HEALTH PARTNERS

BEXLEY KETAMINE PROJECT DATA ANALYSIS

(100 cases)

- Gender: 78% males
- Mean age: 25yrs
- Age ≤25: 37%
- Mean use (days): 20
- Mean ketamine use (gr): 2.74
- Ketamine only: 30%
- Ketamine uropathy: 42%
- MH problems: 66%

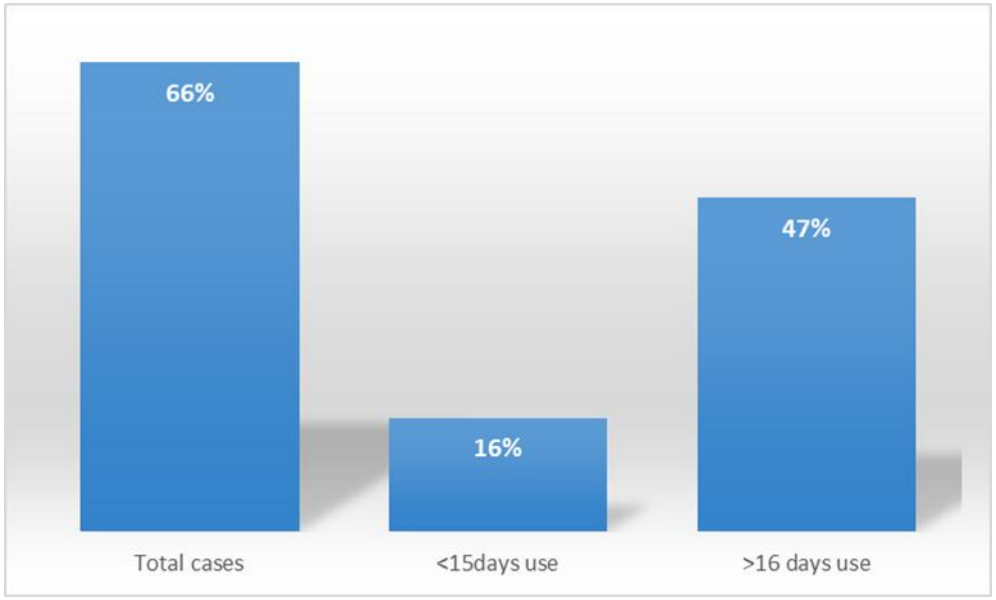
BEXLEY KETAMINE PROJECT DATA ANALYSIS

Table 1

Comparison between types of users (infrequent, frequent, and daily users)

