

that all primary health centres stock essential psychotropic medications and that primary care physicians are trained in the detection and management of common disorders.

Barbui, C. & Hotopf, M. (2001) Amitriptyline v. the rest: still the leading antidepressant after 40 years of randomised controlled trials. *British Journal of Psychiatry*, **178**, 129–144.

Geddes, J., Freemantle, N., Harrison, P., et al (2000) Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. *British Medical Journal*, **321**, 1371–1376.

Jacob, K. S. (2001) Community care for people with mental disorders in developing countries. Problems and possible solutions. *British Journal of Psychiatry*, **178**, 296–298.

Mojtabai, R., Varma, V. K., Malhotra, S., et al (2001) Mortality and long-term course in schizophrenia with a poor 2-year course. A study in a developing country. *British Journal of Psychiatry*, **178**, 71–75.

Szmukler, G. & Thornicroft, G. (2001) What is 'community psychiatry'? In *Textbook of Community Psychiatry* (eds G. Thornicroft & G. Szmukler), pp. 1–12. Oxford: Oxford University Press.

G. Ranjith Affective Disorders Unit, Bethlem Royal Hospital, Beckenham BR3 3BX, UK

V. Duddu Beechhurst Unit, District General Hospital, Chorley PR7 1PP, UK

Author's response: Drs Ranjith and Duddu argue that primary health care workers, because of their commitments to physical health needs, are not able to deliver mental health care. While this is partly true, I believe that the accomplishment of programmes that have been successfully integrated into primary care depends upon empowerment of the primary care staff to manage these problems. Physicians, nurses and community health workers in many developing countries, with their limited training, are not confident in managing mental disorders. Changes in the basic curriculum, training of trainers within primary care and ongoing support in fieldwork are necessary for skills to be transferred. The empowerment of primary care staff to tackle mental health problems is mandatory for the success of such programmes. Obstetric and immunisation services in many parts of the developing world have succeeded because of such empowerment and consequent integration into primary care.

The successful treatment of epilepsy in many mental health programmes is because the primary care staff are confident and competent in managing these disorders. The lack of these components in the management of psychoses and depression has resulted in programmes mainly treating

subjects with epilepsy. The absence of other programmes for treating seizure disorders in the community would argue for retention of this component within mental health initiatives.

The problems of mental illness are complex, with implications for health care, the economy, and social and cultural practices. The current approaches have not delivered reasonable health care in many parts of the developing world. There are no simple solutions. There is a need for debate to generate new and different initiatives in order to overcome the present inertia. A combination of approaches, which harness the available resources, may be more successful than a single strategy.

K. S. Jacob Department of Psychiatry, Christian Medical College, Vellore 632002, India

Need for paediatric–psychiatric liaison

Bass *et al* (2001) have recently drawn attention to the insufficient recognition given by clinical services to somatoform disorders. Although the authors explicitly exclude children and adolescents, most of the issues they raise apply equally to the younger age groups.

It has long been known that impairing functional aches and pains unexplained by medical disorders are common in children (Garralda, 1999). As in adults, those associated with chronic widespread pain and persistent fatigue have been shown to be associated with marked functional impairment including school non-attendance, which is substantially higher than in serious chronic paediatric conditions (Rangel *et al*, 2000). There is considerable continuity with functional symptoms in adulthood and family aggregation of health problems (Garralda, 2000). Although less extensive than in the adult literature, there is evidence for the effectiveness of psychological treatments in children (Garralda, 1999). However, the development of dedicated psychiatric–paediatric liaison services often has low priority, is poorly coordinated and monitored, and the training of paediatric staff in this area is clearly limited.

In line with Bass *et al* I support the view that young patients with severe forms of somatoform disorders require specialised multi-disciplinary treatment which is not

appropriately administered in either a psychiatric or paediatric ward. I would echo the need for a serious joint business case between paediatric and psychiatric providers and general practitioners. Although in itself not sufficient, it might help to increase awareness and action if the Royal College of Psychiatrists were to issue guidelines on the number of paediatric liaison psychiatrists required for a given population and on job specifications.

Bass, C., Peveler, R. & House, A. (2001) Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. *British Journal of Psychiatry*, **179**, 11–14.

