

happen in their social worlds, not in the space between their ears.

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Author's reply: Newly arrived refugees will often see their problems initially in terms of past experience (e.g. war-violence or torture) rather than emotional impact. They share a need for security and safety. However, it would be illogical to conclude that they are thereby free of psychopathology. It is not a case of either one state or the other. Factors operating in different domains frequently interact. This is the situation here.

Interestingly, as many as 11.1% of 522 subjects responded that they had a mental health problem *and* that they now wanted help (i.e. 'Western' treatment). We would expect help-seeking to increase in those with persisting symptoms, in line with experience in treatment services after any major incident.

To assert that significant psychopathology is 'uncommon' is wrong. It implies that civil war, rape and torture do not have important psychopathological consequences in significant numbers of people. This flies in the face of the evidence. It is reminiscent of the problems that Eitinger and others had when trying to justify reparation for some concentration camp survivors on the basis of psychological injury. Surely we have moved on since then.

In this instance, we do not assert psychopathology on the basis of self-report measures. This would have been an overestimate as we demonstrated in our report. An Albanian-speaking doctor undertook semi-structured clinical interviews (in Albanian).

Summerfield refers to additional data in our survey. We wish to present a factual analysis of these. We asked an open

question about respondents' main concerns. The responses to this question are in the respondents' own words but if anxiety, tension, nervousness, stress or trembling are grouped together as likely anxiety symptoms, these were in fact the most frequent of the first priority problems and overall were reported by 21% (of 509 respondents). Sleep disturbance was reported by 16%, depression, hopelessness, sadness, mental problems and (poor) concentration by 8%. Many reported additional somatic complaints or general health problems, probably including a significant additional burden of psychological difficulty. Surprisingly, worries about family and friends were reported by only 17%. Concerns about work/economy (6%) and school/language (3%) were infrequent.

Rather than contradict the responses to the more structured questions, answers to these open questions reinforce our more quantitative findings.

Declaration of interest

This work was undertaken with funding from the National Health Service (NHS) Executive London, Research and Development Programme. The views expressed in this publication are those of the authors and not necessarily those of the NHS Executive or the Department of Health.

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Effect of clozapine on mortality

Duggan *et al* (2003) elegantly model the effect of clozapine on suicide, and highlight that 53 lives could be saved each year if all patients with treatment-resistant schizophrenia were offered clozapine treatment. The model does not, however, take into account the effect of clozapine on mortality from causes other than suicide. Clozapine is associated with weight gain, diabetes mellitus, and increased mortality from pulmonary embolism and other adverse events in addition to the risk of agranulocytosis (Walker *et al*, 1997). Fontaine *et al* (2001) estimated mortality due to clozapine-associated weight gain using data from the Framingham Heart Study. They conclude that the reduction in the suicide rate would be almost entirely offset over 10 years by the increased mortality associated with

weight gain of 10 kg. Walker *et al* (1997) report that mortality from causes other than suicide is increased with clozapine treatment, although overall mortality is lower. To completely model the effect of clozapine on mortality, the effects of the alternatives – active treatment and no treatment – on mortality, including suicide and adverse events related to treatment with other antipsychotics, should be included. These remarks do not detract from the main point that clozapine is still the most effective intervention for treatment-resistant schizophrenia, and mortality is only one outcome to be weighed in the overall risk–benefit analysis.

Declaration of interest

L.S.P. is a UK Medical Research Council Senior Research Fellow and has received investigator-led charitable research grants from Novartis, AstraZeneca, Janssen and Sanofi-Synthelabo. O.H. and R.O. have conducted research through these investigator-led charitable research grants.

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Health care contact and suicide

We read with interest the study by Gairin *et al* (2003), which highlighted the suboptimal working relationship between the accident and emergency department as a first point of contact and psychiatric services. Thirty-nine per cent of suicide victims got in contact with the accident and emergency department at some point in the last year of their lives and, according to the National Confidential Inquiry into Suicides in England and Wales, only a quarter of suicides are preceded by mental health service contact in that same period.

Although I appreciate the above point, I still think that contact with primary services has an equal if not greater role to play

in reducing suicide, especially in those age groups whose members are less likely to attend the accident and emergency department at times of crisis, such as children and the elderly.

