In a community mental health service, even an inner-city one, the rate of violent acts, of any severity, over a 6-month period is more likely to be around 6% (Shergill & Szmukler, 1998). Substituting the figures 6 and 94 in the probability tree the reader will discover that the positive predictive value drops to 0.14; that is, the prediction will be wrong almost nine times out of ten. For very serious violence, perhaps at a rate of 1%, the test will be wrong about 97 times out of a 100. For homicides, at around 1 in 10 000 per annum committed by patients with a psychosis, prediction is meaningless.

Rare events are inherently difficult to predict. Even a test with an impossible 0.9 accuracy for both true positives and true negatives will be wrong more than nine times out of ten at a base rate of 1%. Thus highly statistically significant ROC curves look very limited indeed in their practical application in a community context. How unfair is it then that mental health services in the UK seem to be expected to prevent what is, in practice, unpredictable?

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Australians with mental illness who smoke

This Australian comparison to the editorial by McCreadie & Kelly (2000) demonstrates that the financial costs for Australian smokers with a mental illness, as for British subjects, are substantial.

As part of a detailed qualitative study of a public mental health service in Adelaide, South Australia, encompassing qualitative interviews with 24 community clients and a participant observation of the community and in-patient settings in which they have contact, I found that these smokers experience significant financial and social disadvantage as a consequence of their smoking. Within their community homes and hostels, and in-patient environments, there exists a significant reinforcing smoking culture in which cigarettes provide a central currency for many aspects of people's lives. Smoking provides them with a source of control and autonomy in the face of overwhelming powerlessness, fear of illness relapse, and stigma. However, a vicious cycle of loss, debt and need serves to compound the predicaments of these smokers. Some basic data are presented in Table 1.

In Australia, the current average cost of one of the cheaper brands of cigarettes is $10.40 for a packet of 40 (from a survey of two supermarkets and two suburban convenience stores; recommended retail prices for the equivalent brands, as quoted by Phillip Morris and British American Tobacco Australia Ltd, were approximately $2 more). Of this, the amount returned to the government in excise is $7.79 (Australian Taxation Office, 2000). Therefore, a person with a mental illness who smokes 40 cigarettes per day gives to the government $54.53 per week in the form of tax, or $2835.56 per year. All participants in this study receive a government pension and most live alone in public rental accommodation. The current rate of the Disability Support Pension is $197.05 per week (Centrelink, 2000). Hence, such a person who smokes 40 cigarettes per day returns approximately 27.7% of their benefit to the Australian treasury.

Following the introduction of population-wide anti-smoking measures, there has been an overall reduction in the prevalence of smoking to about 25% of the Australian population. However, this is not the case for people with a mental illness. According to a National Mental Health Strategy survey (Jablensky *et al*, 1999), 73.3% of people with a psychotic illness smoke. With a prevalence of psychosis at 4.7 per 1000 population aged 18–64 years (Jablensky *et al*, 1999), there are probably at least 53 416 people with psychosis in Australia (Australian Bureau of Statistics, 2000*a*,*b*). If 73.3% smoke, and smoke on average 40 cigarettes per day, the contribution to the treasury is approximately $111 million per year. People with a mental illness are, through their smoking habit, contributing substantially to the cost of their own care.

For people with a mental illness the financial and personal consequences of their dependence on smoking impact on all aspects of their quality of life, and their ability to manage their mental illness. We are in danger of further polarising this population, already stigmatised by their mental illness, if the perpetuation of the poverty cycle in which they find themselves is not addressed.

Table 1 Characteristics of participants (n=24)

Variable	Mean	Median	Range
Age	43	42	25–63
Years smoked	27	24	4–50
Current cigarette consumption	40	35	20–75
Age at smoking onset	15	14	10–24
Quit attempts	Multiple	Multiple	0 to Multiple

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Lowered seizure threshold on olanzapine

Olanzapine has been licensed in the UK since 1996 for schizophrenia. Along with other atypical antipsychotics it is being used increasingly, with roughly equivalent

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