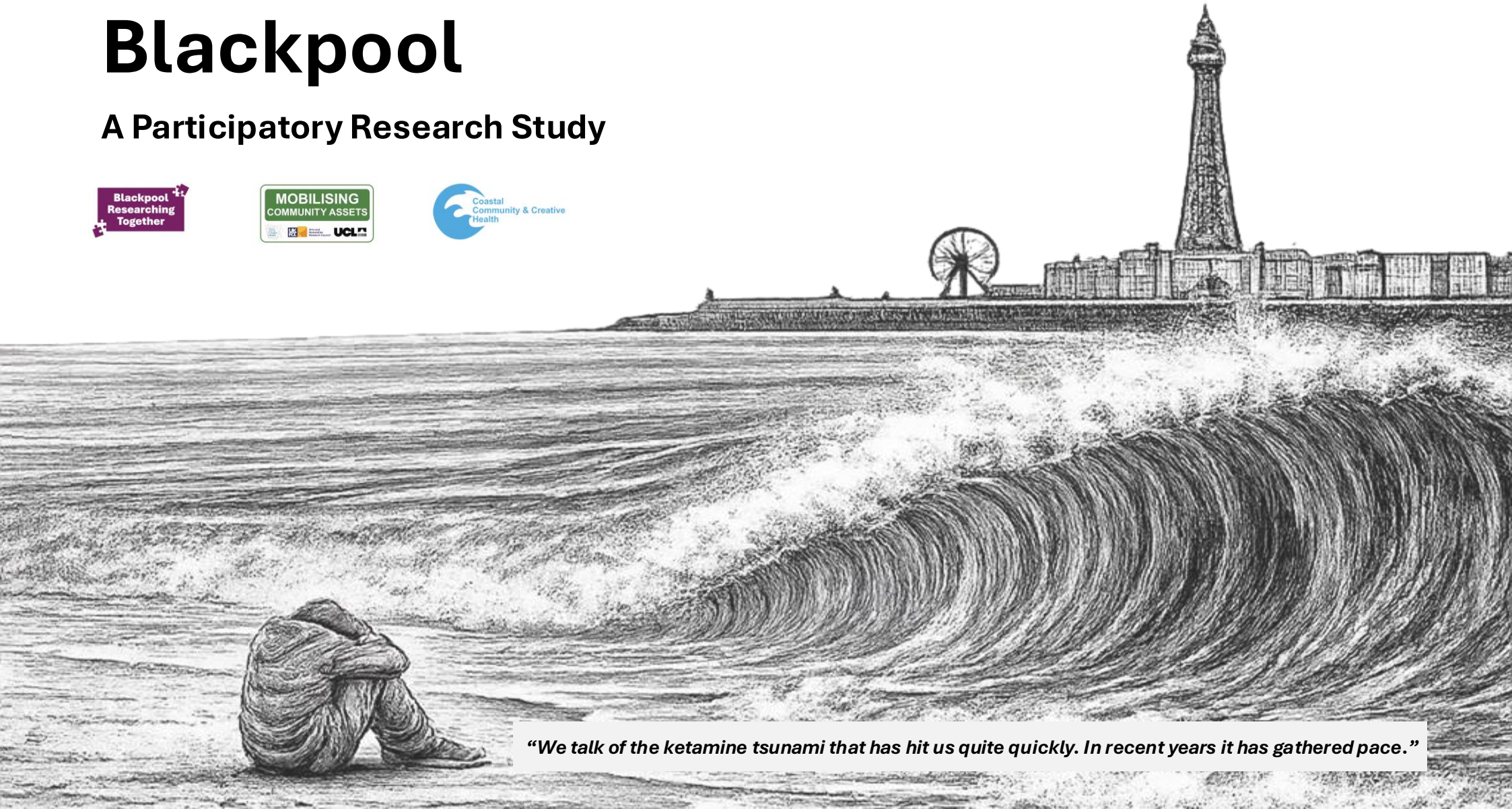
Ketamine Use in Blackpool

A Participatory Research Study



"We talk of the ketamine tsunami that has hit us quite quickly. In recent years it has gathered pace."

This report is a collaboration between three research projects: Mobilising Community Assets to Tackle Health Inequalities (Grant Ref: AH/W006405/1; PI: HJ Chatterjee), Coastal Communities and Creative Health and Blackpool Researching Together.

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Horizon, Blackpool (Alcohol, drugs and sexual health support)
Lancashire Constabulary
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OHID Health Improvement (Northwest)
Population Health Improvement (Blackpool), Lancashire and South Cumbria ICB
Renaissance Blackpool (Drug and Alcohol Support)

What Do You Mean?

Poem by Wayne Anderson

ADASH family practitioner, Adolescence Service, Blackpool Council

From being a baby, chaos was my theme,
Mum still drinking, lost in a dream.
Mental health sinking, no light in the scene—
You ask me questions… what do you mean?

My lullabies? Sirens in the night,
Bedtime stories? Screams, not delight.
Broken glass, promises unseen—
You call it childhood… what do you mean?

Fists flew like birds in a stormy sky,
Love turned to war, no reason why.
Partners came, then left the scene—
You say "domestic"… what do you mean?

I sat in rooms where grown-ups spoke,
Big words, blank stares, hearts that broke.
Decisions made, I stayed unseen—
You say "support"… what do you mean?

One day I'm home, next I'm gone,
Packed my bag, Nan's house at dawn.
"For your safety," cold and clean—
You say "protection"… what do you mean?

Safety felt like silence, not care,
No one asked, no one was there.
My voice was static on a machine—
You say "heard"… what do you mean?

You say "trauma,"
I say "Tuesday."
You say "resilience,"
I say "doomsday."
You say "attachment,"
I say "routine."
You label me—
What do you mean?

I read faces before I read books,
Dodged moods, mastered the looks.
Smiled while breaking, nodding through pain—
You say "coping"… what do you mean?

You say I'm "acting out,"
I say I'm screaming in.
You say "he's difficult,"
I say—where do I begin?

Cannabis calms the chaos inside,
Drowns the noise I've learned to hide.
The fear, the nights I couldn't dream—
You say "addicted"… what do you mean?

You say I'm safe, but outside I'm bruised,
Some man hurt me, left me used.
I tried ketamine to float, to flee—
You say "escape"… what do you mean?

It's not just a high—it's a hush,
A break from the ache, the mental crush.
Not self-hate, it's self-relief—
You say "abuse"… what do you mean?

But now the drug begins to bite,
K cramps hit me every night.
I need more just to feel serene—
You say "dependence"… what do you mean?

Hospitals, stents, my body's worn,
Advice is given, but I'm torn.
I nod, I smile, I don't take it in—
You say "engaged"… what do you mean?

I'm sinking deeper, losing ground,
My health declines, no strength is found.
DNR written, future unseen—
You say "recovery"… what do you mean?

Rehabs fail, the drug's too loud,
Family speaks, but I'm not proud.
Their words don't reach me through the screen—
You say "hope"… what do you mean?

Then Nan dies… and something shifts,
Her love, her strength, her quiet gifts.
She never asked for much, just tried—
And somehow, that love turned the tide.

I reflect, I pause, I start to see,
She believed in the man I could be.
No more ketamine, no more shame—
You say "healing"… I feel the same.

So what I mean is—
I've been escaping,
Longing for peace,
From all that's been shaping.

But Nan's love lit a spark in me,
A reason to fight, a way to be free.
I'm giving life a second chance,
No longer numbed in a drugged-out trance.

For her.
For me.
For the man I want to be.
What do you mean?

I mean…
I finally see.

Dr. Neil Hartley-Smith
Chief Medical Officer
Blackpool Teaching Hospitals NHS Foundation Trust.

Dr. Arif Rajpura
Director of Public Health
Blackpool Council

Councillor Jo Farrell
Cabinet Member for Communities and Wellbeing
Blackpool Council

Foreword

Ketamine misuse among young people has become one of the most urgent public health challenges facing Blackpool today. This is not simply a matter of individual choices or isolated incidents. It reflects deeper issues, health inequalities, deprivation, instability, and wider social determinants that shape the environments in which many of our young people grow up. Addressing ketamine use requires us to look beyond symptoms and confront the structural conditions that place some communities at greater risk.

The consequences of ketamine use are being felt across our borough. We are seeing the impact on young people's physical health, mental wellbeing, educational engagement, and future life chances. These harms do not stop with the individual; they place significant strain on families, schools, and already stretched local services. The ripple effects of rising safeguarding concerns, increased hospital attendances, and greater pressure on frontline teams are clear indicators that this issue requires collaborative, evidence driven action.

Using a co-produced approach, this report brings together over 50 professionals and people with lived experience, providing a clear, honest picture of the scale of the challenge while remaining firmly focused on solutions. The emphasis throughout is on collective action, building trust, breaking down stigma, and creating interventions that truly work.

Central to this work is the recognition that prevention and early intervention are critical. Upstream approaches, including education, youth engagement, and trauma informed care offer the greatest opportunity to reduce harm before it escalates. These approaches align closely with wider public health priorities around mental wellbeing, substance misuse prevention, and reducing health inequalities, reinforcing the need for joined-up thinking across systems.

The strength of Blackpool's approach lies in the shared efforts of multidisciplinary team partners. To effectively address this health crisis we need genuine partnerships, shared accountability, and a willingness to work differently where needed.

The NHS, local authority, voluntary and community organisations, police, and schools are most effective when they work alongside people with lived experience because no single organisation can meet this challenge alone.

Those affected by ketamine use are central to this report. Their lived experience brings depth, honesty, and relevance, ensuring that recommendations for solutions are rooted in reality. Co-production has helped to build trust, improve engagement, and create responses that people believe in.

We are committed to continued investment in prevention, partnership working, and co-produced practice. With shared determination and coordinated effort, we can reduce harm, strengthen support across our communities, and create new opportunities for young people. Through this collective work, Blackpool can place itself at the forefront of innovative action to address the ketamine crisis and build a brighter future for our children and families.

Contents

Introduction

Ketamine misuse has been highlighted by many health and community professionals across Blackpool as a growing problem, escalating at an alarming rate, with increased national media attention raising awareness and concerns.

This research takes a participatory and systems mapping approach to understand the main drivers and effects of misuse amongst the Blackpool youth, with a view to co-producing place-specific community-led prevention strategies to support young ketamine users and to address the wider determinants of health influencing their behaviours.

We have been gathering and analysing interview and workshop data from a range of services and providers across Blackpool who are supporting ketamine users, including: Blackpool Victoria Hospital, Blackpool Council Public Health, Adolescent and Children's services, Drug and Alcohol support services, Lancashire Constabulary and other local community support services.

These findings reveal that Ketamine has become the "*drug of the moment*". Its popularity is driven by affordability, accessibility, and social reinforcement among peers.

Despite education initiatives on the severe harms caused by Ketamine misuse, risk-taking persists. Some of the harms mimic UTIs, leading to misdiagnosis and missed early intervention opportunities by GPs in Primary Care.

Here we highlight key findings from a study involving many collaborators and contributors from across Blackpool and beyond. Their insights, experience, knowledge and expertise have been vital in understanding the scope and severity of the ketamine crisis in Blackpool.

