Release
Drugs, The Law & Your Rights

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Release Submission to ACMD's call for evidence on Ketamine

The following document is a response to the Advisory Council on the Misuse of Drugs (ACMD)'s call for evidence on "ketamine harms assessment".

Section 1: About yourself / your organisation

Q1. Please indicate below if the following statement is applicable:

☐ My submission should be considered a personal response reflecting my professional experience in this area and therefore not representative of the organisation I work for.

× My submission should be considered as representative of the organisation I work for.

☐ My submission should be considered lived or living experience.

Q2. Please describe your personal expertise within this area and/or the nature of your organisation and your role:

Release is the UK's centre of expertise on drugs and drug laws. We provide legal support, representation and drugs advice to people with a history of drug use or who are impacted by drug laws. We also campaign for evidence-based drug policies founded on principles of public health and human rights, seeking to reduce the harms faced by people who use drugs.

Release also undertakes research analysing the impact of laws and policies on people who use drugs both within the criminal justice and health spheres. We have published multiple papers[1] highlighting racial disparities in the policing and prosecution of drug offences in the UK, as well as demonstrating the global experience of drug decriminalisation[2].

Our clients' experiences drive our policy work: we respond to Government proposals and consultations[3] that impact the lives of the people we work with. This includes responding to housing policies, social welfare policies and other relevant areas.

[1] https://www.release.org.uk/publications/policy-papers
[2] https://www.talkingdrugs.org/decrim/
[3] https://www.release.org.uk/publications/policy-responses

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Release is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations; we're also part of the Vienna NGO Committee on Narcotic Drugs (VNGOC) and the New York NGO Committee on Drugs (NYNGOC).

Q2a. (For healthcare professionals only)
Please select the setting in which you work:

☐ **Primary care (e.g. GP practice)**
☐ **Secondary care (e.g. general hospital)**
☐ **Tertiary care (e.g. specialist mental health or addiction services)**
☐ **Community-based services**
☐ **Other (please specify):** Click or tap here to enter text.

Q2b. As part of your role, do you prescribe ketamine for long-term pain conditions?

☐ Yes
X No

Q2c. What type of service do you provide? (e.g. Mental health, pain management, addiction services, etc.)

We provide several services, including:

- Community legal welfare outreach services: Our legal team provides legal support and representation on issues like homelessness, housing insecurity, social security, and debt to over 1,300 people a year. Our services are located in drug treatment centres, homelessness projects and sexual health clinics across 21 locations, supporting vulnerable and marginalised people.
- Drug Advocacy service: We provide advocacy advice to people accessing drug treatment services, ensuring their voice and needs are centred in their care.
- The National Helpline: We respond to over 2,000 queries annually from people seeking advice on a myriad of matters, including criminal law, employment issues and harm reduction/ treatment advice.
- Harm Reduction Hub: Based in our office, the Harm Reduction Hub[4] is a community drop-in centre and needle and syringe programme for anyone to get harm reduction advice, drug testing supplies, and non-judgemental and confidential support and signposting.

Section 2: Ketamine Use and Associated Harms

[4] https://www.release.org.uk/harm-reduction-hub

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Q1a) Why do illicit users of ketamine choose to use this drug?

Ketamine was developed as an anaesthetic, with a less depressant respiratory effect than benzodiazepines and opioids. It has dissociative, hallucinogenic, and psychedelic effects, which vary with dose. There are several reasons for its illicit use:

- **Recreational**: People enjoy the effects of ketamine. The recreational popularity of ketamine is in part driven by its low price, high concentration, and availability. A gram of ketamine, costing around £10-£20, can be split amongst a group of users over the course of an evening. This is much cheaper than a comparable evening spent drinking alcohol, or using a common stimulant like cocaine. One gram of ketamine is also much easier to transport, for example to a club or festival, than the comparable amount of alcohol.
- **Pain management**: The anaesthetic effects of ketamine make it useful for pain management. Again, the low price, high concentration, and availability makes ketamine particularly convenient. Additionally, the relatively low depressant effect of ketamine, compared to benzodiazepines and opioids, makes ketamine attractive for prolonged pain management.
- **Mental health support**: the mood altering effects of ketamine make it useful for mental health support, often to manage anxiety or depression. It is widely known that ketamine is used as a clinical treatment for depression, which will attract users struggling to manage their own mental health symptoms otherwise.

