effectiveness in mania (Ferrier, 1998). After talking to an advocate at a day centre who told her that it was an 'experimental' treatment, the patient became anxious and asked to discontinue treatment. Her mania subsequently worsened.

While junior doctors sometimes see patients with a nurse or other doctor on the ward, and are thus fairly open in their interactions, advocates usually see patients alone either on or off the ward (sometimes in day centres). There is thus a feeling that advocates are giving advice in private which others may not be aware of.

The title of Thomas & Bracken's article was "Putting ethics into practice". I am concerned that the ethics of some advocacy movements are not those of doctors but that they may be using their access to vulnerable people (psychiatric patients), to promote their own anti-medical establishment political agenda. It would be mistaken to 'dismiss' them as being 'anti-psychiatry' as Thomas & Bracken state. To dismiss them would be to ignore their destructive ideology-driven power. Local advocates have told ward patients that nurses are unable to fight back if attacked, a tacit encouragement of violence against staff.

My experience of advocacy has suggested that while the concept is a good one, in practice there are problems.

Reference

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Guidelines for the police and psychiatric services

Sir: Your special article 'Police training for the management of dangerous patients' (*Psychiatric Bulletin* January 1999, **23**, 46–48) drew attention to an important aspect of the relationship between the police and psychiatric services.

Another area of police practice impinging on psychiatry needs to be highlighted, as it is a cause for concern. This is the widespread practice of the police bringing people from the community to be 'assessed' at psychiatric hospitals, without placing them on Section 136 of the Mental Health Act 1983.

The usual scenario is that the police attempt to arrest an individual, but on becoming aware of a psychiatric history, decide to divert the person to hospital.

This practice is worrying for a number of reasons: it results in a large number of patients being escorted/detained by the police outside of the protection of Section 136 of the Act. It may encourage people to escape justice by hiding behind a psychiatric label. Also the person may be coerced unwillingly to go to hospital, which subsequently may leave trusts open to litigation by patients claiming they were taken to hospital and detained on wards illegally.

It appears imperative that this practice is monitored on a local basis, and guidelines drawn up between the police and psychiatric services regarding best practice in this grey area.

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Healthy debate about the fragmentation of services

Sir: I am pleased to see that my article (*Psychiatric Bulletin*, January 1999, **23**, 31–33) has generated questions and debate from medical colleagues, National Health Service Management and the media. They all had specific and valid questions and concerns on the feasibility and difficulties of single gender wards.

The most frequent question was about problems which may arise in all male wards once single gender wards are established universally in a district. Most colleagues fear that single gender male wards may become extremely difficult to deal with and may turn into unofficial intensive care units.

The concern around fragmentation of services and difficulties in coordination has been brought forward by a senior practitioner with a special interest in services. I have to admit that the coordination of continuity of care in our specialist service has taken an enormous effort. It has been through personal endeavour, universal good will and collaboration that the difficulties in working with four sectors and six adult general psychiatry consultants have been, only partly, overcome. Being served by several different community teams, organising Care Programme Approach meetings, keyworking systems, outpatient follow-up by each one of them has been a daunting task. We still are in the process of reorganising the follow-up system.

Questions around length of stay in hospital have come from different sources including Department of Health officials. The problems of aggregating difficult to treat female patients with complex needs has not been overcome in our

service. Length of stay of women in our service compare unfavourably to women in mixed wards. But perhaps the task of a specialist service should be to respond to complex needs.

The most important debate has been whether a district should have a specialist psychiatric service for women or whether districts should offer generic single gender services for males and females separately. It is rewarding to see that the Department of Health has a strong interest in the subject and has supported the establishment of single gender wards. However, it is difficult to predict which practice will yield better results in the form of patient/carer satisfaction, decreased violence, decreased length of stay in hospital, re-hospitalisation rates and eventually more successful community care.

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Usefulness of HoNOS

Sir: Since 1997 we have been using Health of the Nation Outcome Scales (HoNOS) for those in long-term supported accommodation and community care. There are limitations, but in a pragmatic sense we are finding them very useful and increasingly so with experience. In some cases we also use the self-report Avon Scale. We would like to see more use locally of HoNOS (and perhaps the Avon Scale) in the acute sector teams and the in-patient settings, also the depot clinics and so on. Such use, we find, fosters good practice and improves communication about patients between professionals.

HoNOS often indicates clear improvement on the introduction of new interventions (such as the use of clozapine) and we have also found purchasers of health care taking an interest. The rumour is that they will insist on the use of HoNOS as a condition of funding in future.

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