Main findings of this report

Ketamine use among school children (primary and secondary) has doubled

A&E

Data indicates a rise in A&E attendance related to ketamine use

12-fold increase in people starting treatment for ketamine

60% reported nasal and bladder problems*

56% reported 'K' cramps*

78% experienced abstinence syndrome*

Patterns of use appear shaped by social determinants, nightlife culture, easy availability, price, and perceived low risk

Blackpool's ketamine crisis is a "*perfect storm*" of affordability, accessibility, and social normalisation

Some young adults report they used substances as a form of "self-medication" for ADHD

NICE

There is currently a lack of

- NICE Ketamine treatment guidelines
- Harm reduction strategies
- Local Ketamine clinical pathways

Funding needs to be made available to offer young people a trauma informed multi-team coordinated approach

Collection of data on the prevalence of ketamine, patterns and associated harms needs to be statutory

MDT

Blackpool could be at the forefront of the national ketamine response through coordinated, data-informed, multidisciplinary action

Individuals, creativity, and lived experience are driving some of the most effective local innovations

*The landscape of ketamine use disorder, Harding et al. [1]

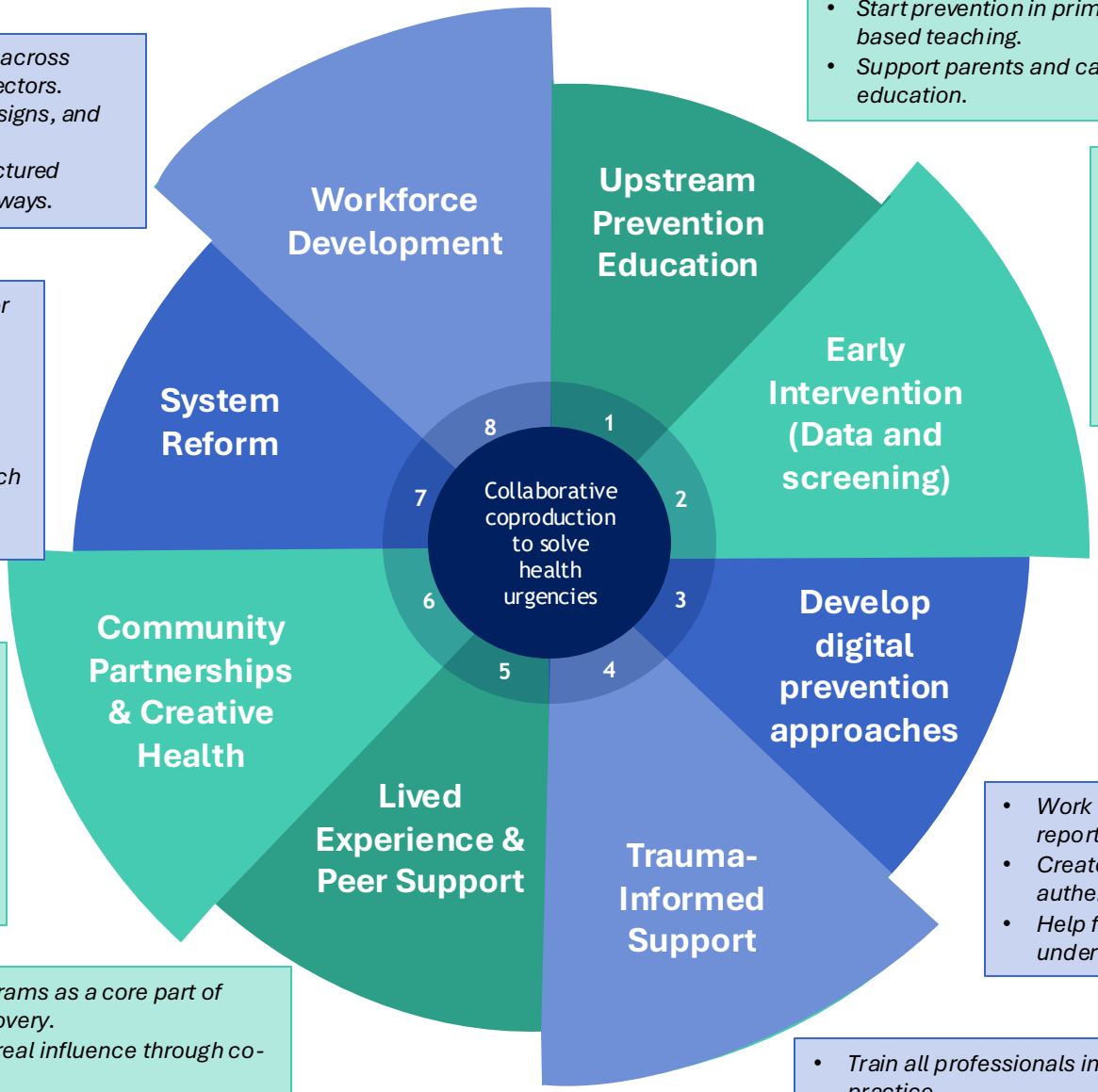
Recommendations

- *Implement multi-team training across health, education, and youth sectors.*
- *Include ketamine harms, early signs, and digital supply in training.*
- *Turn frontline insights into structured learning and clear referral pathways.*

- *Make prevention education programmes mandatory, properly funded and link to safeguarding.*
- *Link schools to specialist partners for resources and training.*
- *Start prevention in primary schools with honest, skills-based teaching.*
- *Support parents and carers with practical, stigma-free education.*

- *Develop a national clinical framework for ketamine harms.*
- *Redesign treatment to include medical, psychosocial, and family support.*
- *Protect staff time for training and wellbeing.*
- *Understand supportive mechanisms such as informing police about ketamine suppliers*

- *Make the gathering of ketamine data statutory.*
- *Create a shared data system for schools, health, and youth services highlight risk hotspots.*
- *Screen early in schools and primary care.*
- *Use real-time alerts to track emerging trends.*



SNOMED CT codes used in the NHS for ketamine misuse or related disorders include: 724715004 – Dependence caused by ketamine 26416006 – Drug abuse (disorder) (general category for substance misuse) 191816009 – Substance abuse 428311000000106 – Ketamine poisoning (if overdose/ intoxication is documented)

- *Commission joint projects across health, education, arts, and community groups.*
- *Remove barriers that limit grassroots reach.*
- *Leverage local strengths to embed creative approaches such as art, media, storytelling into prevention and recovery.*

- *Work with tech platforms to monitor and report risks.*
- *Create youth-led online content that feels authentic and challenges drug culture.*
- *Help families and professionals understand digital supply routes.*

- *Fund peer-led programs as a core part of prevention and recovery.*
- *Give young people real influence through co-production.*
- *Use creative methods like theatre and digital storytelling to build trust.*

- *Train all professionals in trauma-informed practice.*
- *Combine emotional, family, and practical support in drug interventions.*
- *Address exploitation, pain management and mental health as core issues, not side effects.*

Section 1: Blackpool Participatory Study

Over the past six months we have been conducting a series of interviews and workshops, alongside desk research, to understand the scale of Ketamine use in Blackpool.

Findings reveal that: trauma, social determinants and vulnerability, workforce capacity, service gaps, drug market accessibility, and systemic failures contribute towards the weaker access points.

Co-production, trust building between services and lived experience were enablers to good programme outcomes.

"The impact on the NHS is going to be catastrophic."

Drug Worker, ADASH Adolescence Service Blackpool Council

"It would help if they had one big team to support people and not work in isolation for example: housing, drug services and mental health so you can access mental health support easily and housing as all these go hand in hand. If you don't have a roof over your head and a safe space to stay, how are you supposed to address your drug use and this will further impact on your mental health."
Case study, 'Alfie'

1.1 Methodology

We used a systems mapping and participatory action research approach, where young people and professionals worked together as co-researchers.

Interviews with key stakeholders gathered both personal experiences and professional insights to understand ketamine use and support in Blackpool. These included:

- People with lived experience
- Drug Service providers
- Public Health teams
- VCFSE sector
- Local research team
- Lancashire Constabulary
- Health Education Leads
- NHS Clinical Consultants
- OHID (Office for Health Improvement and Disparities)

In interviews and co-production workshops, co-researchers mapped out the services and support available in Blackpool for ketamine prevention, treatment, and recovery. Together, we created a systems map showing the local service and community support network.

We also gathered information from regional network meetings, local reports, and media coverage related to ketamine to understand the scale of the problem.

The findings were analysed to identify common themes and patterns, helping us build a shared understanding of young people's ketamine use, treatment, and recovery. These insights were regularly shared with co-researchers for feedback.

Alongside this, we carried out two rapid reviews of existing research: one on recent ketamine studies and another on innovative drug interventions for young people.

We worked in iterative cycles, checking, refining, and planning, to make sure the report reflects the priorities of co-researchers. This approach kept the research grounded in real-life experience and professional knowledge, ensuring the results are valid, transparent, and collectively owned.

1.2 Co-production workshop

Co-producing a shared understanding of ketamine use among young people using a systems mapping approach:

A systems map was created to explore key factors influencing support within the system for Ketamine users in Blackpool. Developed from qualitative interviews with stakeholders, it presents a locally grounded, multi-sector perspective.

The mapping approach, inspired by Jessiman et al. [1], provides an opportunity to collectively identify feedback loops, leverage points, and systemic barriers, moving beyond linear models.

The Ketamine users' systems map places people with lived experience at the centre to help us better understand how services, policies, and stakeholders interact. The map is not a definitive model but offers a visual tool for reflection and strategic planning.

System Map Domains:

The family, community and peer support system

Local and national commissioning

Clinical and statutory services
Education (Schools & colleges)

Criminal justice system

Arts, culture and leisure services

Research bodies and institutions

Housing and environment

1.3 Mapping a ketamine user's treatment and recovery journey

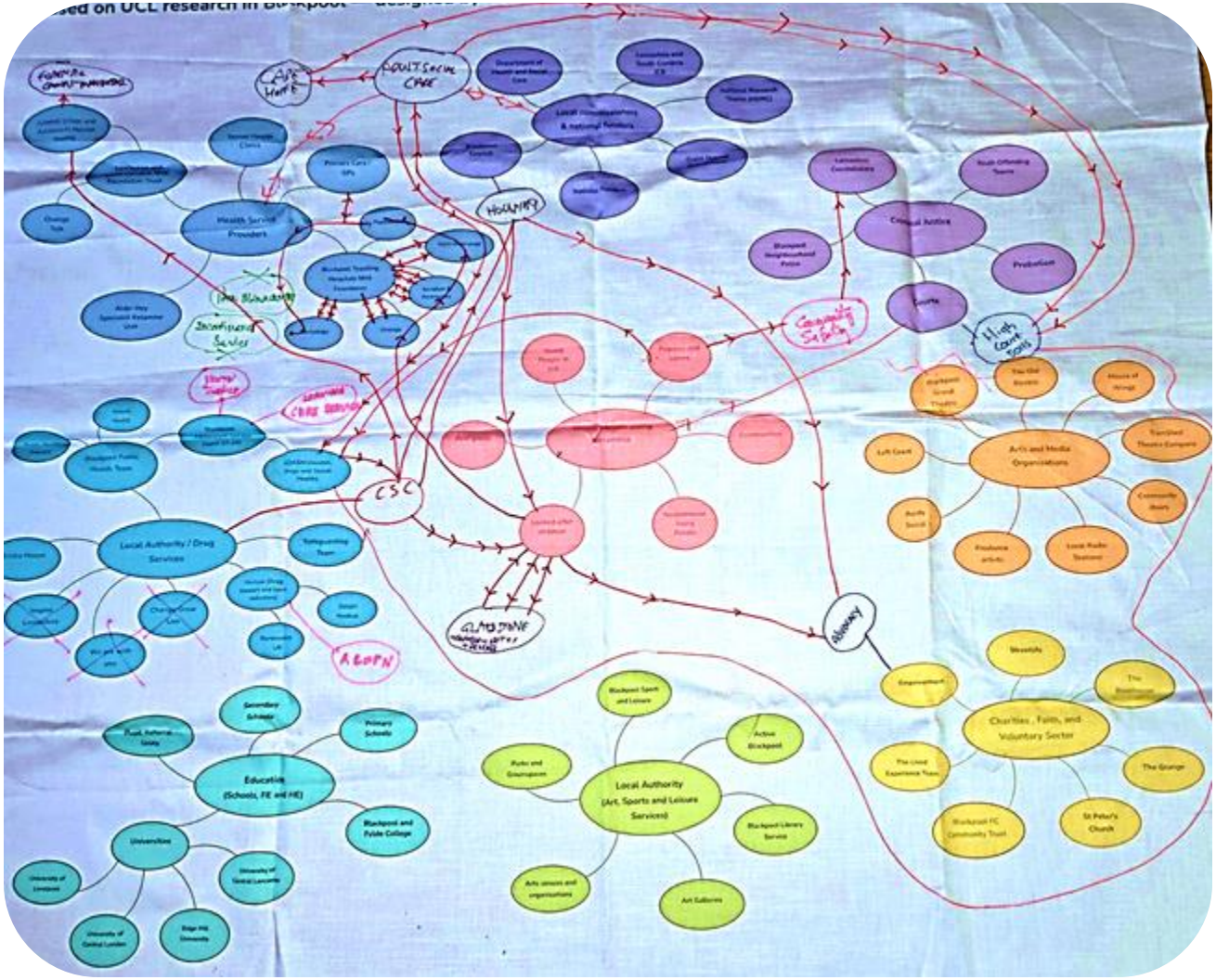
During coproduction, system maps were used to identify approaches to prevention, harm reduction, treatment and recovery for 14–18-year-old ketamine users.

This systems map depicts the journey of one young person in Blackpool previously under DoLS*, revealing a history of bereavement, mental health challenges, and early ketamine use. His pathway involved multiple services, frequent A&E admissions, and referrals to urology for severe bladder damage. We learnt that this is a pattern echoed by many young users.

