Non-attendance, non-residence, non-acceptance

Killaspy *et al* (2000) is one of several studies that demonstrate that non-attendance at psychiatric services is an index of increased pathology and greater need (Swofford *et al*, 1996; Crawford & Wessely, 1998) and serves as a corrective to earlier suggestions that non-attenders are not usually worthy of being seen (Robin, 1976). Although the authors suggest that the first episode of non-attendance "may be an important time to intervene to attempt to prevent loss to follow-up of those with serious mental illnesses" the trends in psychiatric services are increasingly moving in the opposite direction. The growth in geographical sectors covered by community teams has many advantages (Johnson & Thornicroft, 1993), but has naturally led to the dangers of preferentially looking after easier patients who belong within the area rather than difficult ones who might (with luck) go away if they are not seen. Although this behaviour might be considered ostrich-like in view of the fact that Killaspy *et al* found that patients who did not attend were more likely to be readmitted, they also noted that 27 (7%) of their patients were untraceable. I suspect that most of these were extremely ill, highly geographically mobile patients who would have absorbed a significant proportion of psychiatric resources if they had been contacted proactively and who would have been seen as imposing an additional burden on services that should be primarily involved in caring for the 'real' residents in the catchment area.

We have considerable evidence of this in the inner-city area of Paddington, where there are high rates of continuous psychiatric morbidity and more than 1 in 50 of the population is referred annually (Shipley *et al*, 2000). This is largely because so many of the population are geographically mobile and would normally stay only briefly in the area. Even when there is intervention by the psychiatric services in the form of admission there is a five-times greater chance that such patients will be admitted to a hospital outside their area (Lamont *et al*, 2000) and not taken on by mainstream services. The general consequence of this is that those services that are specifically focused on the most geographically mobile population (e.g. homeless people with mental illnesses and street outreach projects) often find it difficult to arrange transfer of their patients when they eventually settle to a more permanent base because the services in the area concerned do not regard them as proper residents. I have found that patients who have transiently lived in the Paddington area are often returned there by other services on the grounds that their care belongs in the area and the patients wish to return.

In practice it is unlikely that the sound recommendation of Killaspy *et al* that services be more active in seeing non-attenders would be followed because it is likely to lead to the growth of imported psychopathology of severe mental illness and increased psychiatric morbidity in the areas concerned. We have recommended elsewhere (Lamont *et al*, 2000) that the best way forward in tackling this problem is to create regional teams not preoccupied with catchment area boundaries, who could provide consistent and appropriate care for this forgotten non-attending population.

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Cigarette smoking in patients with schizophrenia

We read the article by McCreadie & Kelly (2000) with interest. The study indicates a high rate of cigarette smoking in patients with schizophrenia. It concluded that typical patients who smoke return 18–31% of their state benefits to the Treasury in the form of taxes on the purchase of cigarettes. However, the authors have not taken into consideration the cost of smoking-related diseases such as ischaemic heart disease and chronic obstructive airways disease. Inevitably, patients suffering from such diseases require expensive cardiorespiratory investigations and medication, which results in substantial expenditure by the National Health Service. Thus, perhaps the Treasury would be better off if patients did not smoke.

A review article by Felker *et al* (1996) has outlined various studies which indicate increased morbidity in psychiatric patients due to various medical conditions, including cardiovascular and respiratory problems. It is difficult to show the extent to which these diseases are caused by cigarette smoking, but we all know that there is a strong association between cigarette smoking and cardiorespiratory problems.

Felker, B., Yazel, J. & Short, D. (1996) Mortality and medical comorbidity among psychiatric patients: a review. *Psychiatric Services*, **47**, 1356–1363.

McCreadie, R. G. & Kelly, C. (2000) Patients with schizophrenia who smoke. Private disaster, public resource. *British Journal of Psychiatry*, **176**, 109.

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McCreadie & Kelly (2000) highlight the enormous financial cost of cigarette smoking to patients with schizophrenia and extrapolate from their data that those who smoke return 18–31% of their benefits to the Treasury, thus substantially contributing to the cost of their care. We directly measured the cost of smoking to a group of patients in Waterford and found that those who smoke spend an average of 29% of their income on cigarettes (McDonald & Sheppard, 1996). They thus contributed 24% of their income back to the Treasury in Ireland through this source alone, a proportion more akin to income tax for most people. This confirms the calculations of McCreadie & Kelly.