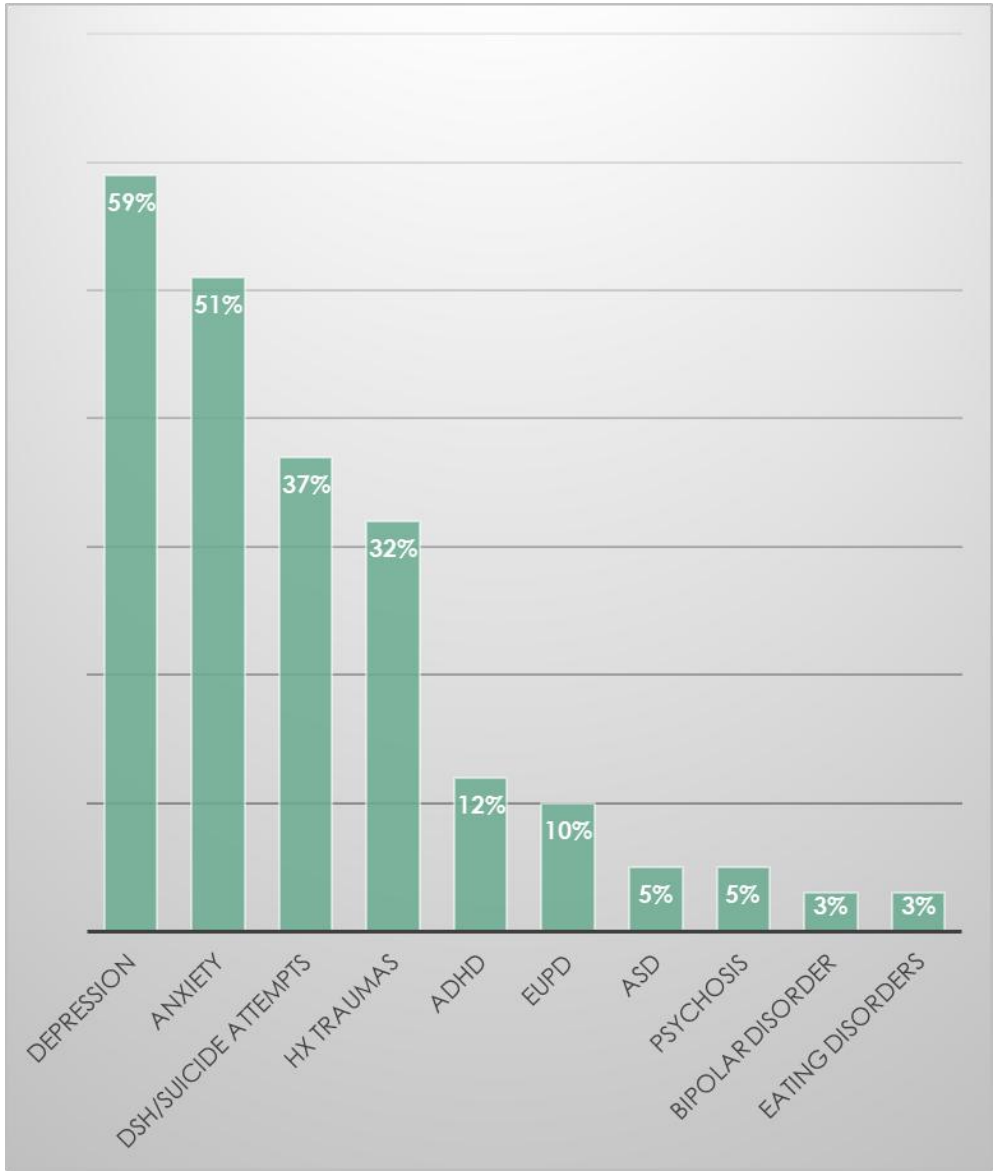
Variable	Infrequent (≤ 3 days/week)	Frequent (4-6 days/week)	Daily
Number of patients	29	31	40
Gender			
Male	19 (65.5%)	24 (77.4%)	27 (67.5%)
Female	8 (27.6%)	5 (16.1%)	12 (30.0%)
Others	2 (6.9%)	2 (6.5%)	1 (2.5%)
Mean age at triage (SD, Range), years	26.28 (7.17, 19-47)	25.26 (5.26, 18-42)	26.23 (4.24, 18-34)
Mean age started ketamine use (SD), years	19.29 (5.87)	19.10 (4.05)	19.35 (3.70)
Mean length of use (SD), years[a]	7.11 (4.85)	6.16 (4.30)	6.88 (3.18)
Mean ketamine dose (SD), grams/day	1.75 (0.96)	3.24 (1.96)	2.78 (1.59)
Mean frequency of use (SD, Range), days/30	6.03 (3.54, 1-10)	18.29 (3.44, 15-25)	
Prevalence of polysubstance use, n (%)	23 (79.3%)	18 (58.1%)	21 (52.5%)
Prevalence of KIU symptoms, n (%)	4 (13.8%)	16 (51.6%)	25 (62.5%)

Relative frequencies are displayed for each group.



BEXLEY KETAMINE PROJECT

MENTAL HEALTH



BEXLEY KETAMINE PROJECT

MENTAL HEALTH

PRP Service Users views about mainstream treatment provisions

Professionals do not understand ketamine addiction.

Services are tailored for Class A drug users

Limited interventions for young adults with a ketamine addiction

They don't relate to older Class A users in the group settings. Embarrassment due to frequent visits to the toilet.

Limited availability for inpatient detoxes and residential rehab

General views of lack of understanding of the impact of ketamine addiction by primary care clinicians, A&E staff and other medical professions


acorn
a calico group service

Ketamine: current challenges, successes and next steps for treatment

Residential Treatment and Inpatient Detoxification

Delivered by representatives of the Collective Voice Tier 4 forum

Scene Setting – Ketamine and Tier 4 Settings

Significant increased demand for services for people using ketamine and the nature of these has shifted noticeably:

