

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.

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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.

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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

now know that serotonin is involved in depression, obsessive–compulsive disorder, anxiety disorders, aggression, schizophrenia and goodness knows how many other psychological disorders, yet we proudly tell our patients with depression that their illness involves a problem with serotonin. To complicate matters further we now have to tell them that there are countless different versions of serotonin.

‘Biological reductionism’ occurs in all spheres of biology. It is time that this reality was accepted and ceased to be used for devaluing the arguments of those who profess what some others may deem politically incorrect theories. I make a special plea to journal editors, as the frequency of this retort is such that free (and potentially legitimate) speech is at times being compromised.

Abed, R. T. (2001) Evolution and psychiatry (letter). *British Journal of Psychiatry*, **178**, 179.

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One hundred years ago

General hospitals and mental diseases

OUT-PATIENTS suffering from mental disorders have been for long treated at St. Thomas’s Hospital and elsewhere. The results of experience have shown that good work has been done in relieving many sufferers and in avoiding the necessity for asylum care in not a few cases. The quarterly court of governors of the Newcastle

Infirmary has decided to institute such a department, as reported by the *Newcastle Evening Chronicle* of Nov. 1st. Dr. G. H. Hume, in bringing forward the motion, pleaded for the fundamental ideas of prevention and cure, and it has been decided that a physician, qualified as the rules require and occupying an appointment in a public asylum in Northumberland or Durham, should attend at the

infirmary one day in each week and prescribe for the out-patients placed under his care.

REFERENCE

Lancet, 24 November 1900, 1515.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

Corrigendum

Specificity and heterogeneity in children’s responses to profound institutional privation. *BJP*, **179**, 97–103. Authorship of this paper

should read: M. L. Rutter, J. M. Kreppner and T. G. O’Connor and the English and Romanian Adoptees (ERA) study team.