The discussion highlighted the need to reframe ketamine addiction as a crisis requiring an urgent ketamine-specific pathway. Attendees stressed the importance of rapid intervention during the short window before physical harm escalates, yet uncertainty remains over which service should lead. Ideas included family testing kits and wider training for A&E, urgent care, GPs, pharmacists, and pain specialists, as current awareness is inadequate.

Co-researchers discussing prevention and harm reduction, agreed that pathways must offer hope, fun, and address underlying wider determinants, alongside greater investment and commitment from the ICB and NHS Trusts.

* The deprivation of liberty safeguards (DoLS) are designed to ensure that patients are kept safe when they cannot make their own decisions.



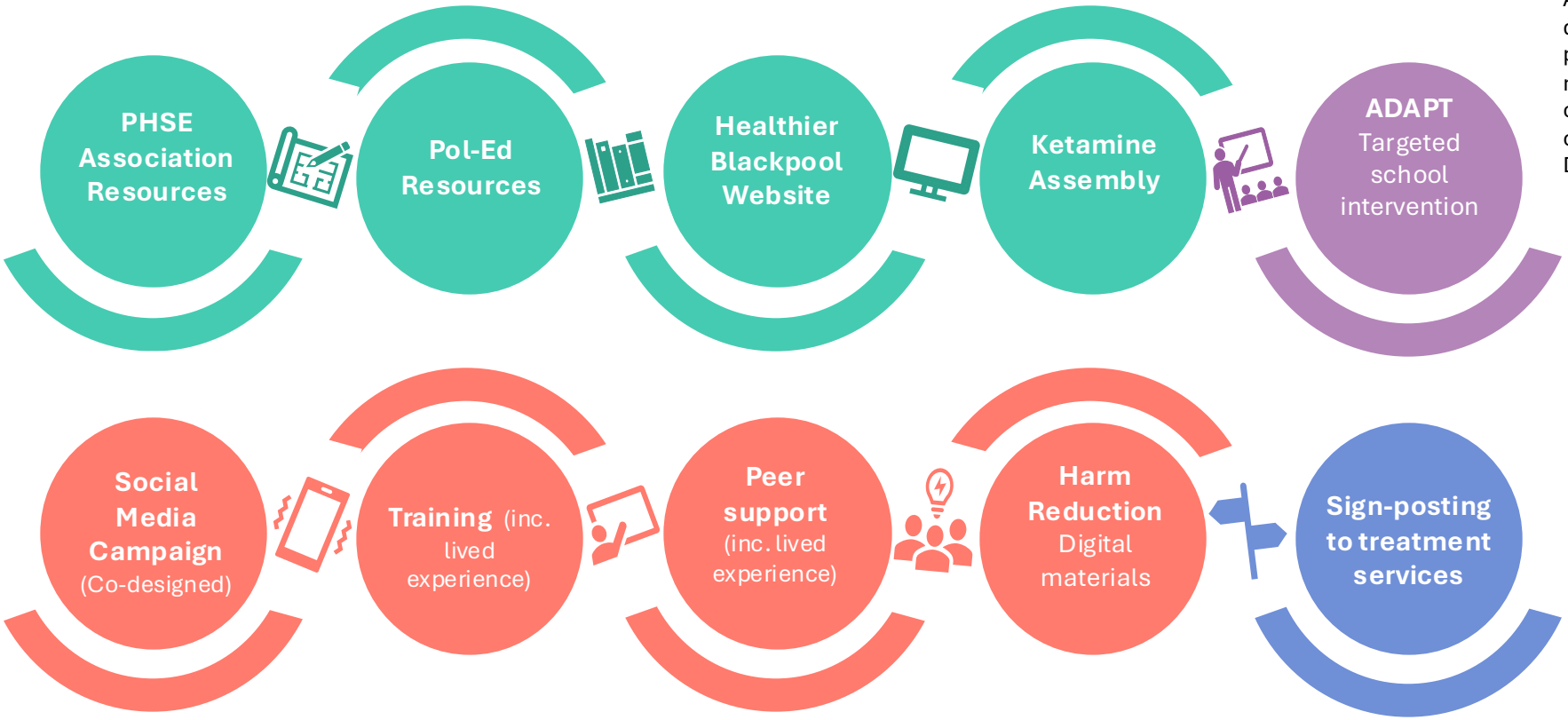
A co-created Systamap of one ketamine user's journey through the system
Blackpool Co-production Workshop September 2025

1.4 Blackpool ketamine - advice, guidance & further support

School drug prevention education resources:
PHSE Association, Pol-Ed and Healthier Blackpool, includes lesson plans, guidance, CPD and resources.

Ketamine assembly (multi-disciplinary team)
Public Health, Blackpool Teaching Hospital, Lancashire Constabulary and AWAKEN (Blackpool Council's exploitation team)

ADAPT (ADASH)
Adolescent Drug & Alcohol Prevention Training
A targeted, science-based drug education 6-week programme, challenging misconceptions, teaching consequences, building coping skills, and using DBT-informed approaches.



Co-produced resources and lived experience
Public health have co-produced a social media campaign with Blackpool and Fylde Sixth Form College public health trainers are embedding lived experience into harm reduction training and digital materials

Advice, guidance and sign-posting
Advice, harm-reduction support, guidance and signposting to drug and alcohol treatment services for young people is provided through ADASH (under 25s) and Horizon (over 25s).

1.5 Ketamine support in Blackpool: PROJECT K.

PROJECT K offers a confidential and safe space for people over 18 to talk about addiction and sensitive health issues. The idea came from client feedback, with Horizon recovery practitioners' Steve and Mollie recognising the need for a dedicated group.

"From what we've seen, ketamine use is on the increase particularly amongst young people, but there are no face-to-face, peer-led groups in the area – that's why we started PROJECT K" - Mollie, recovery practitioner, Horizon, Blackpool.

PROJECT K is providing a completely safe space for current users or people in recovery from ketamine, empowering them to openly speak to each other about the mental and physical symptoms of using ketamine. The group has established access to Urology and Mental Health services, and encourages ketamine users to engage with services to aid recovery.

Recovery practitioner Steve said: "Ketamine is quite different to most other substances in its culture of usage, as well as effects it has on the mind and body. That's why it is pivotal to have a group that is specific". He continued: "One of the main symptoms of ketamine use is bladder damage, which is why many users seek a safe space for honest conversation with people who understand their situation".

The group is open to anyone over 18 and not just Horizon service users, but Mollie and Steve both recognise that there is also a need to support younger people under 18 and their families.

Mollie has produced a very informative "reel" which she is promoting on social media to "help break the stigma around ketamine use". She says "We know that social media is the main way that young people are accessing information about ketamine, including how they buy ketamine, so that's why we are working on a social media campaign".

PROJECT K support groups take place every Tuesday at Winstone House at 199 Church Street in Blackpool, from 5:30pm to 6:30pm. The sessions are run on a drop-in basis, with no booking required.

1.6 Key interview findings

Trauma, vulnerability and social determinants

The sharp rise in ketamine use reflects deep social and emotional deprivation, creating cycles of harm that require trauma-informed, holistic interventions. Strategies must combine educational support, family engagement, and creative approaches that target the social and economic determinants of community wellbeing.

Service gaps (a) Prevention and harm reduction

Non-statutory PSHE, fragmented RSHE guidance, and academy autonomy create inconsistent drug education, with limited youth-relevant resources; gaps in alternative provision and off-rolling leave vulnerable young people unseen, while schools can refuse training and external input, undermining prevention efforts.

Drug market, accessibility, and digital supply

Social media normalises ketamine use through memes, influencer culture, and algorithmic amplification, while weak regulation and low parental awareness turn platforms into digital marketplaces, exposing even primary-aged children and highlighting failures in current online safety measures.

Co-production, trust building, and lived experience in innovation

Embedding lived-experience and building creative partnerships could strengthen engagement and create credible content. Structured training, and co-produced resources enable authentic prevention messaging, while multi-agency collaboration and youth participation would drive innovation and system change across fragmented services.

Workforce capacity and training gaps

Widespread gaps in ketamine-specific awareness among parents and professionals, compounded by misconceptions, workforce burnout, and fragmented commissioning, leave services reactive, under-resourced, and reliant on individual initiative.

Service gaps (b) Data, treatment and recovery

Fragmented data systems, poor cross-agency coordination, and lack of research leave ketamine harms underestimated; crisis-driven services, inadequate detox pathways,. Gaps in youth provision is compounded by stigma, housing instability, and disengaged parents.

Systemic failures and commissioning

Underinvestment driven by austerity has pushed services into crisis mode, with fragmented systems, misdiagnosis, long waits, and risk-averse cultures undermining prevention, youth-specific care, and innovation. Ketamine support is reactive rather than coordinated or co-delivered.

1.7 Trauma, vulnerability and social determinants

“There are a percentage of young people who I think are the ones that are probably struggling with some kind of complex trauma, that's kind of what we know.” **Programme Director, Blackpool Researching Together**

The Blackpool Ketamine crisis has a unique risk profile with rapid onset of serious physiological harm. Early identification and proactive health interventions are critical, yet stigma and hidden use complicate timely treatment and responses. Ketamine use is both a symptom and driver of vulnerability.

It was reported that young people described experiences of physical pain, emotional distress, stigma, and exploitation. These factors reinforce cycles of harm, with ketamine often used as a coping mechanism for pain, trauma, deprivation, and living with symptoms related to neurodiversity.

Key insight: Prevention and care require a new integrated, trauma-aware approach that supports families, strengthens protective factors, and addresses the social determinants that fuel initiation and escalation.

Early trauma-informed approaches were repeatedly identified as essential. Respondents stressed the need for support that recognises the links between social, physical, and emotional suffering.

Social and emotional deprivation, unmet educational needs, family strain, and socioeconomic hardship form a core backdrop. For some, ketamine use is connected to sexual exploitation, peer pressure, and disrupted home environments.

Despite escalating medical and social impacts, young people are not deterred by the health consequences of Ketamine misuse. Lived-experience narratives were considered more credible and effective than fear-based messaging.

“...all their mates just think it's normal to wear a nappy.”
Director of Lived Experience, Empowerment Charity

“His ketamine use was not simply recreational; it was a way of coping with overwhelming emotional pain and unresolved trauma. Supporting him required a trauma-informed, compassionate approach that addressed both his substance use and the underlying causes.” **ADASH Case Study**

“We are noticing quite a large link to young people, especially girls, where they’ve got some sort of ADHD linked to it ... even if there’s not a diagnosis, there’s some sort of question mark around it.” **ADASH Drug Worker.**

“Definitely seeing a rise in exploitation linked to ketamine use as well. They’re even calling it now sexploitation because it’s linked to financial exploitation and sexual exploitation.” **Blackpool Council Exploitation Team**

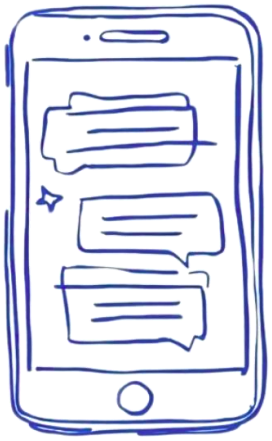
“So, we're talking complex needs adults, and all things multiple disadvantage. So those people, the furthest away from treatment, who you could claim are the hardest to engage, although I'd argue that services are not easy to engage with. I don't particularly like that term, hard to reach. Those who have multi-layered needs, entrenched trauma and aces, adults who have usually had experience of the care system themselves and have suffered significant trauma, are those who we deem as multiple disadvantaged. A person experiencing a combination of homelessness, substance misuse, mental health issues, offending, and domestic abuse, either perpetrator or victim, often finds both roles interject, usually due to the toxicity of the relationship.” **Public Health Programme Lead**

1.8 Drug market, accessibility, and digital supply

Understanding ketamine use in Blackpool [2]

Social media platforms now act as engines of normalisation, where memes, influencer content, and competitions transform ketamine into a youth-facing digital trend.

Dealers use encrypted platforms such as Snapchat, Instagram, and Telegram to create fast, low-risk access routes. Gamified sales tactics and coded emojis help bypass scrutiny. As supply has shifted from public spaces to digital channels and private homes, ketamine use becomes less visible to law enforcement, families and professionals. Routine consumption is increasing due to affordability, and easy availability leading to addiction to the substance.



Almost all interviewees noted that children at primary-school age are already exposed, and online safety mechanisms are failing our children and young people.

Encrypted apps and anonymity make traditional policing ineffective. Enforcement agencies reported limited cooperation from tech companies, with data encryption and overseas storage blocking access to evidence.