Q1b) When ketamine is used alongside other substances, which drugs are commonly involved, and what are the reasons behind these combinations?

According to the GM-TRENDS survey[5], young people in treatment who reported daily use most commonly combined ketamine with alcohol (40%), cocaine (35%), cannabis (35%), and MDMA (20%). Typical reasons behind these different combinations are:

- Ketamine and alcohol: to combine the depressant effects of both.
- Ketamine and cocaine: using the stimulant effect of cocaine to offset the depressant effect of ketamine (and vice-versa)
- Ketamine and cannabis: to combine the hallucinogenic effects of both.
- Ketamine and MDMA: as a combination of party or club drugs.

[5]http://gmtrends.mmu.ac.uk/wp-content/uploads/sites/425/2024/10/GM-TRENDS-2023-24-ketamine.pdf

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Q2) What information can you provide on where ketamine is obtained from by users and how it is used?

Ketamine can be bought both in person and online. Typically it comes as a bag of shards or powder, which is ground and snorted. Ketamine can also come as a nasal spray solution, which can be bought pre-made, or prepared by the user. There is a smaller group of ketamine users who use the drug via intra-muscular injection.

Q3) Which populations in the community are most affected by ketamine use and what impacts is ketamine having upon these populations? (Please refer to the details from Section 3 of the ACMD Standard Operating Procedure)

Ketamine's low price and high availability make it particularly popular with children and young people. One in six of the 400 young people in the GM-TRENDS survey reported using ketamine in the past year. A recent letter to the BMJ[6] corroborates this picture, noting that:

> "Data from the 2023 to 2024 Office for Health Improvement and Disparities (OHID) report into substance misuse in those aged 17 and under showed that of the 14,352 CYP engaging with alcohol and drug treatment in England, 8.4% reported ketamine use, up from 4.5% in 2021 to 2022 (2). These figures, however, represent the very tip of a clinical iceberg as many CYP will not be engaging with any services for a wide range of reasons."

Ketamine is also popular with students and young professionals, who additionally report enjoying the lack of comedown or hangover associated with its use. Foster, Stevenson and Akram (2023) found a quarter of undergraduates reporting ketamine use within the previous year, and many in the GM-TRENDS survey report university as the setting in which they began or significantly increased their ketamine use.

Q4a) Please outline any health harms arising from ketamine use within your local area or workplace. (You may wish to refer to the harms listed in Table 2 and 3 of the ACMD Standard Operating Procedure)

[6] https://www.bmj.com/content/389/bmj.r1167/rr-0

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The health harms in our area are reflective of the overall national picture (see Q5) below).

Q4b) Please outline any social harms (e.g. education, crime, housing, employment, family relationships, community safety) arising from ketamine use within your local area or workplace.

We do not see any social harms arising from ketamine use in our local area, or indeed nationally. We do however see harms arising from the criminalisation of ketamine. For instance, in the past year, multiple people have reported to us via our helpline that they have faced having their employment contracts terminated (SOP 4.2) due to workplace drug testing and ketamine found in their system. On one occasion, it was a drug treatment provider that disclosed to a patient's employer that they were in treatment for ketamine use. Incidents like these highlight that the drug itself is not the problem; rather it is the law which produces the social harms most negatively impacting users.

As emphasised in our past response to the ACMD's call for evidence on nitrous oxide, existing drugs laws are disproportionately enforced along socioeconomic, racialised and racist lines – despite drug use itself being ubiquitous across these comparators. Our research shows that the likelihood of prosecution increases more than tenfold for Black people[7].

