



## Commentary

## The problem of mephedrone in Europe: Causes and suggested solutions

We read with great interest the article by Ordak and colleagues regarding potential solutions to the increasing number of hospital visits regarding mephedrone use. Clearly, this is a timely and important issue; and the authors should be commended for attempting to provide an integrative policy and educational framework to address mephedrone-related hospital admissions. However, their approach leaves apart some relevant data that do not fit into their conclusion. For this reason we felt compelled to present this facts and discuss their impact in the author's conclusions.

The authors raise concern about mephedrone-related increased hospital admissions, suggesting it is due to its online availability. They put forward two strategies to address the apparent problem: 1) improve educational efforts about mephedrone and 2) ban websites that supply mephedrone.

As a scientists and educators, we applaud efforts aimed at increasing the intellectual tone surrounding discussions of psychoactive substances because this should ultimately function to keep people safe. Our concern here, however, is that the authors selectively emphasize potential negative effects and, then promote this as if it is "education." Recreational drugs have both negative and positive effects. Indeed, most users seek the positive effects. Omitting certain relevant drug-effects seem more indoctrination than education.

A related point is that multiple statements are made without supporting evidence. The authors state that a large number of people are repeatedly hospitalized due to the strong addictive potential of mephedrone without providing any references. Maybe the authors meant acute toxicity instead of addiction potential, as this could be more easily related to hospital admissions. However, even in that scenario, we could not find evidence supporting this claim. Moreover, evidence shows that deaths attributed to mephedrone remain relatively low [1].

The authors' advocacy regarding increased enforcement efforts also omits certain relevant facts. While there is some contradictory evidence suggesting that restricting access to mephedrone may decrease its availability, there is no discussion of other consequences of this intervention [1]. For example, mephedrone itself, which produce MDMA-like effects [2], appeared when MDMA availability was restricted [3]. The point is that restricting one compound can lead to the appearance of new psychoactive substances. In fact, when mephedrone was banned, other MDMA-like cathinones rapidly appeared on the market [4].

Omitting a discussion of this important issue is less than comprehensive and potentially misleading.

Finally, it is baffling that the authors did not discuss other widely-used interventions to reduce mephedrone-related hospital admissions. For example, mephedrone is sometimes sold as MDMA [3]. This can be problematic—even fatal—for unsuspecting MDMA users who unwillingly and unknowingly ingest it thinking that it is MDMA. One simple intervention is to offer free, anonymous drug-purity testing services. If a sample contains adulterants, users would be informed and some potential harms prevented. These services already exist in most of developed countries [5].

In our opinion, the same scientific rigor and consideration should be applied to all interventions aimed to reduce mephedrone related hospital admissions (and any negative health outcome of recreational drug use). In this sense, at any given situation, all available evidence should be discussed comprehensively before elaborating policy recommendations.

## References

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Received 6 November 2018

Available online 20 November 2018