17% experienced changes in sleeping patterns (mostly lack of sleep), and 23% experienced increased anxiety. Participants noted that other areas of their lives were affected: 6% indicated conflict within the family, 8% experienced financial implications when they had to purchase the medication privately, 9% indicated that they had to travel to and from the clinic several times to check whether medication was available, and 2% had to take time off from work because their level of functioning was affected.

A concern raised by participants was that they had not been adequately informed of the situation where the medications had been out of stock and when medication dosages had been reduced or substituted, even though South African policies and legislation emphasise the rights of users of mental health care to fully participate in their treatment plan.

In conclusion, apart from the costs involved both for the health system as well as service users, when medication is not available it causes hardship in the lives of the individuals who are affected, especially service users in low-income and middle-income countries who are among the poorest. The provision of essential medications is a basic human right. Lack of medication ultimately denies individuals with mental disorders their right to access quality health-care services, enjoy a good quality of life, and to live with dignity. Lack of access to correct medication cannot be seen solely as a logistical or policy issue; it is a human rights issue because it violates an individual’s right to quality health care and dignity. The aspiration of the Sustainable Development Goals of “leaving no-one behind” must be honoured in the name of users of mental health care.

*Charlene Sunkel, Marthé Viljoen
South African Federation for Mental Health, Johannesburg 2000, South Africa
charlene@safmh.org

We declare no competing interests.


## Trends in new psychoactive substances from surface and “dark” net monitoring

New psychoactive substances (NPS) are substances that have similar acute effect profiles to established street drugs, but are not controlled under international legislative agreements. NPS distribution has largely been driven by the internet, with countries such as China and India playing significant roles in their manufacture.

The European Union (EU) has invested considerably in monitoring NPS, with an early warning system in place for over a decade and a steady increase in the number of NPS identified for the first time each year (appendix). When merited, reported NPS might undergo a risk assessment process. A recent example of this was the synthetic cathinone α-PVP (appendix).

Initially, retail of NPS occurred mainly on the surface web—that is, traditional webstores that are indexed and discoverable by search engines. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) identified over 650 different websites selling so-called legal highs on the surface web in 2013. More recently, “cryptomarkets”, which are anonymous marketplaces operating on the so-called darknet, and accessible only via specially configured browsers, have played an increasing role in NPS distribution. In 2015,
data collected from around half of active cryptomarkets estimated a drug sales volume of approximately US$600,000 per day. Monitoring of cryptomarkets has revealed consistency in the proportion of vendors listing NPS for sale, as well the types offered (figure).5 Although traditional illicit substances are more commonly on offer, 15–20% of vendors across larger cryptomarkets list NPS for sale. NPS classes on offer typically mirror the substances most prevalent in consumer group surveys6—hallucinogens and amphetamine-type stimulants. For example, the 2C-x class of empathogens, the psychedelic tryptamine DMT, and substituted 2C-x variants of the NBOMe class are sold by the highest number of vendors across markets. α-PVP is also available on cryptomarkets and is sold by around 5% of NPS vendors.5

There appears to be a funneling of popular NPS from surface web markets into cryptomarkets once legislation changes ban their sale. This presents new challenges for law enforcement because cryptomarket vendors use sophisticated security measures to enhance anonymity and diversify risk in the event of marketplace seizures or scams. Additionally, cryptomarkets may be becoming more decentralised, thereby removing the marketplace as a hub for distribution, rendering interception by law enforcement substantially more difficult.

Online communities on both surface web and darknet markets provide a platform for anonymous discussion of substance use and purchase, and may foster harm reduction discussions. In these communities, online vendors depend on consumer feedback to maintain trust with the community, and are thus accountable for the products they sell.7 People using cryptomarkets to obtain drugs report fewer concerns about drug purity, lower levels of exposure to physical violence, and fewer law enforcement consequences compared with obtaining drugs from other sources.8 These are not features of street drug markets.

There is additionally the potential for NPS to be purchased online, from either surface web or cryptomarket vendors, and passed off in street markets as traditional illicit drugs. This practice has most frequently been observed across amphetamine-type stimulants, but adulteration has also been observed across opioid classes. This is especially concerning in vulnerable populations such as people who inject drugs and those with substance use disorders. For example, reports of fentanyl analogue toxicity appear to be on the rise, thought to be due to its use as an adulterant in street heroin.9 In September 2016, one cryptomarket issued a ban on the sale of fentanyl through its market because of the increased occurrence of fentanyl overdoses in the USA.10

Little research exists on long-term effects of NPS use and potential adverse interactions with other medications, illicit substances, or mental health disorders. Although some NPS may mimic the acute effects of traditional street drugs, significant variability exists in dosages across classes, and additional acute effects may accompany expected ones. For example, substances in the 2C-x class, despite often being sold as substitutes for MDMA, have additional hallucinogenic properties to the

Figure: NPS listings on cryptomarkets, January to June, 2016 (A), and contribution of NPS to total listings, 2013–2015 (B)
(A) shows sales across the five largest cryptomarkets. (B) shows overall number of substance listings across all monitored markets, with proportion of NPS-specific listings. 2C-x refers to a family of structurally similar psychedelic phenethylamines. NBOMe refers to a family of hallucinogenic phenethylamines, often analogues of 2C-x variants. D0x refers to a family of substituted amphetamine derivatives, producing psychedelic effects. DMT=dimethyltryptamine. Mephedrone=4-methylmethcathinone. MDA=3,4-methylenedioxyamphetamine. α-PVP=1-phenyl-2-(1-pyrrolidinyl)-1-pentanone. NPS=new psychoactive substances. See appendix for additional detail. Data from Drug and New Technologies monitoring project.1

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Psychiatry’s response to mass traumatisation and the global refugee crisis

After years of suffering, hunger, and war throughout Europe, the Middle East, and Africa, millions of people have been displaced from their homes. In 2015, an estimated 34,000 people per day were added to the 65 million displaced worldwide, of whom 21·3 million are refugees, living in camps, ruins, or on the streets.1 In 2015, approximately 10·8 million refugees were children and young people and it has been demonstrated that those living in refugee camps, particularly adolescents, are exposed to high levels of physical and sexual violence and little access to shelter, food, water, and education.2 Despite the growing number of young refugees and the fact that they spend the majority of their childhood in camps, little attention has been paid to understanding and supporting the mental health of this population and their needs.

The refugee crisis is a tragedy with existential decisions concerning the simplistic categorisation of “them” versus “us”, with deep ethical dimensions for people to contend with as human beings and as professionals. This narrative is plagued with trauma and suffering. Across generations, nationalities, and professions, the refugee crisis poses one of the biggest mental health challenges for our global community. Have health professionals responded adequately? Is it an ethical option to stay on the side-lines?

The only historical reference for a systematic role of psychiatry in times of mass traumatisation is military psychiatry3 where health professionals treated military