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

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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

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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

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