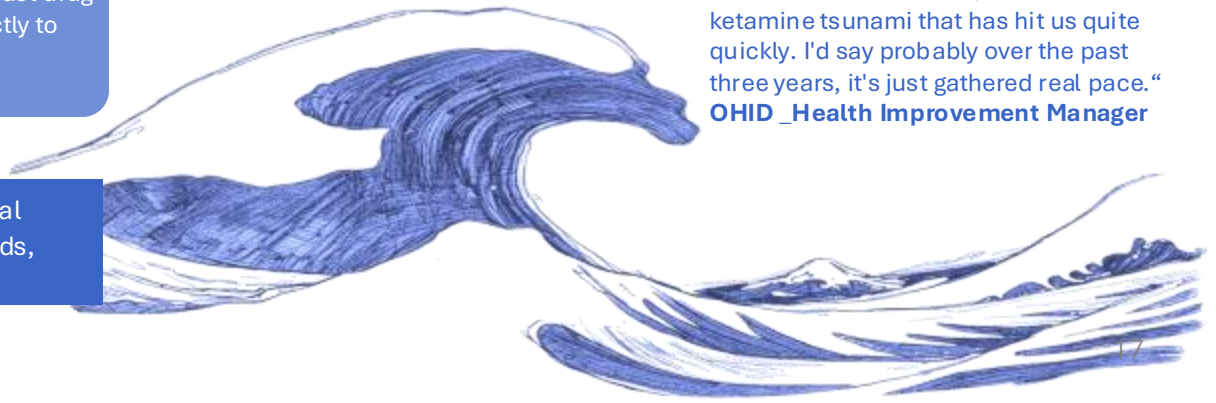
"Children are basically playing this game on Snapchat where they go and share my username, and you'll enter a free prize giveaway for a gramme of ketamine."
Blackpool Council Exploitation Team

" We can find... a county line... within hopefully a few days of it arriving... whereas on a Snapchat or a telegram you don't get... bulk messages... the way we can identify it is so much more difficult. So we solely rely on people to tell us. And you're less likely to get young people reporting to the police about their suppliers. "
Detective Sargeant, Lancashire Constabulary

" All they need to do is go on Snapchat or Instagram and they can get drugs within 30 minutes."
Change Talks Founder

" He used his mobile phone to contact drug dealers and arrange deliveries directly to the hospital."
ADASH Case Study

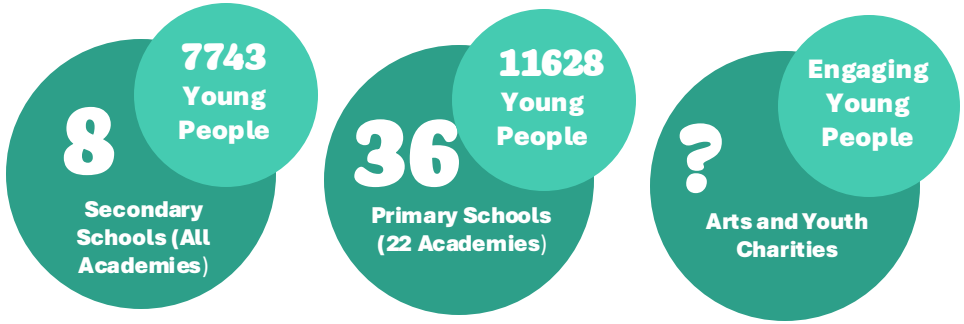
"In relation to ketamine, we talk of the ketamine tsunami that has hit us quite quickly. I'd say probably over the past three years, it's just gathered real pace."
OHID _Health Improvement Manager



Key insight: Collaboration with tech platforms, strengthened digital intelligence, and early-warning systems are needed to anticipate trends, track supply routes, and support timely intervention.

1.9 Service Gaps (a)

Prevention and Harm Reduction



Schools are lacking a consistent approach to drug education. Although Relationships, Sex and Health Education (RSHE) is statutory in England, academy autonomy across Blackpool has created an inconsistency of drug prevention education delivery. There is currently no formal RSHE or PSHE specialism within Initial Teacher Training (ITT). Teachers can only qualify in broad subjects (e.g., Primary, English, Science) resulting in few specialists who can teach sensitive and complex content effectively.

The Keeping Children Safe in Education (KCSIE) guidance emphasises a risk management approach to safeguarding rather than prevention. Statutory guidance allows wide local interpretation, resulting in variable depth and quality of provision across settings.

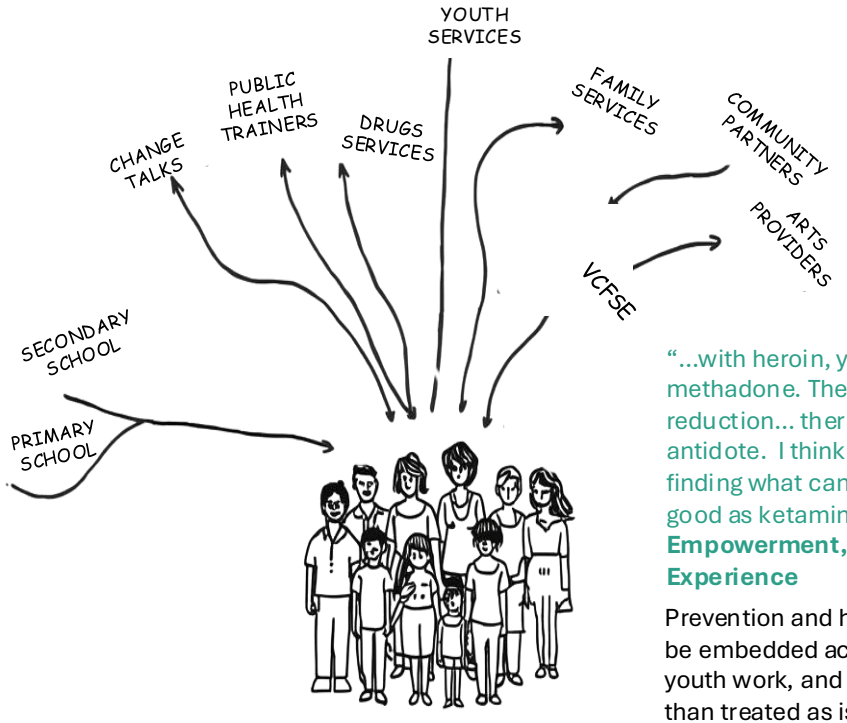
> "Sometimes it's delivered in form times 20 minutes a week. Sometimes it's a whole class assemblies, sometimes it's an hour per week. In most schools it's an hour a week until you get to year 10... and then it's falling away because of the pressures of GCSE.
> **Blackpool Public Health Trainer**

Stakeholders advocated for skills-based, empathetic education introduced from primary age. VCFSE organisations need properly funding for the work they do.

Moralistic, one-off, or punitive approaches alienate at-risk youth; harm reduction content remains limited. Co-produced content, visual storytelling, and youth-led digital materials show strong promise but require sustained support.

> "We know just say no doesn't work. So, we've got to, if they're going to do it, we've got to ensure that they're doing it safely to prevent the harms that it's causing. In education is the key."
> **Blackpool Public Health Sex and Drugs Trainer**

Parents often feel overwhelmed and under-informed. Accessible, community-rooted education could strengthen a prevention culture at home. Community and creative organisations offer untapped potential for engagement, particularly when traditional services are stretched but these also need to be effectively resourced (structurally and financially).



> "...with heroin, you can give methadone. There's no harm reduction... there's no actual antidote. I think something needs finding what can manage the pain as good as ketamine does."
> **Empowerment, Director of Lived Experience**

Prevention and harm reduction need to be embedded across schools, health, youth work, and family services rather than treated as isolated efforts.

.

Key insight: Weak prevention frameworks undermine meaningful harm reduction. Creative approaches help with accessible and inclusive messaging, but youth centred, co produced approaches need sustained investment.

1.9 Service Gaps (b)

Data, Treatment and Recovery

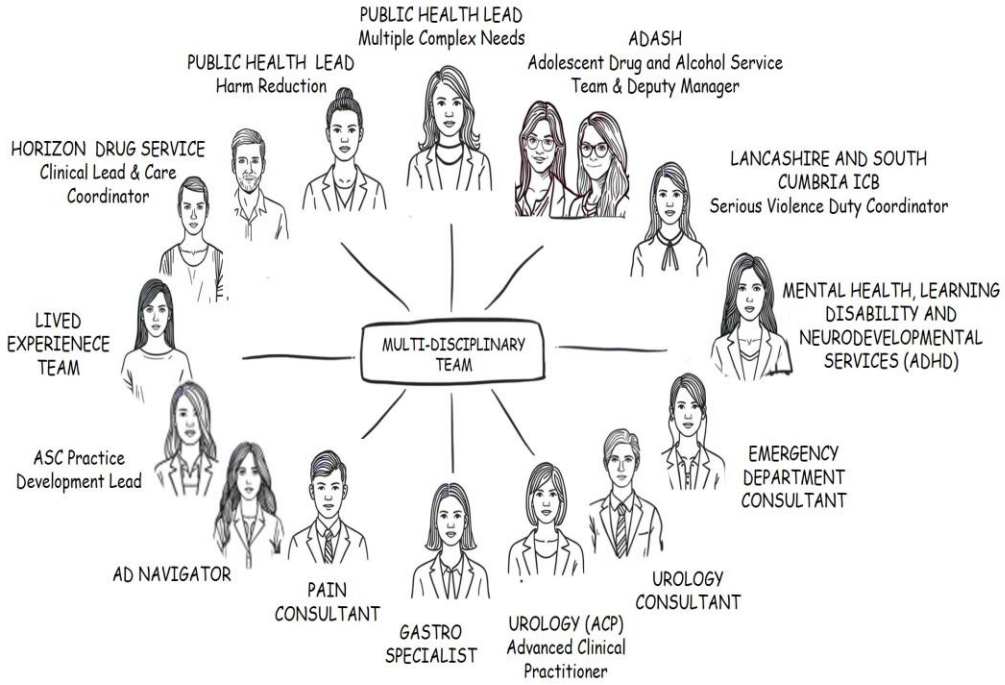
Lack of systematic data collection, cross-agency coordination, and intelligence from digital platforms leaves ketamine harms under-estimated; informal tracking compensates for gaps

Clinical Treatment and Recovery Services are operating in reactive 'firefighting' mode. Without early detection, many young people only encounter support when serious physical or social harm has occurred.

"There aren't any set detox pathways... stopping use can revert symptoms if caught early, but pain is often so bad that urologists are involved... using Botox, bladder flushes, or even bladder removal."
Horizon Service providers

We have one, I think 18. And he just had to be put in a care home or whatever. He's like 18 years old. So it's not the right place for him, but there's nowhere and that's it."
Director of Lived Experience Empower

Structural gaps in detox facilities, residential options, and youth-specific clinical pathways, result in revolving-door patterns, causing a greater financial strain on the NHS.



"The impact is going to be huge financially and burdensome for health and other services in 10, 20, 30, 40 years' time."
ADASH, Drug Worker

Key insight: Strengthening monitoring systems and leveraging community data could help improve targeted responses. A shared clinical framework is urgently required to guide safe, evidence-informed practice.

When education, health, social care, families, and community partners collaborate, and lived experience shapes both design and delivery, support becomes more responsive, humane, and far more effective at disrupting harmful pathways.

"It needs to be done through a specific substance misuse pain management clinic that looks at psychology that looks at physiotherapy, not just a pharmacological intervention... it's about behaviour change. It's about addressing the addiction... one key thing for us was about pulling together an experts MDT panel."
Public Health Programme Lead

"...the consultants that are currently attending that MDT on a monthly basis from BTH directors have come to us and said that we need to reimburse the hospital for their time because the urologist is actually attending in his own time..."
Public Health Programme Lead

"We're being told ... that the ICB are saying those people who are giving their time at the moment for the MDT might not be able to give their time anymore."
ADASH Key worker

This means embedding evidence-informed support across the full continuum of prevention, harm reduction, treatment, and recovery, and ensuring that each stage is shaped with people who have lived experience.

1.10 Workforce capacity and training gaps

Health professionals, teachers, and parents lack awareness of ketamine specific harms. Frontline services face expertise gaps, with limited training access, results in fatal outcomes and additional harms for people affected by the ketamine crisis.