Garralda, M. E. (1999) Practitioner review: assessment and management of somatisation in childhood and adolescence: a practical perspective. *Journal of Child Psychology and Psychiatry*, **40**, 1159–1167.

— (2000) The links between somatisation in children and adults. In *Family Matters: Interfaces between Child and Adult Mental Health* (eds P. Reeder, M. McClure & A. Jolley), pp. 122–134. London: Routledge.

Rangel, L. A., Garralda, M. E., Levin, M., et al (2000) The course of chronic fatigue syndrome. *Journal of the Royal Society of Medicine*, **93**, 129–134.

E. Garralda Imperial College School of Medicine, St Mary's Campus, Norfolk Place, London W2 1PG, UK

Cannabis regimes – a response

de Zwart & van Laar (2001) provide a thoughtful discussion of our recent article comparing alternative legal regimes for cannabis (MacCoun & Reuter, 2001a). We quite agree that any correlation between a rise in cannabis-selling coffee shops and a rise in cannabis prevalence might be coincidental rather than causal; we said so in our article and highlighted this point in its 'Limitations'. Our purpose was not to evaluate the Dutch model on its own terms, but to highlight potential risks and benefits of alternative strategies for the USA.

However, we take issue with several points made by de Zwart & van Laar. First, they question the plausibility of our term 'commercialisation', noting that since 1991 coffee shops have been subject to criminal prosecution for violations of regulations against advertising. But our article explicitly stated that changes in coffee shop regulation probably reduced commercialisation during the 1990s, and for this reason we explicitly argued that our commercialisation hypothesis was limited to the period 1984–1992. At any rate, this argument confuses formal regulations with their implementation; tourists can attest that cannabis is openly promoted in Amsterdam and other cities, with not-so-veiled

references in newspaper advertisements, posters, postcards and shop signs. (Indeed, one can readily verify this by searching for Dutch coffee shop websites on the World Wide Web.)

Second, de Zwart & van Laar claim that “less than half of cannabis consumers purchase the drug in a coffee shop – the majority obtains it elsewhere...”. This statement is apparently based on the Trimbos survey of students. The rule banning minors from coffee shops is difficult to enforce, but one would expect adolescent users to rely less heavily on coffee shops than adult users do. In his intensive longitudinal study of the Amsterdam cannabis market, Jansen (1994: p. 172) claims that the shops account for over 95% of cannabis sales in Amsterdam. In their more recent study of 216 experienced cannabis users in Amsterdam, Cohen & Sas (1998: p. 63) report that 75% of those still using cannabis reported one or more coffee shops as their primary source of cannabis. Given the accessibility of coffee shops in cities and the fact that one can buy enough for a few days (or weeks) each time, there is hardly more reason to make street purchases of cannabis than of instant coffee. But the 5 g purchase limit surely facilitates secondary transactions in which coffee shop clients share or provide cannabis for their (sometimes younger) friends.

Third, we agree that coffee shops are much more common in Amsterdam than in small Dutch towns, although various estimates in the 1980s suggest that more than half of all coffee shops were located outside Amsterdam. But the concentration of coffee shop sales in Amsterdam actually strengthens our inference that commercialisation might promote cannabis use. Urbanicity has not been shown to be an important correlate of prevalence rates in the USA. Yet the recent national survey by CEDRO (Abraham *et al*, 1999) shows that cannabis use was much more prevalent in Amsterdam than in The Netherlands as a whole.

Fourth, de Zwart & van Laar correctly note that school surveys tend to yield higher prevalence estimates than household-based population surveys. Unfortunately, an omitted footnote to our Table 1 obscured the fact that our US source for the “approximately age 18” comparisons was the Monitoring the Future school survey. Trimbos contends that their school survey was specifically designed to facilitate comparisons with that US survey (see Plomp *et al*, 1991: p. 11).

What may be obscured in this exchange is that we hold a mostly enthusiastic view of Dutch drug policy (MacCoun & Reuter, 2001*b*). Indeed, we argue that the coffee shop system has produced few measurable social harms and possibly some benefits by reducing the excessive use of police sanctions and by weakening the link to hard drug markets. Still, an alternative model that might meet the same goals with less risk of promotion is the South Australian system that permits home cultivation of small quantities of cannabis.