Beyond the initial harms associated with enforcement in the criminal justice system, there are lasting consequences for those affected. A criminal record irreparably damages a person's employment (SOP 4.2) and life prospects. This can extend to the loss of housing (SOP 4.3) and the restriction on an individual's ability to travel overseas.

We have discussed the prevalence of ketamine use among young people and students. The criminalisation of their drug use affects their engagement with education (SOP 4.1). Indeed, according to the SOS-UK Students and Drugs Survey - 2020-21[8] 43% of students feared punishment if they were to disclose their drug use to their institution.

[7] https://www.release.org.uk/publications/ColourOfInjustice

[8]https://sos-uk.org/wp-content/uploads/2022/01/6086d5f97f53db34b0d826ab_20210426_SOS-UK20Students20and20Drugs20survey202020-21_FINAL.pdf

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Q5) What are the short-term (acute) and long-term (chronic) adverse effects experienced by people who use ketamine?

The acute adverse effects experienced by people who use ketamine do not differ significantly from those documented in the 2013 ACMD report[9]. A more recent clinical summary is Orhurhu VJ, Vashisht R, Claus LE, et al. Ketamine Toxicity. [Updated 2023 Jan 30]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK541087/

In brief, the acute effects listed are: disorientation, paranoia, dysphoria, anxiety, confusion, slurred speech, dizziness, ataxia, dysarthria, trismus, muscular rigidity, psychomotor, psychomimetic, and acute dystonic reactions (SOP 1.2), hypertension, tachycardia, palpitations, arrhythmias (SOP 1.3), abdominal pain, abdominal tenderness, nausea, vomiting (SOP 1.5), genitourinary symptoms (SOP 1.6), horizontal, vertical or rotary nystagmus, mydriasis, excessive salivation (SOP 1.11), intoxication (SOP 2.1), and delirium (SOP 2.2).

In combination with other drugs, for example other depressants like alcohol, the acute effects can include: seizure, stupor, coma (SOP 1.2), hypotension, brachycardia, myocardial infarction (SOP 1.3), respiratory depression, apnea (SOP 1.4).

The primary chronic adverse effects experienced by people who use ketamine remain the genitourinary conditions documented in the 2013 ACMD report. This “ketamine bladder” can involve urinary urgency, frequency, haematuria, bladder shrinkage, hydronephrosis, and possible renal impairment (SOP 1.6).

Further chronic adverse effects documented include:

- Memory disorder (SOP 2.5) – Long-term recreational ketamine use is associated with measurable cognitive deficits and structural brain changes. UK neuroimaging studies have demonstrated deficits in spatial memory and altered hippocampal activation in heavy users (Morgan et al., 2014, *Frontiers in Psychiatry*). Additional neuroanatomical evidence shows gray and white matter loss in multiple brain regions, including the frontal cortex and hippocampus, which may underlie persistent problems with memory, attention, and executive function (Strous et al., 2022, *Frontiers in Neuroanatomy*).
- Psychological dependence and addiction (SOP 2.7) – Ketamine carries a significant risk of psychological dependence, characterized by the development of tolerance, craving, and withdrawal-like symptoms such as anxiety, depression, and dysphoria upon cessation. High-dose recreational use can

[9]https://assets.publishing.service.gov.uk/media/5a7ce1bbed915d7c849adce3/ACMD_ketamine_report_dec13.pdf

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lead to dose escalation and compulsive patterns of consumption. These effects are supported by preclinical and clinical evidence highlighting rapid tolerance and withdrawal dynamics in ketamine users (Mark A. Horowitz, 2020, Are we repeating mistakes of the past? A review of the evidence for esketamine, Cambridge University Press)

