1995). Thus, a patient able to make and communicate a decision to refuse essential treatment on the basis of a delusional belief that the doctors were trying to harm him or her or that supernatural forces would cure them, would pass the capacity test. Few individuals with mental disorders fail such tests (Appelbaum & Grisso, 1995).

A necessity to appreciate the implications of accepting or rejecting a course of action could be added to the definition. However, this might be imprecise, and would still not include suicidal patients who refused life-saving interventions in the knowledge that they would die, or patients with mania who realised that treatment would remove their feelings of elation and power.

Rather than being a 'solution for our times', the proposals would actually discriminate against such patients, in denying them access to treatment because of their psychiatric symptoms and causing greater 'incapacity'.

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S. P. DAVIES, *Specialist Registrar in Psychiatry, Whitchurch Hospital, Cardiff*

Model of forensic psychiatric community care

Sir: We read the paper by Whittle & Scally with interest (*Psychiatric Bulletin*, December 1998, **22**, 748–750). Unlike many forensic services, South Thames West has had a community forensic service for over 10 years and only since 1991 has had its own medium secure beds. In 1995 a consultant was appointed to re-organise open forensic beds and to develop an outreach forensic service to meet demand in the furthest points of the region (West Sussex). The open forensic beds provide a seamless parallel service for community forensic patients requiring non-secure admission and for medium secure patients requiring a trial of non-secure hospital care.

The outreach service is integrated with local psychiatric teams in West Sussex who retain responsibility for patients requiring crisis intervention. Requests for secure beds go directly to the medium secure unit teams. One day a week, the outreach service provides assessment and specialist packages of forensic care at West Sussex clinics or wherever appropriate including in-patient wards, probation offices etc. Setting up security systems at the out-patient sites has been important and staff have to be vigilant. This encourages joint assessment, which best meets service users' complex needs. Our multidisciplinary team is more comprehensive than that described by Whittle & Scally – consisting of a social worker, psychologist, consultant, senior registrar, senior house officer and a community psychiatric nurse. Over five referrals monthly come from local psychiatric teams, the probation service, social services, magistrate's courts and prisons. A referral and management meeting occurs weekly. Referrals are appropriate but all bodies are becoming more assertive in seeking forensic advice.

We have encountered similar issues as Whittle & Scally in working with secondary services. We remain concerned that dangerous patients are construed unconsciously by referrers as automatically transferred to forensic supervision rather than for assessment leaving potentially hazardous gaps in the care plan.

Informal feedback from the outreach is positive. The two models of service provided by this team may offer food for thought to services providing secure units only.

CATHERINE KINANE, *Senior Registrar and* ANNIE BARTLETT *Senior Lecturer and Consultant in Forensic Psychiatry, St George's Hospital Medical School, Cranmer Terrace, Tooting, London SW17 0RE*

Parent satisfaction with receiving information in an attention–deficit hyperactivity disorder (ADHD) clinic

Sir: We would like to report a survey which we did on 97 consecutive couples who had a child on the waiting list for an attention–deficit hyperactivity disorder (ADHD) clinic. These couples were consecutively and randomly assigned to receive information about the clinic and ADHD.

After the first interview, the patients were given a service user satisfaction questionnaire (Attkisson & Greenfield, 1994) which is well standardised and validated and two questions about receiving information about ADHD and the clinic were added. There was good internal consistency among the items on the questionnaire and the two added questions.

Of the 49 couples randomly assigned to group meetings (five groups were held at monthly intervals with 10 couples invited to each) 29 attended and 24 completed the questionnaires.

Of the 48 couples sent a mail out, five said they had not received it and four said they had not read it. Twenty-four completed the consumer satisfaction questionnaire.

In comparing the patient questionnaires there was no difference in patient satisfaction using ANOVA between those who had received the