> "We know that there has been a death that somebody told me about. Unfortunate, really sad, a 28-year-old female who has died from ketamine use went to her GP 8 times and was prescribed antibiotics for a UTI. Was never asked the question around Ketamine."
> **OHID Health Improvement Manager**

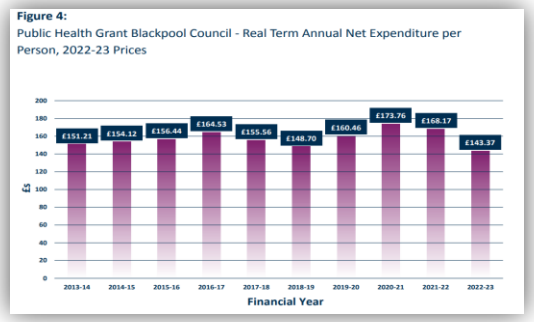
> "A woman presented with bladder tissue coming out in the toilet and the GP said, 'oh, you've had a miscarriage' … and sent her away." **ADASH Drug Worker, ADASH**

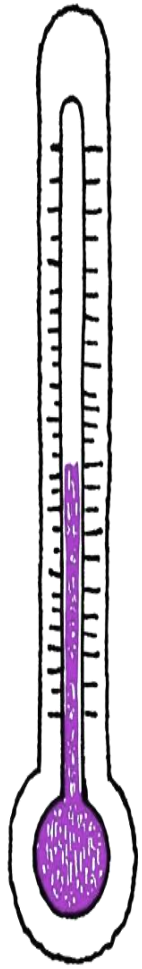
Frontline staff face high caseloads, burnout, and competing priorities, limiting training uptake and proactive prevention. Often practitioners compensate with informal solutions despite the systemic strain.

Practitioners stretch beyond commissioned roles to address urgent unmet needs, yet capacity and funding constraints force partner agencies to withdraw from multi-disciplinary teams, weakening service delivery and collaborative responses

> "We have foreseen this situation ages back and [X] has been instrumental in getting working group going. But this does need funding as it is unreasonable otherwise."
> **Pain Consultant, Blackpool Hospital**

Without formal frameworks or funding, responses remain ad-hoc. National inconsistency and a lack of NICE guidance creates unequal care pathways, relying on individual initiative rather than coordinated systems, leaving treatment fragmented and prevention efforts inequitable.





Since 2010, central government funding for Blackpool Council has fallen by £218 million, representing a 25.4% real-terms reduction

For 2024–25, Blackpool Council faces a £16.2 million funding gap; to close this, all departments must make efficiency savings—such as renegotiation of external contracts, service cuts, and staff unpaid leave.

Despite this long-term reduction, Blackpool has more recently secured significant additional targeted investment for drug and alcohol treatment and recovery, including enhanced Rough Sleeping Drug and Alcohol Treatment funding

Key insight: Strengthening workforce confidence, capacity, and clinical consistency is vital for sustainable early intervention and safe, evidence-informed practice. This can only come with increased investment to support areas trying to address huge health inequities.

1.11 Systemic failures and commissioning

The wider system remains geared toward crisis rather than prevention. Austerity has dismantled local prevention infrastructures, leaving schools and communities without the tools or bandwidth to act upstream. Informal interagency relationships paper over gaps but lack formal recognition or resourcing, making them fragile.

> "...we've got... the short termism of some of the services that we deliver... it's really frustrating sometimes to see the way in which we deliver services and don't always do the best we can with the investment that's available."
> **Drug Worker, ADASH adolescence service Blackpool Council**

Practitioners described working without national guidance, forcing them to improvise clinical responses, this creates an inconsistently across the system.

> "The issue is there is no NICE guidance or pharmacological guidance around the detox process for ketamine... And when I spoke to where one of the facilities was, where they use an alcohol detox pathway, there's no withdrawal scale for ketamine."
> **Blackpool Public Health Programme Lead**

> "Nobody really knows. There's no consistency to anything — treatment pathway, children's social care response, GP response, hospital — there's just no consistency."
> **Drug Worker, ADASH adolescence service Blackpool council**

> "We're all just having to do more than what we're paid to do or commissioned to do because otherwise we're just sitting back and waiting."
> **Drug Worker, ADASH adolescence service Blackpool council**

Participants expressed frustration with what they described as a 'chaotic system'—one without strategic coordination or clear leadership on ketamine and lacking shared data systems or consistent pathways. They emphasised that without shared frameworks, coherent governance, and integrated commissioning, effort remains siloed and reactive. These gaps restrict communication, limit collaboration, and obscure local innovation.

Despite constraints, emergent leadership within Project ADDER and local advocacy networks signals momentum for system-wide reform.

> "There's still that very patriarchal kind of way in which you know the NHS are going through it... we're all talking about change... but when it comes to making decisions... we're probably tinkering around the edges."
> **Chief Executive, Blackpool CAB**

> "Someone needs to make a stance and say, look, we need to do something differently here."
> **Exploitation Team**

Key insight: Coordinated investment, aligned commissioning, and shared accountability are essential to transform fragmented responses into a sustainable prevention and recovery ecosystem.

1.12 Co-production, Trust Building, and Lived Experience in Innovation

> “We did a forum theatre piece based just on Ketamine, and I don't know if you're familiar with forum theatre, but it's where you can change and direct the actors in the scene. And some parents goes, ‘well, it's not like that. This is how it is’. And so, she was invited to get in the performance area, join the actors and literally act out and tell the people how it actually happened.” **Ketamine Recovery Programme Lead, Elisha House**

A strong cross-sector consensus emerged around the value of lived experience, co-production, and building trust. Young people and families reported feeling more engaged when treated as partners rather than recipients of ineffective care.

Peer-led initiatives such as Ketamine Anonymous and Project K are filling gaps where mainstream services feel inaccessible or unrelatable. Co-produced creative approaches, including forum theatre, youth-designed media campaigns, and lived-experience storytelling, enable honest dialogue and more resonant harm-reduction messaging. Some national and regional media coverage has effectively reach families who have then accessed support, although there are concerns around the suitability of young people in recovery being propelled into media highlights.

Community organisations, colleges, football trust programmes, and arts organisations are becoming essential partners in prevention and recovery. However, stakeholders stressed that these innovations require structural support, consistent funding, and the freedom to share outputs without constraints, stepping in where services fall short should not be an option. Their advocacy underscores the system's gaps and its reliance on informal care. These approaches could be brought in to more formalised care in order to reach those most in need and address the challenges of ketamine misuse.

> “So really, it's how do you make that message as consistent and as safe as it can be, not just covering Ketamine, but covering all substances potentially... But yes, it's got to be consistent, and I think it's got to be, and again using negative lived experience can be really quite powerful if you've got a peer who is somebody who you see as a peer going in, and going, you know you don't want to be wearing a port. You know, you don't have to have a bag, you know, these are things you don't want to be, but that that then relies on somebody who is from that cohort. ” **Key Worker Horizon**

One female has made significant progress beyond her own recovery. She is now volunteering with the LET team, using her lived experience to support others and contribute to service development. Her contribution is invaluable in raising awareness, improving clinical responses, and offering hope to others affected by ketamine-related harm. **ADASH Case Study**

Key insight: Individuals, creativity, and lived experience are driving some of the most effective local innovations. Scaling them requires long-term investment, shared governance, and recognition of their role within the wider system.

Section 2: Lived experience

The case studies, interview data and poem shared in this report have all been written by people with direct experience of ketamine use and recovery. They are presented with consent, each providing insight into the emotional, psychological, and personal realities that underpin ketamine use. Much of this is difficult to capture fully through clinical language or service records alone. Lived experience contributions are crucial to health and trauma-informed practice, not only as anecdotal evidence but as a valid and powerful form of data. In this report, these narratives function not as illustrations, but as an analytic lens, articulating themes that strongly align with those identified across the report. These personal stories are not just case studies; they are a call to action.

"During her engagement with support, 'L' remained actively involved with medical services and demonstrated commitment to addressing the physical consequences of her ketamine use. She underwent a camera examination of the bladder and continues to receive bladder instillations as part of her urology treatment. Most recently, she has continued to require specialist care due to ongoing bladder issues including Botox to the bladder to help with her urgency."
Case study, 'L'

"We know that there has been a death … unfortunate, really sad. A 28-year-old female who has died from ketamine use went to her GP eight times and was prescribed antibiotics for a UTI. Was never asked the question around Ketamine."
OHID Health Improvement Manager

2.1 Lived experience themes

Determinants and impact

Early and repeated trauma as the foundation of ketamine use (Trauma is not a background factor - it is the primary driver)
Early and repeated trauma was often central to people's ketamine use. Substance use was not about seeking risk or excitement, but about trying to cope with pain that started long before they began using drugs. Many described experiences of abuse, neglect, instability, or feeling unsafe while growing up. Participants shared that ketamine helped them escape memories, anxiety, and overwhelming emotional distress. These experiences suggest that, for many, ketamine use developed to survive unbearable internal experiences rather than as recreational behaviour.

Substances as self-regulation and emotional anesthesia
We found that ketamine is being used as a replacement for an absence of safety, emotional attachment, and psychological needs.

Long term physical harm and irreversibility
Participants spoke openly about the serious physical harm caused by long-term ketamine use, particularly bladder and urinary problems. We found that many people were unaware of the severity and permanence of these harms when they first began using. Stopping ketamine did not always stop the pain or physical damage. Several participants described living with ongoing health problems even after stopping use, which created additional emotional distress and challenges in recovery.

Holistic

Consistent, relational care as the turning point
We found that consistent and trusting relationships with professionals were often described as key turning points. Seeing the same worker, feeling believed, and building trust over time made it easier to stay engaged with support. The quality of relationships often mattered more than the type of intervention offered.

Love, meaning, and identity as catalysts for recovery
Participants rarely described fear of consequences as the main driver for recovery. Instead, recovery became possible when they experienced connection, purpose, and a sense of identity beyond substance use. Participants spoke about the importance of feeling valued, loved, and hopeful about their future. Many described recovery as rediscovering who they were, what mattered to them, and where they belonged.

Systemic change

Importance of professional language and lived reality
Our research highlighted a gap between how services sometimes describe individuals and how those individuals experience themselves. Some participants described appearing cooperative while internally feeling disconnected or dissociated. Participants told us they were more likely to engage when they felt listened to, respected, and involved in decisions about their care.

Fragmented systems can mirror chaos describe in lives
We found that disjointed support systems often reflected the instability many participants had experienced throughout their lives. Moving between different services, repeating their stories multiple times, or experiencing inconsistent support made them feel rejected or forgotten.

2.2 Mark's Story

It started with more than just a craving for drugs, when I was young, I craved chaos. As a kid, I knew that I loved risk and rebellion. In primary school, I was hanging out with boys that were much older. They were all about 2-3 years older and they introduced me to drugs, and that's how I first tried ketamine. We mixed it with cocaine to make it last longer.

Ketamine felt like an escape, and I think I've got undiagnosed ADHD, because ketamine made me feel calm, like I had control. But that didn't last. What started as a £10 bag for the weekend spiralled fast. Soon, I was using up to 13 grams a day. The damage was brutal. I was in agony; Ketamine wrecked my bladder. I became incontinent, urinating jelly, vomiting blood. I went to my GP and A&E countless times, but they kept saying kidney stones and was sending to me different specialist clinics… I knew exactly what was wrong but couldn't admit the truth in front of my mum. They sent me to the 'gum' (sexual health) clinic, and even though I sat there knowing it was ketamine,

I couldn't stop. I was an addict. I ended up wearing nappies because of the burning.

My health got worse. My skin turned grey, I couldn't hold down a job, and I became suicidal. I ended up in hospital, but that didn't work. Eventually, I begged my sister for help when I could barely breathe.

I tried 'Inspire', but sitting in groups with older heroin users didn't help. Later, I found 'We Are With You', and they were amazing. My sister finally told my Mum the truth, and she paid for detox in Carlisle. I lasted five days in a recovery house before relapsing. That's how strong the pull was.

Everything changed when my mum saw Tom Ryde on telly… she reached out to Elishia House. At first, I didn't want to admit addiction was a disease. But slowly, I started to engage. I've learned recovery is possible. It's hard, but I'm finally seeing the benefits, I've found a connection, hope, and a future I never thought I'd have. I've even started making my own Tik Tok videos to share my story and to try and help others.

The knowledge shared by people with lived experience is essential to understanding the reality of the ketamine crisis and in shaping action that will work. We aim to provide a grounded, collective understanding of ketamine use in Blackpool.

Mark joined Elisha House's young person's ketamine programme after his mum reached out for help. Elisha House based in Colne, Lancashire takes referrals from Blackpool and across the North of England. They offer accommodation and support to men in recovery.

Since writing this report, Mark has relapsed and is currently using ketamine again within the community. Carl Molyneux, a manager at Elisha House says:

"It's not unusual for young people like Mark to relapse, ketamine use can be complex, and recovery is rarely a straight line. At Elisha House, we continue offering support even when someone returns to the community and begins using again. What matters is that they know we haven't given up on them. Recovery isn't a quick fix; it's a lifelong journey. Our role is to help young people learn to live with the challenges of addiction while building the stability, confidence, and support networks they need to move forward."