- Hepatic/gastroenterological (SOP 1.5) – Chronic or intermittent ketamine use has been linked to hepatobiliary abnormalities. Imaging and clinical reports describe dilation and irregularity of intra- and extra-hepatic bile ducts, elevations in liver enzymes, and presentations that mimic cholangitis or biliary obstruction. Symptoms generally improve upon stopping ketamine (LiverTox: Clinical and Research Information on Drug-Induced Liver Injury [Internet]. Bethesda (MD): National Institute of Diabetes and Digestive and Kidney Diseases; 2012-. Ketamine. [Updated 2018 Apr 25]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK548337, Teymouri, A., Nasoori, H., Fakheri, M. *et al.* Features of biliary tract diseases in ketamine abusers: a systematic review of case reports. *J Med Case Reports* 18, 84 (2024). https://doi.org/10.1186/s13256-024-04421-6)

Concerning fatalities (SOP 1.1), the Office of National Statistics registered 244 deaths [10] in England and Wales between 2014 and 2023 where ketamine was mentioned on the death certificate. Given the rise in ketamine use since 2013, it does not appear that the mortality rate associated with ketamine use has increased notably in the time since the ACMD's previous report.

Q6) Are ketamine users aware of the adverse effects that could be caused by ketamine use?

Users of ketamine who access Release's services are often knowledgeable about the harms of ketamine use, but they are less aware of potential options for support than other drug users who we work with. This is in part because, until recently, ketamine users have made up a very small fraction of the total population of different drug users in treatment. According to the most recent OHID report Adult Substance Misuse Treatment Statistics 2023 to 2024[11], the proportion of adults entering treatment in 2023 to 2024 with ketamine problems rose from 1.6% in 2022 to 2023 to 2.3%.

[10]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/2732deathsregisteredwhereketamineismentionedonthedeathcertificatebysexageandregioninenglandandwales2014to2023

[11]https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2023-to-2024/adult-substance-misuse-treatment-statistics-2023-to-2024-report

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Q7) What methods might be effective in better informing users about the risks of use of ketamine and other substances?

Improved harm reduction-based drug education in schools will be critical to informing young users of ketamine about risk and giving those individuals the tools to manage risk.

The GM-TRENDS survey found that ketamine use among young people and students is destigmatised, and that the drug has largely shed its former "dirty" reputation. Educational approaches that assume (or try to create) an aversion to ketamine use therefore seem likely to come across as out-of-touch. We suggest an approach that instead introduces the risks alongside the methods, resources, and programmes that a ketamine user can access to manage them. Informing users about the risks of ketamine use must be understood as a public health campaign aiming to reduce the harm of an already well-established social practice of drug use, and not as the introduction of a shocking fact that will deter (continued) drug use.

More broadly, we need a national public harm reduction information campaign that is informed by people who use drugs, and by drug workers in communities. Many of the failures of the current approach to information are not specific to ketamine.

Q8) Are there any areas where you believe further education, training, or resources are needed to better address ketamine use and its associated harms?

We need further education for the entire public if we are to address ketamine use. As discussed above, ketamine use is widespread and growing among young people and students; reducing harm from this already-present ketamine use requires government-led public health campaigns, education on safer drug use, and on drug checking.

Turning to resources, safer snorting materials are critical resources for improving public health, since they can reduce the transmission of hepatitis C virus (HCV) and also serve as an important engagement tool between drug workers and people using ketamine. Currently, drug workers cannot use this key tool due to section 9a of the Misuse of Drugs Act, which prohibits supplying paraphernalia. At present shared snorting equipment is not a major route of HCV transmission, but as ketamine use continues to rise, it could become an increasingly common mode of transmission. When HCV elimination funds run out, this could leave the entire population at risk.

Q9) Do you recommend any other actions to better address ketamine use and its associated harms?