- Change in demographics i.e. younger people, treatment naïve
- Increased physical health needs and types of significant clinical complexities with evidence of lasting damage prior to admission
- An increase in emergency admissions and assessments - people are often only getting funded for treatment once their physical health has dramatically declined rather than residential options being considered as an earlier intervention.
- Often people have had a shorter period of drug use prior to admission than with other substance use due to the impact of use
- Significant number of external physical health appointments and delays to access these
- Increasing mental health needs including suicidal ideation
- Increased clinical prescribing for wider needs i.e. for wound care due to urine burns
- Increase need for district nurse support during treatment stays
- More family/loved one involvement
- Increased costs and a static funding model
- Pathways for care are not consistent or able to meet need

CV

Residential Services have adapted and continue to

- Suitable environments including single ensuite rooms
- Flexing admission criteria particularly around medications
- Purchasing of vehicles (or additional) to support transport to appointments
- Reviewing staffing needs and responding through increases to clinical staff with further specialisms, nursing care, increasing staff ratios and increased 1:1 support
- Changing programme structures, timetables and content
- Advocating for specialist support

CV

Lived Experience

People in residential treatment for their ketamine use told us barriers included:

- Embarrassment
- Stigma
- Lack of specialist support (especially for young people)
- Poor mental health
- Pain management – difficult to access provision and get on the residential pathway
- Fear
- Paranoia
- Trauma and abuse
- A belief that ketamine use is not taken seriously by some healthcare professionals

We welcome Lauren and Mikey to share their experiences with you

Lauren and Mikey

CV

Recommendations

- Attitudinal Change
- Consider Detox and Residential Treatment earlier on in the pathways
- Funding longer programme length – interrupted programme, time for improvements to health to gain maximum therapeutic benefit- flexible and dynamic to need
- The need for more intensive and specialist care earlier
- Easier access to urology and pain management services nationwide
- Improved access to face to face home assessments to get right support earlier and consideration of suitability for Tier 4 placement
- Grey areas for those between 17-18 for inpatient care , there is also not enough room for under 18 care in the UK to supply the demand
- Improved support for loved ones/Family during the process for accessing detox and residential

"I cannot imagine what would have happened had the service not intervened in time and the funding for detox and rehab had not been granted." – *Jacks Mum*

CV

Nicole's Story

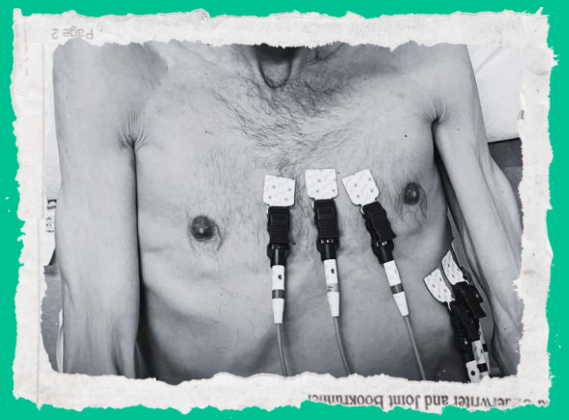
Nicole is a mum to 1 year old daughter. She was taking ketamine daily anally. She had physical health needs including an anal prolapse and incontinence. She was wearing pads continuously which GP refused to prescribe as it was not a 'medical' cause and a specialist had agreed. She was struggling to pay for these. She was told surgery on her bladder would not be considered until she was abstinent. Following an inpatient detox she arrived at the Phoenix National Family Service with her daughter.

Service Adaptations and support

- Funded the pads and continuously advocated for prescribing of these
- Highlighted discrepancy in prescribing approaches across local authorities which meant disruption to continuation of medication
- We supported daily phone calls and advocated for the surgery she required and was able to get her the operation during her residential stay
- We planned activities from shop runs to days out meticulously ensuring access to toilets discreetly, so she did not feel excluded or that she was causing disruption
- Increased flexibility around urine testing and switched to oral tests accordingly
- Safely adapted medication times to respond to pain needs
- Worked specifically on behaviours that were to avoid/minimise the need for the toilet which directly impacted on health and nutrition

CV

Jack's Story



Jack is a caring 24 year old with career ambitions ahead of him. He became known to Birchwood by an online referral from his aunt following what began as social ketamine use to daily use to cope following bereavements and the loss of his home and job. He weighed 6st 10lbs, with bladder and Kidney problems and requiring reconstructive surgery on his nose. His family were scared of losing him as he was "so poorly and so very weak". Jack was refusing to attend hospital following previous negative experiences and perceived stigma.