Aside from a curiously reduced risk of lung cancer (Gulbinat *et al*, 1992), patients with schizophrenia have increased mortality from heart and lung disease (Mortenson & Juel, 1993) and it is likely that cigarette smoking contributes largely to this. In addition to such adverse health effects, cigarette

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smoking clearly represents a huge financial burden on patients with schizophrenia. Money spent on cigarettes is not being spent on clothing, leisure pursuits and personal possessions, which could help to increase the quality of life of these patients. Smoking may be intimately associated with pathophysiological aspects of schizophrenia and further research should be done to clarify the relationship between nicotine consumption and the neurochemistry of schizophrenia. However, health care professionals should be aware of the extent of the financial disadvantage associated with this habit in order to help those patients who might wish to quit through encouragement and support and through prescription of nicotine supplementation where appropriate.

Gulbinat, W., Dupont, A., Jablensky, A., *et al* (1992) Cancer incidence of schizophrenic patients. Results of record linkage studies in three countries. *British Journal of Psychiatry*, **161** (suppl. 18), 75–85.

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Mortensen, P. B. & Juel, K. (1993) Mortality and causes of death in first admitted schizophrenic patients. *British Journal of Psychiatry*, **163**, 183–189.

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Imaginal exposure or cognitive therapy in the treatment of post-traumatic stress disorder

Tarrier *et al* (1999) report no significant difference in outcome for patients with post-traumatic stress disorder who received either imaginal exposure or cognitive therapy. They conclude that "clinical benefits for both treatments were maintained".

In the absence of a control group such a conclusion is not warranted. Their findings are open to a number of interpretations, including significant improvement in spite of harmful effects of either or both treatments – supposing, that is, that there were two treatments. Meanwhile, their suggestion that more research is needed does merit support.

Tarrier, N., Sommerfield, C., Pilgrim, H., *et al* (1999) Cognitive therapy or imaginal exposure in the treatment of post-traumatic stress disorder. *British Journal of Psychiatry*, **175**, 571–575.

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Induction of manic symptoms by novel antipsychotics

There have been scattered reports of mild states of agitation induced by novel antipsychotic agents, in particular disturbed affect during a switch study of risperidone (Ashleigh & Larsen, 1998) and doubtless other cases which have never been reported. At least 19 cases have been reported of risperidone-induced mania (Lane *et al*, 1998; Zolezzi & Badr, 1999). Fitzgerald *et al* (1999) reported a case of olanzapine-induced mania and state that only one similar report existed previously. A Medline search revealed six other cases in the past five years (further details available from the author upon request) and to this series we now add an eighth.

A 55-year-old woman with a 20-year history of chronic anxiety and recurrent depressive episodes developed subjective excitement, increased psychomotor activity, insomnia, irritability and racing thoughts within three days of being prescribed olanzapine 2.5 mg nocte. Her condition rapidly normalised on cessation of olanzapine. There were no features suggestive of akathisia. It should be noted that this case may be slightly weakened by a previous manic episode some 20 years previously.

There have been a small number of reports to the manufacturers' adverse-events database (manufacturers' personal communications) for sertindole, quetiapine and amisulpride where the induction of manic-type symptoms following commencement of the drugs has been a possibility but direct causal effect could not be established with certainty. No such reports could be found in the literature or by application to the manufacturers in respect of clozapine. Clozapine has been cited as having mood-stabilising properties in bipolar affective states (Suppes *et al*, 1999).

The attribution of manicogenic properties to risperidone, olanzapine, sertindole, quetiapine and amisulpride suggests some shared pharmacological characteristics between these agents and most antidepressants, although amisulpride does not bind to serotonin receptors. We conclude that states of agitation, sometimes severe enough to resemble mania, although infrequent, may be a complication of some, if not all, novel antipsychotic agents with the possible exception of clozapine.

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Zolezzi, M. & Badr, M. G. (1999) Risperidone-induced mania. *Annals of Pharmacology*, **33**, 380–381.

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