- Create a national drugs early warning system which:
  - Is easily accessible,
  - Is widely known about by members of the public,

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    - Has the option for members of the public to submit reports to promote better buy-in from communities of people using drugs.
- Increase funding for harm reduction and promote the development of stand-alone harm reduction services.
- Reform the licensing system for drug checking to provide a national framework enabling quick, low cost, establishment of these potentially life saving services.
    - Scale up existing drug checking services.
    - Make drug checking universally accessible so that recreational users can readily access the service.

Eliminate the criminal penalties associated with ketamine, to create an enabling environment for ketamine users to approach support services.

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Section 3: Interventions and Access to Support

Q10a) Can you provide examples of interventions employed within your local area or workplace to address ketamine use (e.g. prevention, harm reduction, treatment and recovery interventions)? If so, what evidence is there of the effectiveness of these interventions (eg: formal evaluations)?

We run a drop-in Harm Reduction Hub in central London. Hub visitors have asked for advice and resources both to manage their ketamine use, and to reduce the risks associated with their ketamine use.

Visitors with access to illegal ketamine, concerned about its contamination with other drugs (frequently opioids), have come to ask about drug checking, to buy reagent test kits, or to send samples and receive results from the WEDINOS drug checking service.

Other visitors have come for safer snorting material, to reduce the risk of HCV transmission associated with unsanitised, shared, or improvised equipment. As mentioned above, the Misuse of Drugs Act does not currently allow us to provide this material, so we can only give advice on safer methods.

Q10b) What approaches or interventions have proven effective in ensuring that individuals at risk of, or experiencing, harms related to ketamine use receive timely and appropriate support?

While further research on effectiveness is needed, there is published research showing the benefits of:

- Harm reduction education[12]
- Dedicated referral pathways[13] for people using ketamine who present to urology departments in hospitals, in order to ensure quick access to drug treatment services.

Q10c) What are the barriers to early intervention, and/or treatment entry for people developing ketamine-related harms?

Criminalisation and fear of punishment hinders people seeking the support they need when experiencing ketamine-related harms. We have already mentioned how 43% of students were found to fear punishment if they were to disclose their drug use to their institution.

[12] https://www.tandfonline.com/doi/abs/10.3109/00952990.2016.1141211

[13] https://www.cambridge.org/core/journals/bjpsych-open/article/optimizing-care-for-ketamine-use-disorder-an-interdisciplinary-treatment-model/86A32ACAE639B21CFFEA2E5F733606FE

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Similarly, a UK survey of young people's drug use conducted by NeuroSight in consultation with SSDP UK and DrugScience Student Society[14] in 2020 found that 16% of young people in the UK reported that they were scared to get medical help when in a "scary" situation with drugs. The barrier to intervention is criminalisation, not simply a stigma around drug use; the GM-TRENDS survey discussed earlier notes that ketamine use is widely destigmatised among young people and students.

Further research from British Columbia[15] found that prior to drug decriminalisation 83% of young people reported "police-related barriers" to accessing harm reduction services, which fell to 65% after drug decriminalisation was implemented.

Section 4: Legal Classification

Q11a) To what extent does the legal classification of ketamine (e.g. as a Class B drug under the Misuse of Drugs Act) influence user behaviour, such as decisions around initiation, frequency of use, or cessation?

There is no clear evidence to suggest that users reduce frequency of use or make more effort towards cessation in response to the specific legal classification of ketamine. When observing the effects that reclassification had on other substances, there is some evidence that initiation may be deterred; however, existing ketamine users are likely to continue their use. A survey into mephedrone use[16] after its ban in 2010 highlighted that 63% of people continued to use it after scheduling. Deaths with mephedrone also happened after its scheduling.

There is also evidence that the ketamine market reacts to ketamine's reclassifications in the UK, in that reclassification promotes substitute substances to appear in the market. This means that for people who will continue to use ketamine, the likelihood of experiencing drug harms will increase. For instance, ketamine's classification as a class C substance saw the appearance of methoxetamine (commonly known as MXE), a new psychoactive substance which was first sold as a "legal high." The appearance of analogues in the drug market was likely a reaction to more stringent controls over drug access; these analogues can take up large consumer portions of previous

[14] NeuroSight. Student Drug Behaviour and Mental Health during COVID-19: 2020. 2021.

