

Again this reviewer sincerely wished that these interesting data were ploughed through more thoroughly and their broader implications were presented.

The authors chose to exclude mortality studies and iatrogenic conditions such as adverse effects of medication. This is quite disappointing. If colleagues in medical specialties are to be impressed with the seriousness of physical co-morbidity in schizophrenia, it is by learning the high mortality rates. Likewise, leaving out iatrogenic illnesses from the otherwise exhaustive review misses another opportunity of informing practitioners and policy makers of the very conditions that are most preventable, since they are caused by us. It is this reviewer's impression that our medical colleagues are more eager to learn about co-morbidities that they can do something about, than risk factors that are beyond the practitioner's immediate control. For example, it is more useful to know of the risk of death from benzodiazepines prescribed to a schizophrenia patient with co-morbid sleep apnoea than it is to be aware of the rates of chlamydia, Gilbert syndrome, urinary incontinence, etc.

All in all, a quick and easy reference guide and a good starting point for trainees and readers interested in co-morbidity but one that does not fully address the challenges of co-morbidity nor exploit the potential for advancement of knowledge from its study.

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Multidimensional Outcomes in 'Real World' Mental Health Services. Follow-up Findings from the South Verona Outcome Project. Edited by A. Lasalvia and M. Ruggeri. *Acta Psychiatrica Scandinavica Supplementum* no. 437, volume 116. Blackwell. 2007.

Evaluations of mental health care usually only assess small groups of atypical patients, using a narrow range of outcomes, and report short-term follow-up findings. This remarkable collection of papers presents evidence that is far more important and also far more difficult to amass, namely data on the course and outcome for a large-scale case-series of routine patients from across a whole catchment area, who are followed up for 6 years with the regular use of standardized assessments scales. The results are intriguing.

While the wild fires of debate on hospital or community care continue to rage, Lasalvia, Ruggeri and their colleagues from the South Verona team simply

present here a vast treasure chest of high-quality information compressed into the six papers of this *Acta* supplement. They show that the transformation of their mental health service to a system that uses relatively few beds has taken place progressively over 30 years, and depends upon a having many layers of services available outside hospital, which over time have substituted for the need to provide many hospital beds. Their follow-up data over 6 years (still medium term in the context of long-term disorders) tend to reinforce the earlier findings of Ciompi and Harding that outcomes for people with psychotic disorders are better where there is a more complete ascertainment of cases and with longer term tracking. On the other hand, the results for people with depression are less reassuring showing hybrid pictures of an improving mental state but deterioration in physical symptoms.

The authors' assessment of routine needs assessment is also novel and produces striking findings, namely that what staff and what patients recognize as unmet needs are in different domains. They interpret these findings using the Camberwell Assessment of Needs to mean that both points of view are valid, although almost non-overlapping, and that a treatment plan should recognize both perspectives, for example through some form of negotiating process.

They continue this theme by examining in detail the satisfaction with services of the patients they treat. They have a distinct advantage, because the Verona Service Satisfaction Scale which they created is one of the few to have been shown to be sensitive to change. Again the results have important implications because their services were rated highly for coordination and for staff treatment and behaviour. However, patients were less impressed by the physical layout of facilities, the quality of information given to them, and the low level of involvement for relatives and family members. If a service wants to identify weaknesses and to improve the quality of care that it offers, then information like this is exactly what it needs.

Extending this theme, the authors examined the characteristics of patients who expressed their views by choosing to stop attending for treatment. A specific paper on this patient group reveals that the most common reason for discontinuing treatment was dissatisfaction with care, and that people who did this rarely subsequently sought help from other agencies. Therefore it seems that for people whose conditions are not so severe that they repeatedly have to make contact in times of crisis, then there is a substantial proportion who find the care offered, on balance, unacceptable and who rarely give services a second chance to help. The responsibility to help then usually

falls to family members alone, and a paper on 'caregiver burden' shows that, contrary to some previous studies, over 6 years this impact lessened for most relatives. Indeed the only predictor for such burden at follow-up was the level of caregiver burden at baseline. So the families who most need support can be identified from the earliest stages of treatment.

Routine outcome assessment is often talked about, but rarely put into regular practice. This thoughtful set of papers summarizes nearly a decade of painstaking effort in Verona, and shows that: a well organized

service can include regular assessments by ordinary staff using standardized scales; that these can be highly informative for individual care planning; and that the aggregated data can illuminate important questions about which aspects of care are effective and are valued by patients, or which fall short of their expectations. I look forward to seeing the 12- and 18-year outcome data!

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