per patient. This finding can be explained by analysing the patterns and intensity of contact with psychiatric services for patients belonging to this diagnostic category, particularly in-patient care and sheltered accommodation: 28·3% and 6·1% of them were respectively admitted to hospital and to sheltered accommodation, a proportion higher than the proportion of patients belonging to other diagnostic groups. These results are not surprising when considering the South-Verona system of care, where patients in need of hospitalization can be quickly identified and admitted, as a result of patients being cared for by the same team inside and outside hospital (Tansella *et al.* 1998). Such continuity of care is particularly advantageous for the most severely disabled and disturbed patients.

In a previous study on the outcome of mental health care in South-Verona we showed that higher psychopathology and poorer functioning at baseline predicted higher costs and, in turn, cost predicted poorer functioning at 6-month follow-up (Ruggeri *et al.* 1998). We argued that, if within a service resources are correctly assigned, the more severe the patient status at baseline the more resources should be prospectively allocated; during the follow-up, the more severe the patient status the more resources should have been spent. While longer follow-up is needed, the results of the above study showed that clinicians in South-Verona behave exactly in this way and direct most efforts at those who are most ill in a continuing self-adjusting process. The results of the present study confirm those findings and may be useful for managers and clinicians who want to apply the same criteria for allocating resources, taking into account the characteristics of patients seeking care from different services.

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