Service Adaptations and support

- Home visit to Jack by Birchwood. The next day they collected him to see the specialist GP
- Advocated for him with his own GP to conduct ECG
- Wrote to both GP and his community substance use team to raise the concerns and risk to life
- Funding was initially agreed for residential treatment but this was challenged and Jacks needs advocated for and an additional 4 weeks funding for inpatient detox obtained
- On admission Birchwood arranged for and encouraged Jack to be taken to hospital accompanied by his family – he had an 11 hour wait in A&E on a chair. Birchwood staff made efforts to educate A&E staff but they had limited understanding of ketamine-related complications. Jack self discharged and went home.
- Birchwood spoke to his family and worked with Jack to agree to go to a different hospital and Birchwood contacted the Hepatology department and Susbtance use team and he was placed on the A&E list ahead of his arrival and was seen immediately. He was rushed to the resuscitation area.
- He stayed in hospital for 8 days with a detoxifcation regime co-ordinated by Birchwood.
- He was discharged from hospital to Birchwood to commence his residential programme

Questions

NHS
The Mid Yorkshire Hospitals
NHS Trust

NHS
Barnsley Hospital
NHS Foundation Trust

A Urology Viewpoint

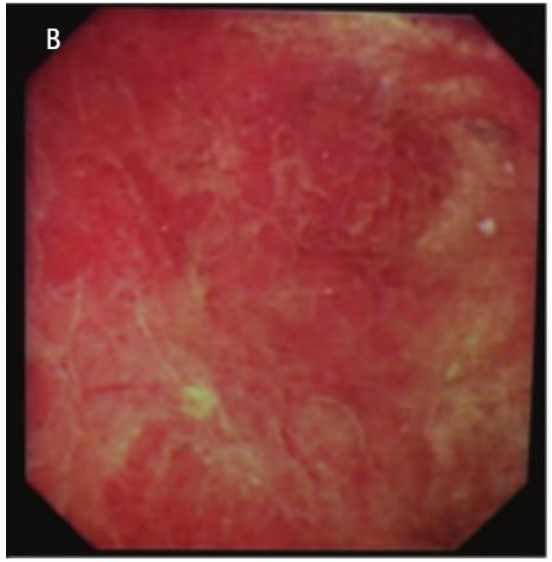
Miss Alison Downey

Consultant Urologist with subspecialist interest in Female, Functional, Reconstructive and Neuro-urology

Mid Yorkshire NHS Teaching Trust

Effects of Ketamine

- Profound Uropathy – Lower urinary tract symptoms, haematuria, pain
- Progression to renal obstruction (reflux or strictures)
- Sexual Dysfunction
- GI and Hepatobiliary Dysfunction
- Cognitive Impairment
- Cardiac Dysfunction
- ??Potential Malignancy



BJU Int 2024 doi:10.1111/bju.16404

Review

BJUI
BJU International

British Association of Urological Surgeons Consensus statements on the management of ketamine uropathy

Mohammed Belal[1], Alison Downey[2], Ruth Doherty[3], Ased Ali[2], Hashim Hashim[4], Andy Kozan[5], Magda Kujawa[6], Mahreen Pakzad[7], Tina Rashid[8], Nadir Osman[10], Arun Sahai[9], Suzanne Biers[11] on behalf of the BAUS Section of Female, Neurological and Urodynamic Urology

What are the barriers to care?

- Recognition and Education – Clinicians, Addiction services
- Patient – awareness, social taboo, fear
- Access – GP, Urology, Pain Team, A&E, Addiction services
- Cross-specialty care – who is in charge?
- Communication/co-ordination between community and secondary care
- Geography – multiple NHS trusts, councils, addiction services

An example: My Local Geography

- Cover a population of ~1 million
- 2 hospital trusts (4 hospital sites with 3 A&E depts.)
- 2 ICBs
- 3 substance addiction services (BRS, TP, CGL)
- 3 councils

Local Pathway(s)

Barnsley Hospital

Referral triaged by Urology Consultant

↓

Joint Clinic at Barnsley Hospital

↓ ↓ ↓

Follow-up with BRS | Intervention | D/C

Mid Yorks Trust

Referral triaged by Urology Consultant

↓

Recon clinic with SCT

↓ ↓ ↓

Referral to TP or CGL | Intervention | D/C

Other work

The British Association of Urological Surgeons

- Development of national consensus guideline for management
- Recognition and Education – sessions delivered to A&E, GP, social workers, safeguarding teams, probation service…….
- Development of information page with BAUS
- Awareness – involved with all local substance cessation services and local councils
- Ongoing – direct referral pathway, ?access to ultrasound from cessation services?

