The authors state 'this trial can be seen as an effectiveness rather than an efficacy trial, because it evaluated feedback under realistic conditions'. We wish to say that, generally speaking, the effectiveness of an intervention is meaningful after the efficacy has been established. Although there was an attempt to provide feedback, we felt that the one-time sending of an electronic communication is neither complete nor strong enough an effort at feedback and, realistically speaking, is likely to go unnoticed. The study, however, highlights an important point regarding the poor quality of most websites concerning serious medical or public health matters. Although quacks or uncertified self-claimed experts can be prosecuted under law, there are a number of websites promising help for people who are suicidal, but which fail to deliver on the quality or extent of information available to individuals seeking help.[2] There is a need for regulation or a mandatory professional certification of the content of websites, especially in such matters where life can be at stake. Short of that, interventions need to be planned so that they are readily acceptable and effective in ensuring a positive change in the content of suicide prevention websites.

1 Jorm AF, Fischer JA, Oh E. Effect of feedback on the quality of suicide prevention websites: randomised controlled trial. *Br J Psychiatry* 2010; **197**: 73–4.

2 Van Ballegooijen W, van Spijker BA, Kerkhof AJ. The quality of online suicide prevention in the Netherlands and Flanders in 2007. [In Dutch.] *Tijdschr Psychiatr* 2009; **51**: 117–22.

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Author's reply: The point of our study was to see whether a very simple, cheap feedback intervention might work to improve quality of website information. Clearly, it either did not work or the effect was small. It is quite possible that more elaborate feedback interventions might work. This needs to be tested. However, if these were to work, would they be of any practical use? Is anyone going to go to the trouble of routinely monitoring website quality and personally contacting website developers to give them feedback? Who would fund this sort of work? There is also the related issue of who would resource website owners to carry out substantial revisions. In this regard, it is interesting that after our trial was over, one website administrator wrote to us saying that they had now revised their website in response to our feedback. The reason they cited for the delay is the limited resources they had as a non-government organisation.

Readers of our article may be interested in another study on feedback which only came to our attention after our trial was completed. This was a much larger randomised controlled trial ($n = 299$ URLs) from the field of pharmacology and gave feedback on quality of information on the drug sildenafil. Like our trial, this one found no effect of emailed feedback letters.

1 Martin-Facklam M, Kostrzewa M, Martin P, Haefeli WE. Quality of drug information on the World Wide Web and strategies to improve pages with poor information quality. An intervention study on pages about sildenafil. *Br J Clin Pharmacol* 2003; **57**: 80–5.

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Cannabis and psychosis

We read with interest the recent study by Henquet and colleagues.[1] As well as providing further support for the well-established theory that cannabis may worsen or re-awaken psychosis in vulnerable adults, this study reports the fascinating and novel finding that cannabis appears to differentially affect mood – with patients with a psychotic disorder, but not controls, reporting improvements in negative affect following cannabis use. On the other hand, cannabis enhanced positive affect in patients and controls alike.

Previous studies have been contradictory regarding the effects of regular cannabis use on mood. Denson & Earleywine found that regular users reported less depressed mood and more positive affect than non-users,[2] whereas Degenhardt and colleagues reported that heavy cannabis use and depression were associated.[3] The reason for these differences is not clear, but may be due to differences in cannabis composition, as pure delta-9-tetrahydrocannabinol is anxiogenic when given acutely, whereas cannabidiol appears to ameliorate these effects.[4]

The finding that patients derived more benefit from cannabis use in terms of mood suggests that the association of early cannabis use with subsequent onset of psychosis may not, in fact, be a causative relationship as previously reported.[5] Rather, early cannabis use in these (already vulnerable) individuals may be more likely as they derive more benefit – in terms of mood enhancement – than individuals who are not at risk of psychosis. Henquet and colleagues also report that the effects on mood are acute, whereas effects on psychosis are subacute. It would be interesting to determine whether the effects on mood and psychosis occur with equal frequency earlier in the illness, because if psychosis emerges only with repeated dosing, this may be a further maintaining factor in early use.

Regardless of the aetiological relationship of cannabis use to psychosis onset, this study highlights an important point – people take cannabis because they feel that they derive benefit from it, and patients with psychosis are no different in this respect. In terms of clinical practice, this paper highlights one reason why service users may continue to smoke cannabis, despite the fact that it clearly worsens their psychotic symptoms. This awareness can add to our understanding and attitude towards the service user, and enable us more creatively to help the service user find alternative ways to boost their mood.

1 Henquet C, van Os J, Kuepper R, Delespaul P, Smits M, à Campo J, et al. Psychosis reactivity to cannabis use in daily life: an experience sampling study. *Br J Psychiatry* 2010; **196**: 447–53.

2 Degenhardt L, Hall W, Lynskey M. Exploring the association between cannabis use and depression. *Addiction* 2003; **98**: 1493–504.

3 Denson TF, Earleywine M. Decreased depression in marijuana users. *Addict Behav* 2006; **31**: 738–42.

4 Bhattacharyya S, Morrison PD, Fusar-Poli P, Martin-Santos R, Borgwardt S, Winton-Brown T, et al. Opposite effects of delta-9-tetrahydrocannabinol and cannabidiol on human brain function and psychopathology. *Neuropsychopharmacology* 2010; **35**: 764–74.

5 Moore TH, Zammit S, Lingford-Hughes A, Barnes TR, Jones PB, Burke M, et al. Cannabis use and risk of psychotic or affective mental health outcomes: a systematic review. *Lancet* 2007; **370**: 319–28.

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