Duckworth & McBride (1996) have reported that 80% of elderly suicide victims received no psychiatric referrals, and according to Harwood *et al* (2001), only 15% of elderly people who died by suicide were under psychiatric care at the time of death.

In our study, analysing coroners' inquests of 200 cases of suicide in old age in Cheshire, 1989–2001 (Salib & El-Nimr, 2003), the role of primary care was emphasised. Interestingly, even those victims who were known to psychiatric services still preferred to contact their general practitioners (GPs) in the last few weeks before the fatal act.

One conclusion might be that people whose GPs acknowledged their mental health problems and cared to refer them to a specialist service were able to build a more meaningful therapeutic relationship with their doctors and readily contacted them as a final desperate act in the last period of their lives. A well-trained GP can act not only as an effective first point of contact but also a final one!

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Assertive outreach in Tyneside

Priebe *et al* (2003) have questioned whether the findings of the Pan-London Assertive Outreach Study can be generalised to assertive outreach services in the rest of the UK. Cornwall & Haveman (2003) evaluated the Newcastle and North Tyneside assertive outreach service using the same research

instruments as those in the Pan-London study, so direct comparisons can be made.

After 17 months of operation, the Newcastle and North Tyneside team was similar in size to the London mean ($n=56$) with a score on the Dartmouth Assertive Community Treatment Scale (Teague *et al*, 1998) of 3.5 (medium fidelity to the model). The team has care programme approach (CPA) responsibility and small case-loads, operates out of office hours but without dedicated in-patient beds and, at the time of evaluation, no consultant psychiatrist. It thus corresponds to a Cluster B team in the Pan-London study (Wright *et al*, 2003).

Patient contact frequency and duration was higher than the London mean with an average face-to-face contact of 94 minutes per week. There was also a greater focus on patient engagement, with this being the primary focus in 33.1% of contacts. Engagement with the service in assertive outreach patients was compared with a random sample of community mental health team (CMHT) patients on enhanced CPA. There was no difference in the level of engagement, raising the possibility that the focus on engagement was having an impact in a previously hard-to-engage patient group.

Similar to the London study (Billings *et al*, 2003), team members were fairly satisfied with their jobs and most were not experiencing high levels of burnout. Compared with two local CMHTs, assertive outreach staff reported a higher level of personal accomplishment, replicating the Pan-London study finding. Another common finding was that the assertive outreach staff rated lack of support from senior staff in the service as a greater source of stress than did CMHT staff. Team members also identified dual diagnosis as an unmet training need.

Newcastle and North Tyneside patients were more likely than London patients to be White (86% *v.* 45%) or living alone (68% *v.* 52%). More surprisingly, they had significantly higher levels of alcohol misuse or dependency (31% *v.* 16%) and drug misuse or dependency (40% *v.* 20%). This reflects the fact that the Newcastle and North Tyneside service may be managing a more severely ill patient group, with 93% having experience of compulsory admission and 70% having had an in-patient admission lasting more than 6 months. Using the mean MARC severity score (Huxley *et al*, 2000), assertive outreach patients in Newcastle and

North Tyneside had significantly more severe problems than the sample of local CMHT patients on enhanced CPA (7.4 *v.* 3.4; $t=6.35$, $d.f.=83$, $P<0.01$; mean difference=4.0, 95% CI 2.7–5.3).

Wright *et al* (2003) have suggested that the London teams are assertive community treatment-like teams, but that the US assertive community treatment model may not easily translate to the UK context. The Newcastle and North Tyneside data contrast with both the London data and data from the UK700 study (Burns *et al*, 1999) in terms of the strong focus on patient engagement. Longitudinal studies are needed to determine whether this will actually enhance engagement and whether that improves outcome.

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Treating maternal depression?

Cooper *et al* (2003) reported a randomised trial with mothers with post-partum depression that compared routine primary care, non-directive counselling, cognitive-behavioural therapy (CBT) and psychodynamic therapy and found that psychological therapy improved maternal mood in the short term but the long-term effect was no better than spontaneous remission.