Major Barriers

- Pain Management – provision of chronic pain team, medication that works?
- Management of nephrostomies in rehab setting
- High DNA rates
- Working in silos, often services reliant on individuals

What we know – Ketamine in the South

- Hampshire Inclusion Adult & Young People's Services in Partnership with Catch 22
- Portsmouth Partnership with SSJ
- IOW Adult & YP Services
- Dame Carol Detoxification Service in partnership with Two Saints
- Steep increase in Ketamine Users in treatment 18-25 & 25-35 roughly 66/33% Male/Female

What we have

- People successfully completing community & residential treatment (+NA)
- Ketamine Nurse Partnership with Catch 22 – Assessment, Advice, Advocacy & Coordination
- Dedicated Family & Carer Support Group for those with Ketamine problems
- 8 Ketamine Detoxes in DCDS - all successful (Dynamic, cooperative approach to symptomatic relief)
- Good Lived Experience Involvement

What we need

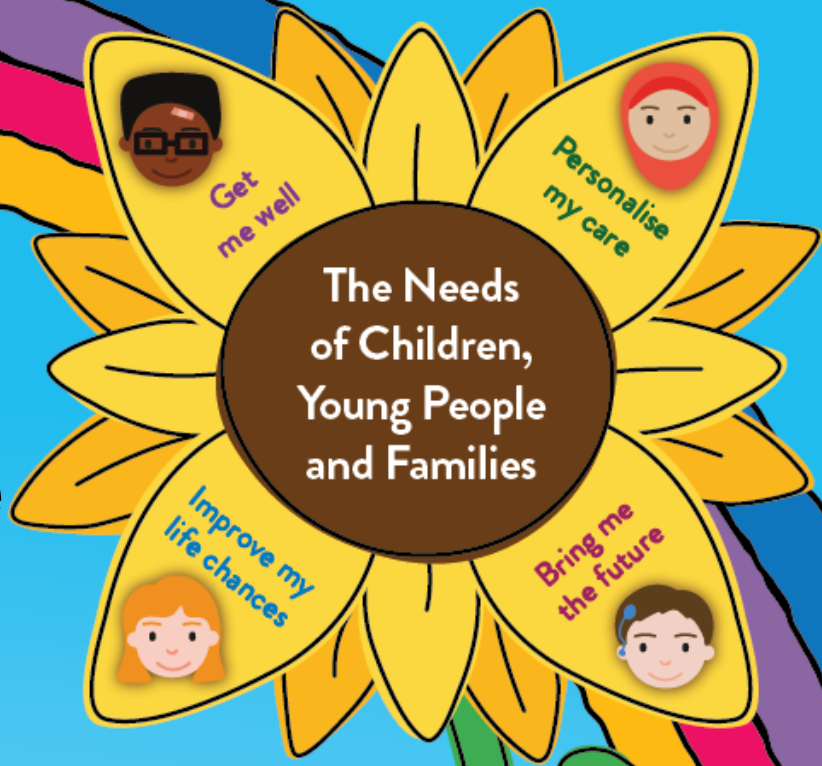
- More & Better Tailored Interventions for people using Ketamine
- More stable & reliable Pathways with Urology & Primary Care
- Pain relief is a MASSIVE challenge- circuitous routes to get, frequently, nothing
- In treatment services - individually tailored Harm Reduction without Stigma

Complex Healthcare Systems- Compounded by Stigma

- Stigma of drug use – illegal, negative connotations, considered self-inflicted- internalised as shame
- Stigma associated with incontinence – odour, visible signs of wetting
- Double jeopardy- client feels unworthy of treatment and is ashamed to disclose use or to access services
- Staff may be judgemental, derogatory or unwilling to adapt treatment to the person's needs