Abraham, M. D., Cohen, P. D. A., van Til, R., et al (1999) *Licit and Illicit Drug Use in the Netherlands, 1997*. Amsterdam: Centre for Drug Research (CEDRO).

Cohen, P. & Sas, A. (1998) *Cannabis Use in Amsterdam*. Amsterdam: CEDRP Centrum voor Drugsonderzoek, Universiteit van Amsterdam.

Jansen, A. C. M. (1994) The development of a “legal” consumer’s market for cannabis: The “coffee shop” phenomenon. In *Between Prohibition And Legalization: The Dutch Experiment in Drug Policy* (eds E. Leuw & I. H. Marshall) pp. 169–182. Amsterdam: Kugler.

MacCoun, R. & Reuter, P. (2001a) Evaluating alternative cannabis regimes. *British Journal of Psychiatry*, **178**, 123–128.

— & — (2001*b*) *Drug War Heresies: learning from Other Vices, Times, and Places*. New York: Cambridge University Press.

Plomp, K. N., Kuipers, H. & van Oers, M. L. (1991) *Smoking, Alcohol Consumption And The Use of Drugs By School children From The Age Of 10*. Amsterdam: VU University Press.

de Zwart, W. & van Laar, M. (2001) Cannabis regimes (letter). *British Journal of Psychiatry*, **178**, 574–575.

R. MacCoun Goldman School of Public Policy, University of California at Berkeley, 2607 Hearst Avenue, Berkeley, CA 94720-7320, and RAND Drug Policy Research Center, USA

P. Reuter School of Public Affairs, University of Maryland, and RAND Drug Policy Research Center, USA

Monthly variation in suicide is still strong in the USA

Yip *et al* (2000) reported that the seasonal variation of suicides in England and Wales had declined in recent decades. This does not appear to be the case in the USA. Monthly data for the number of suicides were available for the period 1960–1998 (National Center for Vital Statistics, 1960–1999; additional data J. McIntosh, personal communication, 2001). Chi-squared tests were conducted for each year for the monthly distribution (correcting for the number of days in each month), and contingency coefficients calculated in order to

Table 1 Summary by decade of suicides in USA

	Mean number of suicides per day			
	1960s	1970s	1980s	1990s
January	54.59	69.05	78.08	84.12
February	55.61	70.22	79.92	84.24
March	58.75	72.93	83.47 ¹	86.55
April	60.62 ¹	74.68 ¹	83.18	86.80
May	59.69	74.52	81.47	86.27
June	57.26	72.54	81.02	87.56 ¹
July	56.36	70.56	81.54	86.33
August	56.76	71.75	81.52	86.34
September	56.47	72.22	79.51	85.35
October	56.47	71.31	77.56	82.80
November	55.33	69.40	78.11	80.86
December	53.72 ²	66.65 ²	74.14 ²	76.81 ²

1. Peak.

2. Trough.

control for the number of suicides each year. There was no linear trend in the contingency coefficients over the 39-year period (Pearson $r=0.033$). The month with the peak number of suicides varied over the 39-year period, but not in any linear fashion (see Table 1 for a summary by decade).

National Center for Vital Statistics (1960–1999)

Vital Statistics of the United States (annual). Rockville, MD: National Center for Vital Statistics.

Yip, P. S. F., Chao, A. & Chiu, C. W. F. (2000) Seasonal variation in suicides: diminished or vanished. Experience from England and Wales, 1982–1996. *British Journal of Psychiatry*, **177**, 366–369.

D. Lester The Richard Stockton College of New Jersey, PO Box 195, Jim Leeds Road, Pomona, NJ 08240-0195, USA

Evolution, biological reductionism and closed minds

Since recently familiarising myself with evolutionary psychology literature, I have been amazed by how frequently scathing criticism is thrown at authors by way of the words ‘biological reductionism’. In a series of letters in the *Journal*, Rose & Lucas (2001) criticise Abed (2001) for, sure enough, using the words “if it is not ‘biologically deterministic’ to claim that...”. This made me chuckle, as Rose declared himself to be a neuroscientist. I fully accept the importance of understanding the neurophysiology of the brain. However, among the amazing revelations of recent years I