2.3 Case Study: Alfie

What has helped you most in your recovery or when accessing drug support?

Easy referral process online – self-referral took minutes, number to contact for advice, my mum spoke to the manager directly and this all helped me to refer back into the service and get the help I needed when I was in crisis with my drug use and using 7g of ketamine a day.

What really helped in my recovery was having the worker staying for a good while after I left rehab and having that consistent person when I came out instead of talking to new people again and repeating my story. I think the difference for me is if you feel the worker is invested in you as a person and cares and not just going through the motions with worksheets, they have to see you as you and connect in order for me to really feel like I want to get out of addiction and just providing emotional support has been huge for me to help me with my recovery.

What challenges have you faced in getting the help you need?

For me at first it was more about accepting that I needed that support, I was always resistant to going to rehab but when GE explained it properly and sat down with me and asked me what my fears were it did not seem bad and showing me round and introducing me to the community and spending time before going to rehab was key to me making that choice.

The challenges I am facing now is the inconsistency in my aftercare plan managed by Urology, Medical professionals do not seem to communicate with each other for example they did not know how painful it was for me and that I was bed bound for two weeks afterwards before doing this op recently where I was meant to have botox in the bladder. The aftercare for people with ket bladder has been really poor, I still don't know where I am at and I just wish I was kept in the loop as it is me that is having to manage the pain and live with this daily.

In terms of medication apart from offering bladder expanders there does not seem to be much progress with this. I have been on Tramadol for over 2 years now and don't seem to be able to reduce them without experiencing significant pain but worry about the repercussions of this. Seems only to be one specialist in Salford in the whole country and waiting list and to get on that they must do a bladder diagnostic and they can't do that s mine so damaged therefore won't accept me without it. I feel at a loss in terms of physical health and the aftermath of ketamine and pathways need to be improved.

Also GP's being more aware instead of just saying you have a urine infection.

What would make services better?

If they had one big team to support people and not work in isolation for example: housing, drug services and mental health so you can access mental health support easily and housing as all these go hand in hand. If you don't have a roof over your head and a safe space to stay, how are you supposed to address your drug use and this will further impact on your mental health

Same goes for drug use, you are using drugs as a crutch and coping strategy for your mental health yet mental health refuse to see you as you are using drugs and this has been a huge barrier for many people. Long waiting lists for mental health whereas if they were a person within a team that has drug services and housing and mental health support would reduce waiting times.

It would make it much better if you had every support service together instead of in isolation so they are all communicating and working together as a whole team to help you so you had drug services, mental health, housing, employment support and positive activities all under one roof.

I was very lucky getting into rehab so quickly as GE pushed this and was persistent with it but I know friends who have had to wait for detox and rehab and their drug use has got worse and the longer they waited the more they weren't ready.

How do substance misuse, mental health and housing relate to you?

Think I have explained before but they are all closely connected, a lot of people use drugs and fall into addiction as they want to 'silence the noise in your head' and ket really did this for me. I did not want to face my problems, it felt too much but ket had a way of just clearing that for me. If I had been able to get the right mental health support instead of using ket to block things out and help me put things into perspective and be able to open up about what has happened to me this would have helped me.

Having a safe space of stability is so important, because without that foundation then you are just 'running on your own with all of those intrusive thoughts and no place to call home'.

2.4 Case Study: ‘H’, a young person with severe ketamine addiction

Background

Two years ago, I was referred a 16-year-old young person, whom I’ll refer to as H, for substance use support. H had been admitted to Blackpool Victoria Hospital with severe stomach pains. It was during this hospital visit that he first disclosed his use of ketamine.

Through our sessions, it became clear that H had been using ketamine since the age of 14. His use had gone undetected for nearly two years, during which time he developed significant physical symptoms, including abdominal pain and urinary issues—both increasingly linked to chronic ketamine use.

H’s substance use could not be viewed in isolation. He had experienced multiple Adverse Childhood Experiences (ACEs). He was living with his grandparents under a Special Guardianship Order (SGO) after being removed from his mother’s care. His mother struggled with severe mental health issues, alcoholism, and was a victim of domestic violence—incidents that H had witnessed as a child, including a traumatic suicide attempt by his mother .
At the age of 10, H experienced further trauma when he was sexually assaulted by a male perpetrator. This event, compounded by earlier instability and exposure to violence, had a profound impact on his emotional wellbeing and coping mechanisms.

H’s story is a stark reminder of the deep connections between trauma and substance use. His ketamine use was not simply recreational—it was a way of coping with overwhelming emotional pain and unresolved trauma. Supporting H required a trauma-informed, compassionate approach that addressed both his substance use and the underlying causes.

Medical Impacts

As H’s ketamine use continued, the physical consequences became increasingly severe. A healthy adult male bladder typically holds between 400–600 ml of urine, with the urge to urinate beginning at around 200–350 ml. In H’s case, his bladder capacity had shrunk to less than 200 ml, leaving him unable to control his bladder and suffering from frequent incontinence.

The damage extended beyond his bladder. H began experiencing kidney and liver complications, prompting further hospital admissions and specialist referrals. Eventually, he required a surgical procedure to insert ureteral stents—tubes placed between his kidneys and bladder to allow urine to drain properly. This was necessary because urine was backing up into his kidneys, posing a serious risk of infection and long-term renal damage.

H’s case is a harrowing example of how ketamine addiction can lead to multi-organ damage, even in adolescence. The need for surgical intervention and long-term medical management at such a young age is a stark reminder of the urgency for early intervention, trauma-informed care, and more robust support systems for young people at risk.

Reflections

H’s story is not just a case study—it is a call to action. It exposes the gaps in our systems, the urgency for trauma-informed, youth-specific addiction services, and the need for earlier, more flexible interventions. It also challenges us to rethink how we define “choice” in the context of young people whose lives have been shaped by trauma, neglect, and pain.

Unlike many other substances where some damage may be reversible with abstinence and treatment, ketamine can cause permanent physical harm, particularly to the urinary tract and bladder. Chronic ketamine use can lead to ketamine-induced cystitis, which causes inflammation, pain, and a dramatic reduction in bladder capacity. In severe cases, like H’s, the bladder can shrink permanently, leading to incontinence and the need for surgical interventions such as stents or even bladder reconstruction.

Young people like H are still developing physically and emotionally. Damage done during adolescence can have lifelong consequences, and the window for effective intervention is often narrow. The irreversible nature of ketamine-related harm makes early detection, education, and trauma-informed support absolutely critical.

2.5 Case Study: Recovery from ketamine use

Background

'L' self-referred for support around her ketamine use approximately 18 months ago. At the point of referral, L was experiencing significant physical health consequences linked to her substance use, including frequent hospital attendances and ongoing appointments with her GP and urology services. Her presentation highlighted both the complexity of ketamine-related harm and the impact this was having on her day-to-day wellbeing.

L has 2 children and she had her first child at the age of 14 years. This was identified as one of the main factors in her using ketamine.

Health and Treatment Journey

During her engagement with support, 'L' remained actively involved with medical services and demonstrated commitment to addressing the physical consequences of her ketamine use. She underwent a camera examination of the bladder and continues to receive bladder instillations as part of her urology treatment. Most recently, she has continued to require specialist care due to ongoing bladder issues including Botox to the bladder to help with her urgency.

As part of her pain management, 'L' experienced further complications and developed a vaginal prolapse. She is currently under the care of gynaecology services. Despite these additional challenges, L has remained engaged with healthcare professionals and has continued to prioritise her recovery.

Recovery and Abstinence

Throughout this period, L has shown exceptional resilience and determination. Despite ongoing pain, invasive procedures, and the emotional impact of long-term health issues, L has remained abstinent from ketamine. She has demonstrated insight into the risks associated with relapse and has consistently engaged with support to maintain her recovery.

Positive Outcomes and Giving Back

More recently, L has made significant progress beyond her own recovery. She is now volunteering with the LET team, using her lived experience to support others and contribute to service development. In the past week, L attended BVH to assist in the training of doctors and nurses, sharing her experience to help improve professional understanding and early recognition of ketamine-related bladder damage.

Conclusion

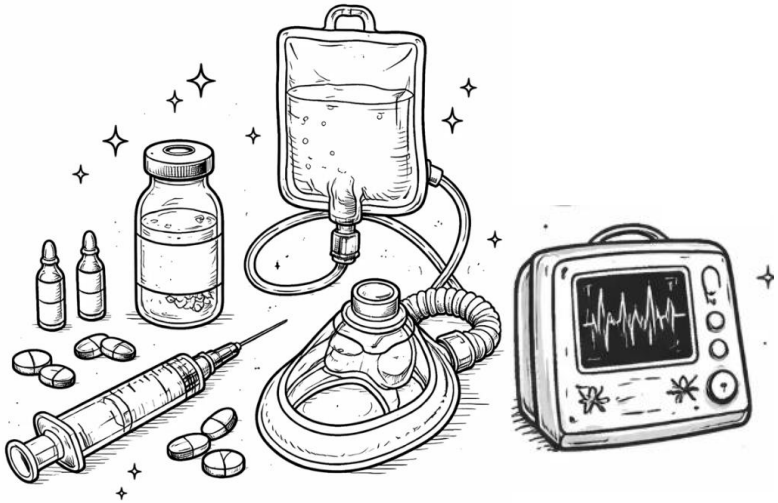
L's journey highlights the severe physical consequences of ketamine use, but more importantly, it demonstrates the potential for sustained recovery with the right support. Her ability to remain abstinent despite ongoing health challenges, and her transition into a role supporting professionals and services, reflects a remarkable recovery journey. L's contribution is invaluable in raising awareness, improving clinical responses, and offering hope to others affected by ketamine-related harm.

Section 3: Rapid Evidence Review of Ketamine Usage and Impact

We conducted a rapid evidence review synthesising research from the past five years, looking at the individual and public health impacts of ketamine use and misuse. While ketamine has established clinical applications such as analgesia and as an antidepressant, its growing recreational use is associated with significant health and social harms. The review highlights current patterns, determinants of use, and key implications for clinical practice, health services, and public health prevention.

"[My patient's] substance use could not be viewed in isolation. He had experienced multiple Adverse Childhood Experiences (ACEs). He was living with his grandparents under a Special Guardianship Order (SGO) after being removed from his mother's care. His mother struggled with severe mental health issues, alcoholism, and was a victim of domestic violence - incidents that [my patient] had witnessed as a child, including a traumatic suicide attempt by his mother."
Case study 'H'

"We've only just really started coming across the younger ones ... but they're already at that stage where the bladders are not functioning anymore. At the hospital we've had them in intensive care, they're already at that stage. They're not getting picked up early enough... It was seen as a party drug. That's not the case."
Charity CEO



3.1 Rapid Evidence Review: What the evidence tells us:

Clinical Use (>1000)*

Legitimate, Evidence based treatment in specific contexts (anaesthesia, treatment resistant depression, some pain conditions, substance use disorders)

Clinical Effects (n=51)

Ketamine has short-term psychoactive and anaesthetic effects, but repeated use is strongly linked to brain, bladder and liver/ biliary damage, plus functional impairment.

Clinical Harm (n=8)

Identifying ketamine-related harm, managing complex presentations, overdose risks, risks of continuing therapeutic ketamine.

KUD (n=25)

(Ketamine Use Disorder) Ketamine can cause a clear use disorder, with tolerance, cravings, escalation, withdrawal-like symptoms, and profound functional and physical harms.