VISION 2030

NHS
Alder Hey Children's
NHS Foundation Trust



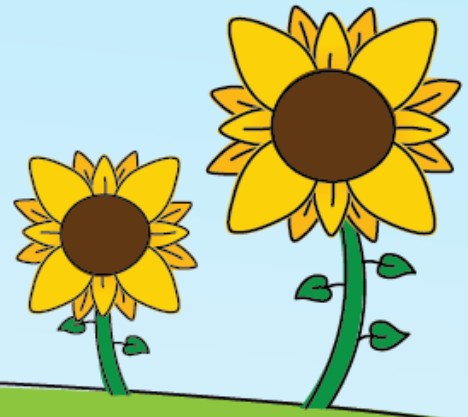
Non-prescribed ketamine use in under-16s

Professor Rachel Isba
Consultant in Paediatric Public Health Medicine, Alder Hey
Professor of Children and Young People's Health, Lancaster Medical School
Trustee, Royal Society for Public Health

respect excellence innovation together openness

The “ket bladder” clinic

- “cohorting” referrals able to wait for the joint clinic (others seen in normal urology clinic)
- 45 patients “on the books” (all < 16)
- lots of co-occurring need (un/met)
- urology including pain management
- conversation, harm reduction, etc.



Management of KIU

- UKRI Accelerated Knowledge Transfer grant
- Lancaster University and Change Grow Live
- 3 months from November
- <16s-specific guidance for ketamine induced uropathy
- please get in touch

Medically managed withdrawal

- some of our bladder clinic patients need extra support to stop using ketamine
- funding from Alder Hey charity for co-design
- bio-psycho-social approach with community partners involved from the start
- watch this space!

Naloxone

- aiming to offer Naloxone packs from November clinic
- pack for young people (including co-developed training)
- pack for parents/carers (using training for adults already used by partners)

North West Young People and Families Substance Use Partnership

Early Break

Northwest Young People and Family Substance Use Partnership

Janine Day

Chair North-West Young People & Families Partnership

Early Break – Operations Director

Northwest Substance Use Partnership

Emerging Trends Amongst Young Ketamine Users

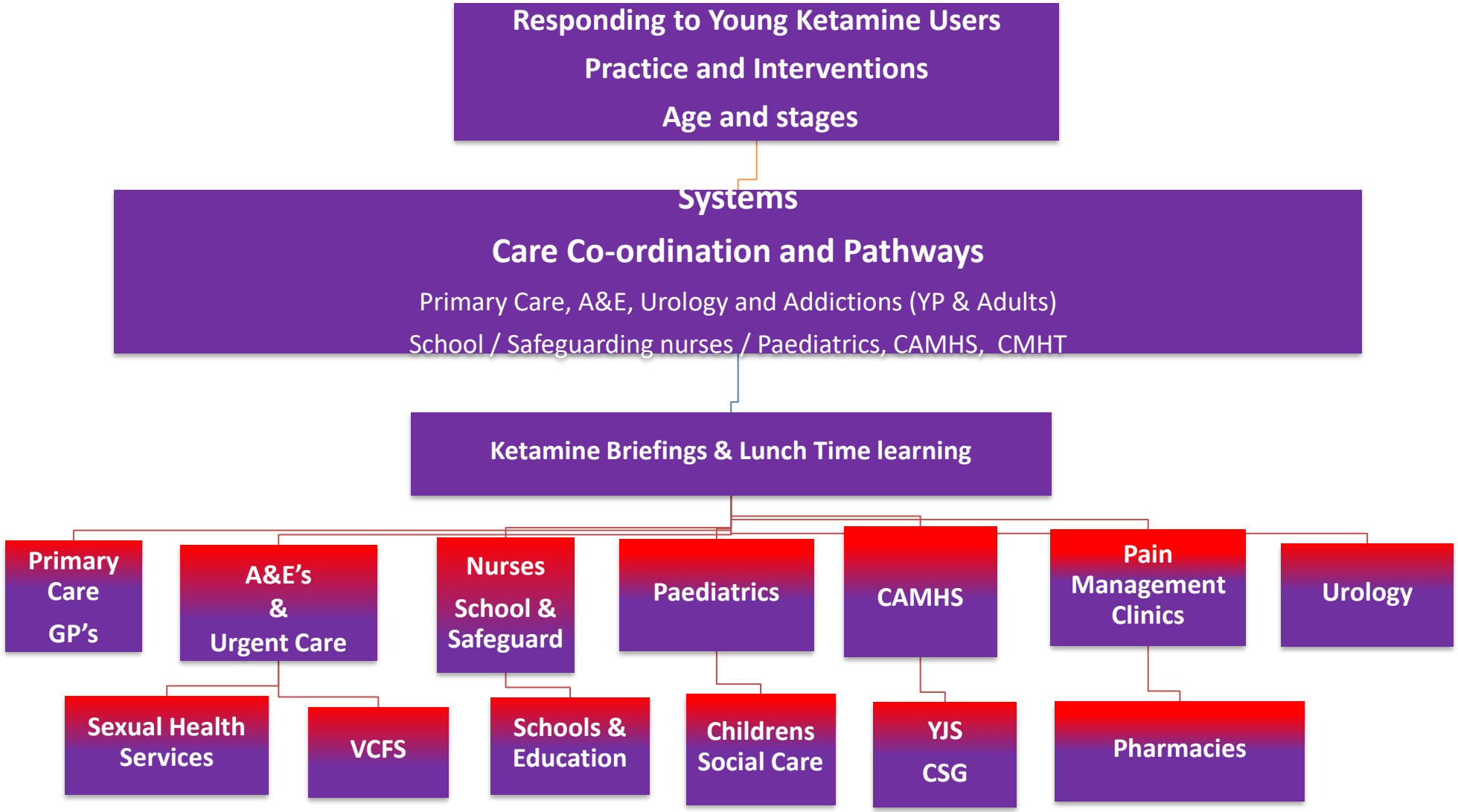
- Northwest Young People & Families Substance Use partnership (NWYPFSUP)
- GM Young Peoples Drug Trends
- Specific Focus Group – Young Ketamine Users Trends
- NWYPFSUP - Think Ketamine Event Nov 2024

