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'.

APPELBAUM, P. S. & GRISSO, T. (1995) The Macarthur Treatment Competence Study 1: Mental illness and competence to consent to treatment. *Law and Human Behavior*, **19**, 127–148.

LAW COMMISSION (1995) *Mental Incapacity (Law Commission Report 231)*. London: HMSO.

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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.

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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

handout by mail and those who attended group meetings, nor was there any difference specifically in the last two questions about obtaining information about ADHD and the clinic. These two questions from patients who had been to the group sessions compared with those who received a handout by post were compared by *t*-tests.

Despite several limitations to this survey, which include 40% not returning their questionnaires, it is noteworthy that those who did return the questionnaires were equally satisfied whether they had attended the group sessions or received the handout by post. If this study is replicated by others it has an implication that could save clinics money and time – that written material mailed out is as effective as having clinic personnel present this information.

ATTKISSON, C. C. & GREENFIELD, T. K. (1994) Client satisfaction Questionnaire-8 and Service Satisfaction Scale-30. In *The Use of Psychological Testing for Treatment Planning and Outcome Assessment* (ed. M. Marvish), pp. 402–420. Hillsdale, NJ: Lawrence Erlbaum Associates.

STUART FINE, *Professor, Department of Psychiatry, University of British Columbia and Director of ADHD Assessment Clinic;* LORELEI FAULKNER, *Nurse Clinician and* PAULINE MULLANEY, *Social Worker, ADHD Assessment Clinic, British Columbia's Children's Hospital, Vancouver, British Columbia V6H 3V4*

Lithium monitoring

Sir: Kotak *et al* (*Psychiatric Bulletin*, February 1999, **23**, 83–86) surveyed lithium monitoring by general practitioners, noted the variability in their knowledge and concluded that monitoring based in their surgeries is potentially hazardous. Similar conclusions were reached by Ryman (1997) and by King & Birch (1998).

The authors suggest that the situation might be remedied by psychiatrists providing greater support and advice to general practitioners, for example, by sending postal reminders of when the next test is due. The problem with shared care arrangements, however, is that errors of communication arise and there can be confusion of responsibility over who does what (King & Birch, 1998).

The new NHS, we are constantly reminded, will be primary care led. Nevertheless I believe there are still areas which are safer when psychiatrists are in charge rather than being relegated to advisers and lithium therapy is one of them. Few arrangements can rival the specialist lithium clinic (or affective disorder clinic) where patients can be given expert advice at first hand and be advised on their results directly.

KING, J. R. & BIRCH, N. J. (1998) Delayed response to abnormal lithium results is no longer necessary. *Psychiatric Bulletin*, **22**, 471–473.

RYMAN, A. (1997) Lithium monitoring in hospital and general practice. *Psychiatric Bulletin*, **21**, 570–572.

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Does a stitch in time no longer save nine?

Sir: The College is running an admirable campaign against the stigma of mental disorder but surely it is essential for the information it gives to the public to be accurate? The College's (1998) document *Mental Disorders: Challenging Prejudice*, says that psychiatrists are licensed to recommend compulsory detention ('sectioning') in a mental health unit when someone is judged a serious danger to themselves or others. How serious is serious? The Act just says the safety of the patient or the protection of other persons. However, even more important is the omission of any mention of admission for the health of the patient, a point that was literally underlined by Virginia Bottomley and John Redwood in their introduction to the 1993 edition of the *Code of Practice*. What has happened? Has the College been careless? Surely it cannot be ignorant of these matters? Or is the College trying to soften the image of psychiatry by denying it has this important responsibility? Deterioration in insightless individuals with psychosis is a tragedy and its prevention by early treatment must surely remain one of our most important duties. It is also one that rational and informed members of the public expect us to fulfil.

Could the College do something to retrieve the situation?

ROYAL COLLEGE OF PSYCHIATRISTS (1998) *Mental Disorders: Challenging Prejudice*. London: Royal College of Psychiatrists.

DAVID TIDMARSH, *Formerly Consultant Psychiatrist, Broadmoor Hospital, Crowthorne, Berkshire RG11 7EG*

Mental disorders: challenging prejudice

Sir: Overall, the Management Committee is delighted with the favourable reception to its Campaign booklets. They are not perfect; neither are they cast in tablets of stone. In our efforts to startle and thereby command attention we have, in particular, invoked the concern of some carers and professionals by our phraseology relating to the above matter. It may be a semantic point, as