Determinants (n=20)

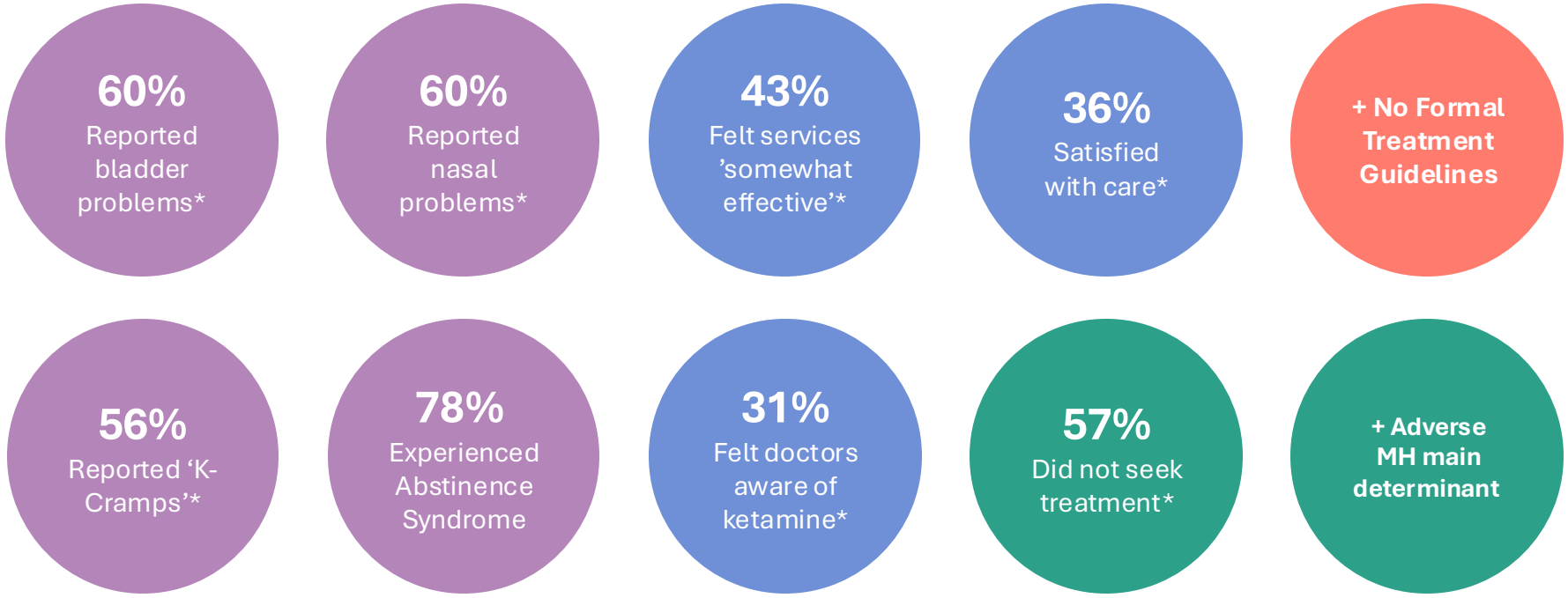
Increasing, global ketamine use, particularly among young adults and nightlife populations, polydrug use, shaped by context, availability and perceptions of risk.

Interventions (n=6)

Multi-layered responses: digital interventions targeted messaging, clinical management strategies, broader population-level approaches.

*total studies > 1000. Introduced into RER until saturation

3.2 Rapid Evidence Review: What the evidence tells us:



***Survey of 274 UK individuals with self identified KUD:**

Harding et al. The landscape of ketamine use disorder: Patient experiences and perspectives on current treatment options [1]

***+ RER literature showed** that the majority of papers outlining interventions noted there were no formal treatment guidelines; Adverse mental health outcomes, psychosis, addiction, anxiety and depression were major contributors to Ketamine use.*

3.3 Rapid Evidence Review: Overview

1. Introduction

This rapid evidence review examines the individual and public health impacts of ketamine use and misuse published over the past five years (October 2020 – October 2025). Ketamine is a dissociative anaesthetic with well-established medical applications, including analgesia, procedural sedation, and emerging therapeutic roles in mental health. However, ketamine is also widely used outside medical settings, and its non-medical consumption has grown in a range of populations, generating significant health and social harms.

This review aims to synthesise current evidence on patterns of medical and non-medical use, explore determinants associated with use and misuse, and assess the implications for public health systems. By focusing on recent literature and grey evidence, the review highlights contemporary trends and ongoing challenges for clinical practice, health services, and population-level prevention.

2. Methods

2.1 Rapid Evidence Review Approach

This review follows a rapid evidence review (RER) methodology [3], concentrating on literature published between October 2020 and October 2025. Exceptions include key earlier publications (e.g., UK governmental reports and foundational background papers) deemed essential for contextualisation.

The objectives of the review were to:

•Synthesise the most recent evidence on the physical, psychological, and public health consequences of ketamine use and misuse.

•Understand determinants associated with medical and non-medical use across different populations.

•Identify emergent or escalating public health concerns, including pressures on health systems.

2.2 Research Questions

The review addresses the following areas:

a) Patterns, purposes, and outcomes of ketamine use in medicine (e.g., analgesia, psychiatric therapies)

b) Nature and extent of ketamine misuse in different populations

c) Health consequences of misuse, including urological, psychological, and neurological effects

d) Determinants of use and misuse across demographic and social groups

e) Public health concerns, including demand on services and population-level impacts

3.3 Rapid Evidence Review: Overview

2. Methods

2.3 Data Sources and Search Strategy

A combination of peer-reviewed databases, grey literature sources, and expert recommendations was used.

Peer-reviewed databases included:
- Scopus (first five pages of results per search)
- Google Scholar (first five pages of results)
- PubMed / MEDLINE
- Cochrane Library
- Embase (where accessible)

Grey literature sources included:
- BMJ publications
- NHS reports
- UKHSA and DHSC reports (2004–2022 and onwards where relevant)
- Other non-peer-reviewed sources providing context (e.g., commentaries, news articles)

Expert consultation: Key articles identified by subject-matter experts

Boolean search strategy:

(ketamine)
AND
(analgesia OR pain OR medical use OR therapeutic OR "clinical use")
OR
(misuse OR Addiction OR abuse OR nonmedical OR "illicit use" OR "recreational use")
OR
(population* OR group* OR community OR "risk factor*" OR determinant* OR characteristic* OR demographic*)
OR
("public health" OR "population health" OR epidemiology OR burden OR prevalence OR incidence OR "health impact")

Search syntax was simplified as needed for platforms with limited operator support (Google Scholar, grey lit). Reference lists of included studies will be scanned for additional material.

2.4 Screening and Data Management

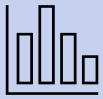
All search outputs were imported into Rayyan for de-duplication and screening. Screening involved title and abstract review

2.5 Inclusion Criteria

Studies were included if they met the following criteria:

Published between October 2020 and October 2025
Written in English
- Relevant to at least one research question
- Peer-reviewed research (e.g., trials, observational studies, systematic reviews) or grey/official reports
- Informal literature (blogs, media) where useful for broader contextual insight

3.3 Rapid Evidence Review: Overview



3. Results

The search identified evidence across six key domains: clinical use, clinical effects, clinical harm, ketamine use disorder (KUD), determinants of use, and interventions. The volume and nature of the literature varied substantially between domains, with far more publications addressing legitimate clinical uses of ketamine than harms, determinants, or interventions.

3.1 Clinical Use (n>1000 records)

A substantial body of literature continues to support ketamine's legitimate, evidence-based use in clearly defined medical contexts. These include anaesthesia, procedural sedation, treatment-resistant depression, specific pain conditions, and in emerging evidence, selected substance use disorders. The recent period shows continued growth in clinical trials and observational research examining optimal dosing, delivery models (e.g., infusion clinics, intranasal formulations), and long-term outcomes, reflecting sustained interest in ketamine's therapeutic potential. The clinical evidence base remains markedly larger than that for non-medical use or population harms [4-27].

3.2 Clinical Effects (n=46)

Evidence on ketamine's physiological and psychoactive effects highlights clear short-term impacts (e.g., dissociation, analgesia, perceptual changes) alongside mounting concerns about the consequences of repeated exposure. Across studies, chronic or high-frequency use is associated with structural and functional harms affecting the brain, bladder, liver and biliary system, as well as broader cognitive and functional impairment. Several studies emphasise the dose–response relationship, noting accelerated risk profiles in frequent or heavy users [28-74].

3.3 Clinical Harm (n=7)

Studies focusing explicitly on harm describe challenges in recognising ketamine-related presentations within clinical settings. These include urological dysfunction, abdominal pain syndromes, complex mental health and substance-use comorbidities, and occasional overdose or toxicity events (often in polydrug contexts). Clinicians face uncertainty when patients are using ketamine both therapeutically and non-medically, raising concerns about risks associated with continuing or discontinuing therapeutic ketamine amidst ongoing misuse. Evidence remains relatively limited but points to increasing complexity of presentations [75-82].

3.4 Ketamine Use Disorder (KUD)

A growing body of literature recognises Ketamine Use Disorder as a distinct clinical entity. Studies describe characteristic features including tolerance, cravings, escalation of use, withdrawal-like symptoms, and significant functional, psychological, and physical harms. KUD is associated with bladder dysfunction, cognitive impairment, and substantial impairment in daily functioning. Despite variability in diagnostic approaches, the evidence consistently demonstrates the potential for dependence and significant harm associated with chronic non-medical ketamine use. Research into effective treatments for KUD remains sparse [28-74].

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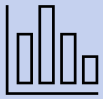
3.3 Rapid Evidence Review: Overview



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3.5 Determinants of Use (n=21)

Determinants research highlights increasing global prevalence of ketamine use, particularly among young adults and nightlife or festival populations. Polydrug use is common, with ketamine often consumed alongside stimulants or alcohol. Patterns of use appear strongly shaped by contextual factors including availability, price, cultural norms, and perceived low risk relative to other illicit substances. Emerging evidence suggests shifts in motivations for use. These range from recreational dissociation to self-medication for mood symptoms, indicating diverse behavioural drivers and opportunities for targeted prevention [83-104].

3.6 Interventions (n=6)

Intervention studies remain limited but point towards the need for multi-layered responses. Evaluated approaches include digital interventions (e.g., app-based harm reduction tools), targeted messaging for high-risk groups, clinical management strategies for KUD and ketamine-related urological conditions, and proposals for wider population-level measures. Evidence suggests that effective responses will require integration across clinical care, harm reduction, mental health services, and public health communication [105-111].

"He was a 17 year old boy. He was a plumbing apprentice and he'd started taking ketamine recreationally with his friends. But then after taking it for a little bit of the weekend, it started to creep into the week... he was relying on it... ended up with a urostomy bag in place."
Charity Founder

"People can go out and have a drink at weekends, but then you have some people that end up an alcoholic. Yeah, and alcohol dependent. So it'll be the same reasons because they're not coping my life and then end up using it [ketamine] all day long."
Lived Experience Director

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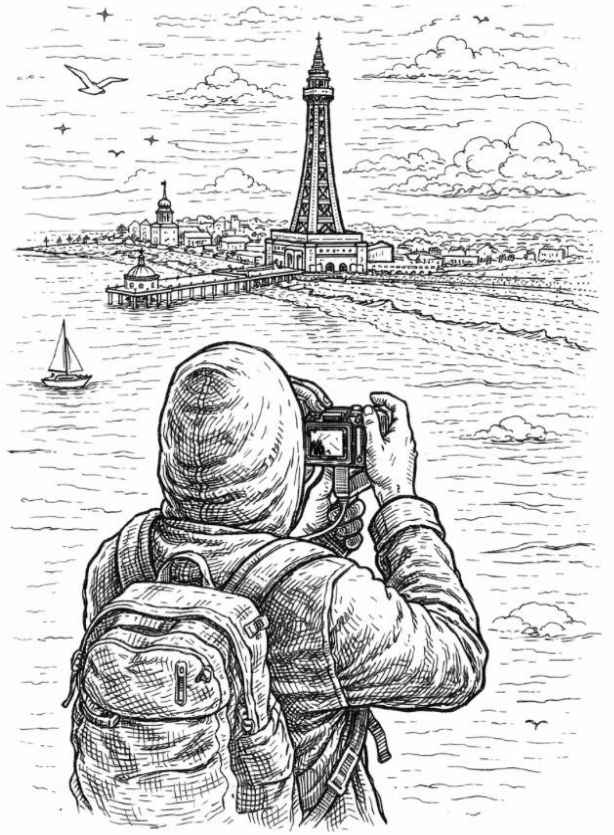
Section 4: Rapid Evidence Review on Innovative Interventions