Think Ketamine Event Recommendations

- Young ketamine users fall under the radar amongst health and social care professionals.
- Develop good practice on what works, prevention, treatment.
- Develop a local systems prevention plan to sequence services, avoid duplication.

Recommendations

Think Ketamine Prevention Approach 2024



Modified Staging system

British Association of Urological Surgeons (BAUS) 2024

Review of research classified into three stages of Ketamine uropathy

- ***Stage 1: The inflammatory phase where cessation of ketamine and oral medications can resolve the situation.***
- **Stage 2:** where structural changes to the bladder occur
- **Stage 3: T**he final stage with permanent changes to the bladder

Apply this learning into ages and stages:

- Considering a pre stage – **"The untouchables" aged 12-15**
- **Community based services felt if they can reach YP interventions were successful in reducing or cessation of ketamine use**
- **I**nclude credible health information on health issues prior and including stage one (inflammation phase)

Emerging learning and consideration young ketamine users

Evidence has demonstrated young people are continuing in experimenting at an earlier age.

- **Recommendation for prevention work to prevent health harms at an earlier (stage 1 urology)**

  For the majority CYP present:

  - 12-14 experimenting / recreational - good health information and harm reduction
  - 14-16 Recreational / problematic
  - 16 + Problematic / dependent

- Need to re address the balance to be more ***responsive*** in practice and avoiding ***reactive*** and understand what's working.
- Young People do not view themselves the same as adults, they tell us they feel the recovery word is stigmatising

Emerging learning and consideration in working with young ketamine users

Interventions:

- To coin a phrase “good old fashioned drugs work”
- Understand what works in ages and stages (<15 prevention, detox, rehab)
- Ensure the pre work is completed prior to any detox (prevention and relapse focus)
- Work with parents who are frightened, typically and seek “quick fixes” potentially paying privately. – we know the relapse rate is high in a too early detox
- Consider for options in community-based detox, (no pill for psychological dependence)
- Consideration to think and speak differently about young ketamine users
  - Referencing adult terminology by professionals saying young people are in recovery feels stigmatising to the young people we speak to.

Early Break

Thank You

Jday@earlybreak.co.uk

Barnsley Community Ketamine Offer:

- The prevalence of Ketamine use in Barnsley is growing with more people accessing support
- We are seeing a younger cohort accessing the service with significant, chronic physical health issues
- Inpatient detox and residential rehab seem to be effective options but may be too early on in recovery
- Currently working on community detox, relapse prevention, MDT approach, mutual aid
- We need to tailor our approach to meet these needs and engage with younger people, earlier on in their drug use

Ketamine:
Building pathways, partnerships, and a person-centred response

Reshaping our services- learning from our experiences

Accessibility and early intervention

Dual focus on health and recovery

Rethinking service design

Considering how we use what we have learnt to reframe services