Suicidal crisis: first regulatory approval of IV racemic ketamine

The March, 2026, decision by the French drug regulatory agency to approve intravenous racemic ketamine for the treatment of adult severe suicidal crisis[1] represents a major step forward in the management of suicidal risk. This national authorisation in France, the first of its kind worldwide, recognises not only ketamine's clinical potential, but also the absence of any officially approved, evidence-based, rapid-acting pharmacological alternative when suicide risk is imminent.

Over the past decade, several randomised controlled trials and meta-analyses have shown that a single or two sub-anaesthetic infusions of racemic ketamine (typically 0·5 mg/kg over 40 min) can reduce suicidal ideation within hours, with benefits maintained for several days or weeks.[2,3]

Intranasal esketamine (the S-enantiomer) is currently the only formally approved drug in several countries for major depressive disorder, where it is framed as a treatment for resistant depression. However, the literature has not confirmed a significant effect of intranasal esketamine on suicidal ideation,[4] suggesting differences related to enantiomeric composition or route of administration. Importantly, generic racemic ketamine is substantially less expensive than intranasal esketamine, which might facilitate broader access.

This authorisation is granted under a compassionate access scheme with a mandatory re-evaluation after 3 years. The authorisation is restricted to hospitals, requires prescription by a psychiatrist, must be embedded within a multimodal care pathway, and is not limited to specific comorbid psychiatric disorders.

Ketamine's short-term benefit-risk profile has been considered favourable, with transient and minor dissociative and haemodynamic effects. Concerns, however, remain about long-term misuse. In this context, national pharmacovigilance and prospective registries are indispensable.

Ketamine is not a panacea. The drug's anti-suicidal effect is time-limited, 10% of patients do not show any positive effect at all, and 50% show a fluctuating response over 6 weeks in one large study;[5] any improvement might wane if underlying vulnerabilities are not addressed; and there is insufficient evidence for reductions in suicide attempts or overall mortality. Hospital ketamine infusions should not divert attention or resources from evidence-based population-level suicide prevention strategies, continuity of care, and access to psychotherapies. Rather, this decision provides clinicians with a tightly regulated option for patients facing very high imminent risk.

Although racemic ketamine has so far been used off-label, we believe that this official regulatory approval, embedded within comprehensive suicide care pathways, could help close the key gap between recognising an acute suicidal crisis and delivering an intervention capable of altering its short-term course.

We declare no competing interests.

During the preparation of this work the authors used ChatGPT 5.4 in order to check grammar and punctuation. After using this tool, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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Published **Online**
April 3, 2026
https://doi.org/10.1016/S0140-6736(26)00594-5

War economies and collapsing health systems

Every 1% increase in military spending drives a 0·62% reduction in public health spending.[1] This trade-off is more intense in low-income countries, where a 1% increase in military spending results in a 0·962% drop in health spending.[1] As global defence budgets surge to historical highs amid escalating conflicts in the Middle East, Ukraine, and beyond, this is not an abstract equation; it is a daily reality for the one in six people worldwide now living under active conflict.[2] Evidence from 1990 to 2017 links conflict to an estimated 29·4 million excess deaths from indirect causes alone, such as disrupted health services.[3] These costs occur through specific and compounding means.[4]

Published **Online**
April 3, 2026
https://doi.org/10.1016/S0140-6736(26)00544-1

First, through direct destruction: WHO has verified 13 attacks on health facilities in Iran since conflict began in February, 2026, with nearly 1000 deaths reported in Iran, and 50 in Lebanon. Lebanon witnessed the closure of 43 primary health-care centres and two hospitals.[4]

Second, through supply chain collapse: WHO's Global Health Emergencies Logistics Hub in Dubai is on hold, with US$18 million in humanitarian health supplies blocked, affecting more than 50 emergency supply requests from 25 countries.[4] This blockade includes $6 million worth of medicine for Gaza that cannot be delivered.

The final way these costs are incurred is through economic warfare (ie, sanctions). Despite formal humanitarian exemptions, sanctions in Iran have caused critical shortages of medicines and medical supplies, with a documented 10–20% foreign currency shortfall for pharmaceutical procurement predating the first strike.[5]

Universal health coverage (UHC) frameworks remain largely blind to this reality. UHC indices measure coverage and financial protection against baselines that assume functioning economies. However, conflict-affected countries are penalised in these metrics for the direct fiscal consequences of war economics (appendix), as countries with higher conflict indices have greater reductions in health spending compared with countries not affected by war. Furthermore, external health aid to low-income and middle-income countries is collapsing by 30–40%,[6] placing affected countries in an acute health budget deficit and making out-of-pocket health spending the only way to finance health systems.

Peace is essential for UHC. UHC should be maintained during periods of conflict, as this is when demand for medical services increases exponentially. Furthermore, we argue that sanctions and blockages should be recognised as quantifiable social determinants of health. Heath facilities must be protected, and access to humanitarian supplies must not be impeded. Health cannot—and should not—be overlooked in the economies of war.

We declare no competing interests.

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See **Online** for appendix

Published **Online**
April 3, 2026
https://doi.org/10.1016/S0140-6736(26)00546-5

Sound mind, sound place: *ibasho* and post-disaster mental health

Although mental health responses after disaster often begin with symptom checklists, triage, and specialist treatment, evidence from Japan shows that this approach is necessary but not sufficient. After the Great East Japan Earthquake in 2011, disaster-related deaths were time-dependent, with nearly half occurring within 1 month and 78% within 3 months.[1] However, mental health needs often persist much longer in affected populations. Although acute mental health assessment matters, long-term recovery also depends on whether people can continue to live safely, sustain relationships, and recover social roles after displacement. In Japan, the concept of *ibasho*, a community-led place that embeds people within larger social networks and meaningful roles,[2] can help with this recovery.

The Sphere concept provides a humanitarian framework for *ibasho* by setting out common principles and minimum requirements for survival with dignity, including the essential services and coordinated support needed after disaster.[3] In the context of mental health, these conditions are dynamic: in the acute phase of post-disaster survival, physically safe shelter, continuity of essential care, family contact, and practical support might matter most; however, community support and specialist care might later assume increasing importance. Japan also offers a clear contrast between the absence and presence of *ibasho* within the same disaster context. After the Great East Japan Earthquake and Fukushima nuclear accident, dementia consultations increased and behavioural and psychological symptoms near evacuation zones worsened.[4] By contrast, active participation in an *ibasho* programme led by older people in another severely affected area was associated with greater self-reported family and neighbourhood recovery.[5] *Ibasho* therefore matters both clinically and socially, making it relevant to both preparedness and recovery.

This insight is not uniquely limited to Japan. Across the world, disasters, armed conflict, forced migration, and climate-related emergencies disrupt housing, care, and ordinary social life. Many displaced people are temporarily housed in reception centres, hotels, modular housing, or mass shelters, with repeated relocation, family separation, and sustained legal and economic uncertainty. Such long-term displacement erodes safety,