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.

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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.

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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. Reder, 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.

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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, 2001*a*). 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

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