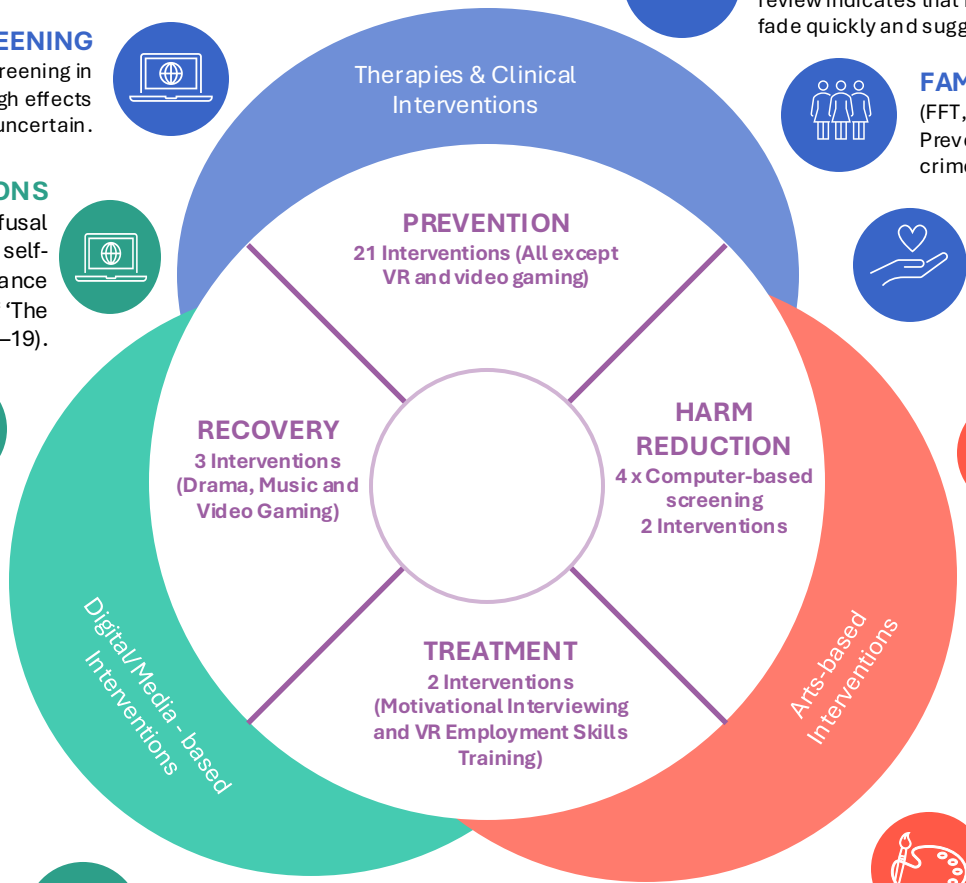
We conducted a rapid evidence review on innovative approaches to interventions to curtail ketamine misuse. Conventional prevention and treatment models often fail to engage with the social, cultural, and emotional realities that shape young people's substance use. In response, we found that innovative approaches move beyond punitive or abstinence-only frameworks, focusing on harm reduction, compassion, and co-production.

"Someone needs to make a stance and say, look, we need to do something differently here ... There's been about 28% of referrals [that] are ketamine ... roughly between about 5 and 10 a month."
Service Provider

"Our young people are saying, you know, AA and NA - I don't want to sit around with a load of old blokes who used to drink."
Drug Worker, ADASH Adolescence Service, Blackpool Council



4.1 Rapid Evidence Review: Innovative Interventions



BEHAVIOUR, MOTIVATION & PSYCHO-THERAPY

(CBT, DBT, IPT AND Motivational Interviewing (MI)) An Australian evidence review indicates that MI alone is ineffective for youth substance use; effects fade quickly and suggests it is more effective when combined with CBT.

FAMILY / SYSTEMS

(FFT, MDFT) A US report on FFT found that it was effective in Preventing substance abuse and reducing involvement in crime, violence e and antisocial behaviour.

HARM REDUCTION

An Opioid Use Disorder review from the US argues that incorporating harm reduction into primary care OUD services improves access, enhances engagement and safety.

COMPUTER-BASED SUBSTANCE USE SCREENING

Three studies suggest that computer-based substance use screening in primary care may improve engagement and disclosure, though effects on substance use outcomes remain uncertain.

WEB-BASED INTERVENTIONS

POP4Teens improved knowledge, risk perception, and refusal skills. RealTeens a gender specific programme improved self-esteem, and coping strategies, sustaining reduced substance use and peer influence long-term. Australian pilot study of 'The Illicit Project improved drug literacy of 169 (aged 15–19).

VIRTUAL REALITY

VR used in a ketamine intervention to improve vocational outcomes, supporting sustaining recovery and supporting reintegration.

GAMING

Gaming interventions build skills through interactive play, improving attention, memory, self-efficacy.

SOCIAL MEDIA

Social media use is associated with adverse health risk behaviours in young people, but further research is needed to determine which aspects of social media are most harmful.

PHOTOVOICE

Photovoice amplifies lived experiences, fosters reflection, builds advocacy skills, strengthens peer support, and promotes community-driven prevention strategies.

FILM

Videos engaged boys; lectures engaged girls; discussions improved attitudes; authentic stories boosted trust, reach, training uptake, and overdose prevention.

MUSIC

Studies examine the benefits of music in treatment programme both identified that music increased motivation for participants to attend and complete the programme and improved resilience.

DRAMA

Theatre in Education prevention programmes have identified how drama can increase knowledge about harms and improve decision-making, attitudes, norms around drug use. Benefits of drama for adults in recovery have been demonstrated.

VISUAL ARTS

Two studies explore the impact of co-creating visual communication educational campaigns. Graphic imagery and language that resonates with young audiences, about health consequences of drug use may be an effective in peer-to-peer prevention.

STORYTELLING

Narrative-based youth projects for substance use prevention hold unique potential by engaging diverse young people in meaningful ways.

4.2 Rapid Evidence Review: Overview

1. Introduction

This rapid evidence review examines innovative approaches to drug interventions for young people. Conventional prevention and treatment models often fail to engage with the social, cultural, and emotional realities that shape young people's substance use. In response, innovative approaches move beyond punitive or abstinence-only frameworks, focusing on harm reduction, compassion, and co-production.

Arts-based and co-produced interventions consider lived experience as an expertise and combine creative, cultural, and community-based practices with clinical and social care. Grounded in local cultures and inequalities, they aim not only to reduce harm but to reshape the systems, environments, and narratives that sustain drug-related crises.

This review synthesises recent evidence on the design, effectiveness, and system-level implications of such approaches. It demonstrates how arts-based and participatory models can strengthen public health responses by fostering engagement, resilience, and equity in drug intervention strategies.

The objectives of the review were to:

• Synthesise the most recent evidence on Innovative drug interventions that move beyond traditional, one-size-fits-all models of prevention and treatment.

2. Definition

More concretely, innovative interventions often:

- Are co-designed with people who use drugs, recognising lived experience as expertise
- Integrate creative, cultural, and community-based practices alongside clinical or social care
- Prioritise harm reduction, dignity, and autonomy, rather than punishment or abstinence alone
- Adapt to local contexts, histories, and inequalities rather than importing generic solutions
- Focus on prevention, care, and recovery as a connected journey, not separate stages.

4.2 Rapid Evidence Review: Overview

3. Results (*n* = 32) Interventions

This review examined 32 innovative drug interventions for young people, spanning clinical, family-based, digital, harm reduction, and arts-based approaches. Overall, the evidence indicates that no single intervention is sufficient on its own.

The participants engaged ranged from small cohorts of 9 young men in recovery to large cohorts across schools (*n* = >4660).

Traditional individual-level approaches, such as **Motivational Interviewing**, show limited effectiveness as stand-alone interventions for adolescents, particularly for stimulant and polysubstance use. Effects tend to be short-lived, reflecting the strong influence of peer networks and social environments during adolescence. However, Motivational Interviewing demonstrates greater value when used in combination with structured therapies, such as CBT, or as part of a broader engagement strategy.

Functional Family Therapy, shows stronger and more consistent evidence for reducing substance use and related harms. FFT demonstrates short-term reductions in marijuana use, crime, and antisocial behaviour by targeting family dynamics, communication patterns, and problem-solving skills. These findings underscore the importance of addressing the relational and environmental contexts shaping young people's substance use, rather than focusing solely on individual behaviour change.

Harm reduction models, especially in relation to opioid use disorder, consistently improve engagement, safety, and autonomy. Integrating harm reduction and medication-assisted treatment into primary care reduces stigma and increases access, particularly for young people who are alienated by abstinence-only services. Trust-building, flexible communication, and family education emerge as critical mechanisms of impact. However, persistent ideological resistance to harm reduction remains a key implementation barrier.

Digital and computer-based screening and **brief interventions** are well supported by evidence as feasible, acceptable, and scalable tools within primary care and school settings. These interventions improve knowledge, delay escalation of substance use, and reduce risky drinking at the population level. Larger, integrated digital programmes also demonstrate benefits for co-occurring anxiety symptoms. Digital approaches appear particularly effective as early intervention and prevention tools, rather than treatment for entrenched use [112-143].

4.2 Rapid Evidence Review: Overview

4. Overall Conclusions

Taken together, the evidence supports a shift away from punitive, abstinence-only, or purely individualised models toward integrated, harm-reduction-oriented, and participatory systems of care. Interventions are most effective when they:

- Recognise lived experience as expertise
- Address social, emotional, cultural, and relational drivers of use
- Combine clinical support with creative, family, and community-based practices
- Connect prevention, care, and recovery as interdependent processes

Across the review, arts-based and participatory interventions consistently demonstrate strengths in engagement, meaning-making, and empowerment.

Drama, theatre, music, photovoice, visual arts, and storytelling approaches improve knowledge, attitudes, decision-making skills, and perceived norms around substance use. They are especially effective in reducing stigma, processing emotions, strengthening identity, and fostering social connection. While long-term behavioural outcomes are less frequently measured, these interventions show strong promise as complementary strategies that address dimensions of substance use often neglected by clinical models.

Media-based, narrative, and digital communication strategies achieve high reach and can positively influence knowledge, stigma, and intentions, especially when messages are authentic and aligned with young people's experiences. Evidence suggests that didactic or fear-based messaging is ineffective, whereas narrative-based and peer-informed content is more trusted and impactful.

The emerging evidence for interactive technologies, including **video games and virtual reality**, suggests potential benefits for skill-building, cognitive functioning, and self-efficacy, particularly for young people in treatment or recovery. However, this evidence base remains small and requires further evaluation.

"There are only two facilities in the UK that accept young people under 18 for inpatient rehab. I successfully secured funding, and [my patient] was admitted. Unfortunately, this was the first of three attempts at residential treatment. Each placement broke down within weeks due to behavioural issues or incidents where [my patient] was found to have smuggled substances into the facility."
Case study 'H'

Section 5: Conclusions

Several recommendations arise from our research. There is an opportunity for innovation in early intervention, data collection, and collaborative creative and community partnerships. Development of a national clinical framework for ketamine harms should be a priority.

Gathering ketamine data needs to be statutory to ensure individuals are identified and supported, for example through a shared data system throughout schools, health and youth services to highlight risk hotspots. Early screening and improved data collection can help to establish region-wide trends.

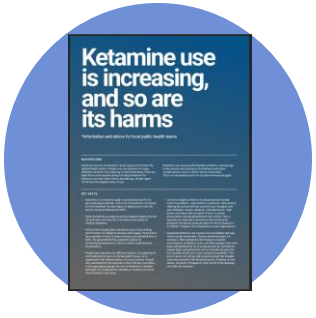
When funding is allocated to the right areas, particularly towards young people and prevention, then it has strong potential to be very successful.

Clear pathways need to be put in place for those at high risk, ensuring access to appropriate clinical treatment, especially pain management, alternative medication options, and healthcare.

5. Useful resources

2026: UK GOV Ketamine: an updated review of use and harms

2024: Blackpool's Public Health Ketamine Briefing

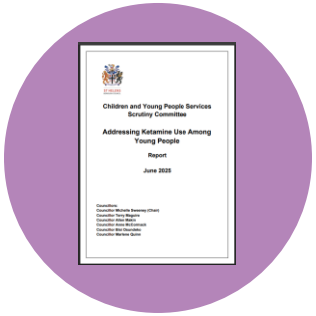


2026: OHID Ketamine awareness fact sheet

2026: Project K support group video by Horizon

2023: ADASH Referral Leaflet

2020: Innovation and Collaboration: Blackpool's approach to addressing drug-related deaths

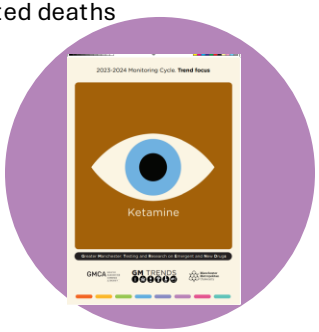


2025: St Helens Addressing Ketamine Use Among Young People

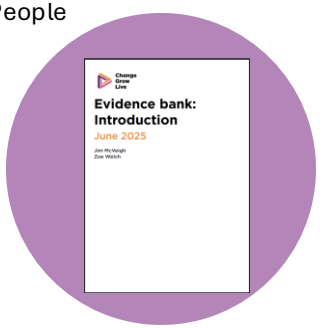
2026: Healthier Blackpool Ketamine Leaflet

Horizon Website

Horizon Ketamine Harm Reduction Leaflet



2025: GM Trends: Ketamine Report



2025: CGL: Ketamine Evidence Bank

2026: Healthier Blackpool: Ketamine The Facts

ADASH Website

Click here for report references