[15] McAdam E., Sayre E.C., Verdicchio C., Kali-olt Sedgemore, Fast D., DeBeck K., Indigenous Collaborators Circle, Policing and Access to Harm Reduction Services among young people who use drugs before and after decriminalization of personal possession, 2025, unpublished and presented at ISSDP 2025. https://www.issdp.org/wp-content/uploads/2025/06/Final-Conference-Programme-ISSDP-2025.pdf

[16] https://www.sciencedirect.com/science/article/pii/S0955395921000098

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markets and have higher health risks[17] involved due to poorer health messaging on them and no evidence on appropriate dosage or long-term effects.

Q11b) How might a change in legal status (e.g. from Class B to Class A) affect users' willingness to seek support, engage with harm reduction services, or access treatment?

As stated in Q11a) have already witnessed increases in ketamine prevalence and related harms with ketamine's classification from a class C to a class B substance. Adult treatment presentations in England involving ketamine rose from 116 in 2005/06 to a peak of 2211 in 2022/23, a nineteen-fold increase, with a 30% rise in the last two years. Total adults in treatment for ketamine reached a record 3,041 in 2022-23, up 30% on the previous year. Notably, treatment presentations began rising in 2015/16, the year after ketamine was reclassified. The rise in ketamine-related harms have followed changes in its legislation, as well as market changes in terms of its end-consumer purity levels and knowledge around the substance.

A change in ketamine's legal status will likely reduce willingness amongst people incurring ketamine harms to engage with drug treatment services, as heightened criminal penalties associated with the substance will evoke more fear of inadvertent criminalisation when seeking support. Evidence shows that criminal drug laws can reinforce societal and self-stigma in those consuming substances, which in turn[18] "negatively impacts mental health, social and environmental conditions for people who use drugs".

As research has shown[19], "drug criminalization probably deters moderate drug use to a higher extent than it deters escapist and over-frequent drug use", and moderate drug users may adapt to criminalisation in ways that involve more harmful or more frequent drug use. But, as mentioned above, research in British Columbia indicates that there are significant "police-related barriers" to accessing harm reduction services, which decreased after decriminalisation. We can infer that while harsher penalties and stricter legal status may not affect ketamine use, they will prevent users from accessing harm reduction services and treatment.

[17] https://onlinelibrary.wiley.com/doi/10.1111/dar.12259
[18] https://journals.sagepub.com/doi/epub/10.1177/00914509231179226
[19] https://journals.sagepub.com/doi/full/10.1177/20503245251348260#sec-4

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Q11c) What factors are most likely to deter individuals from initiating or continuing ketamine use (e.g. legal consequences, health risks, cost, availability)?

Drug decriminalisation in Portugal, in combination with increased harm reduction funding, resulted in decreased continuing drug use in the general population[20]. Meanwhile, attempts to deter ketamine use through increased criminalisation or increased investment in disrupting supply through policing have evidently not worked in Britain over the last decade.

Some ketamine users mention health risks as a reason they seek to discontinue ketamine use. However, as discussed above, the threat of social harm from criminalisation often presents a deterrent to accessing treatment. In order for this factor to become effective, we need enabling conditions.

The illicit use of ketamine as a painkiller or a mental health support could be deterred by providing healthcare solutions that are comparably cheap and accessible. This would address one of the root causes for ketamine initiation.

Finally, recreational use could be deterred through investment in education campaigns in combination with increased funding of social and community programs, particularly for young people, as alternatives to recreational ketamine use.

[20]https://transformdrugs.org/assets/files/PDFs/Drug-decriminalisation-in-Portugal-setting-the-record-straight.pdf