

Who are the children and young people attending the UK's first ketamine-induced uropathy clinic for under 16s?: an early insight into sociodemographic features

Non-prescribed ketamine use and associated adverse effects are rising in the UK, including among under-18s,^{1,2} with 8.4% in treatment now reporting ketamine use.³ Rising ketamine-related referrals led Alder Hey Children's NHS Foundation Trust (Liverpool, UK) to establish a ketamine-induced uropathy (KIU) clinic.⁴ Uropathy is a pathological condition of the urinary tract causing symptoms such as dysuria, urinary frequency/urgency and incontinence.⁵

Given the paucity of data about this population, we analysed the sociodemographic characteristics of clinic attendees to better understand their needs as part of a wider project looking at the use of ketamine by under-16s. Referrals were predominantly from primary care and emergency departments across the region, using the standard urology pathway. Referrers had connected urinary symptoms with ketamine use.

Demographic data were collected for the first 60 KIU patients; one patient was

referred in 2023, nine in 2024, with rapid escalation in 2025 leading to the establishment of the clinic in May. Partial postcodes were used to determine patients' Index of Multiple Deprivation (IMD) quintile, with quintile 1 being the most deprived areas⁶.

Data were collected relating to neurodiversity, adverse childhood experiences (ACEs) and care experience. Where possible, age at first ketamine use was collected, but poor patient recall meant it was not possible to accurately capture patterns of use.

Mean age at referral was 14.5 years (range 13–15 years) and 43/60 attendees were female. Where ethnicity was recorded (53/60), all identified as white British, similar to the regional population (90% white British).⁷ Over 70% of clinic attendees (n=43) lived in an IMD quintile 1 area (see figure 1). Formal neurodiversity diagnoses were: autism, n=4 (7%), ADHD, n=6 (10%) and autism/ADHD, n=6 (10%). At least one ACE was reported in 72% and 20% were care-experienced.

Ketamine use often started at age 13 years (range 12–15), around 1–2 years before presentation. Attendees frequently reported use of other drugs (50%), alcohol (27%) and vapes (48%). Facilitated referral to community drug and alcohol services was made where required. At the time of data collection, 12 patients had been discharged as their symptoms were

resolving and they reported cessation of ketamine.

Patient characteristics suggest the burden of harm for KIU in under-16s is not equally distributed. The KIU clinic population was significantly more likely to live in the most deprived IMD quintile (70%) compared with those attending Alder Hey (53%, $p=0.008$, χ^2 test) and their regional (31%, $p<0.001$) and national (20%, $p<0.001$) peers.^{6,8}

Clinic attendees also had significantly higher than background levels of ADHD and/or autism (27% vs estimated 6%; $p<0.001$), care experience (20% vs 0.67%; $p<0.001$) and ACEs (72% vs 47%; $p<0.001$).^{9–11}

These findings need to be considered when co-designing services for under-16s who use non-prescribed ketamine to ensure access improves inequalities and care is delivered in a trauma-informed and accessible way.

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IMD quintile of areas in which young people attending ketamine induced uropathy clinic reside

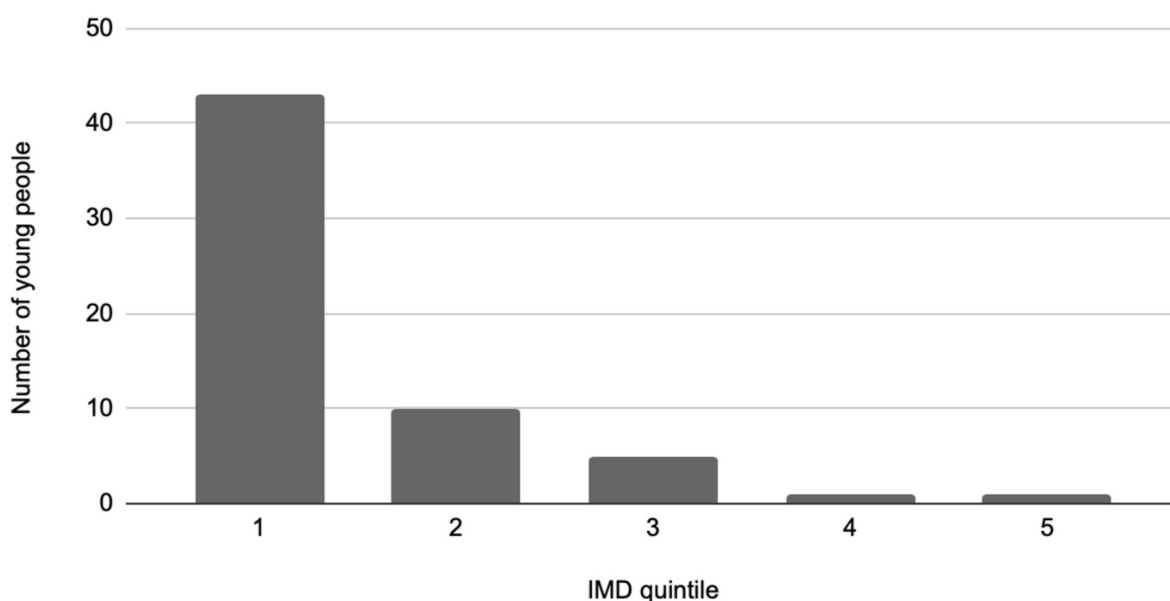


Figure 1 Bar graph showing the number of young people attending a ketamine-induced uropathy clinic who reside in each Index of Multiple Deprivation (IMD) quintile area. NB: If this population reflected the general population (ie, evenly distributed across IMD quintiles), 20% of the population would reside in each quintile.

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