of appeal. On Section 2 an appeal will be heard within a month whereas on Section 3 an appeal is not heard in practice until the fifth or sixth month. Thus in some cases a 6 month order may be preferred because it allows the psychiatrist more time to treat the patient before his/her actions are called into question, particularly where a patient has previously appealed successfully against an order.

I also note that our overall section rate as a percentage of all admissions has been consistently lower than that of Southampton and Barrow. (See Table II). It is speculated that this might be a reflection of the predominantly rural nature of Coney Hill's catchment area. It is known that urban areas collect greater numbers of mentally ill patients; perhaps it could be argued that urban regions therefore have more disturbed or dangerous mentally ill patients that require compulsory admissions than rural regions. Clearly more research is needed to answer this question.

Our more frequent use of emergency sections than either Southampton or Barrow may be attributable to rural areas in Coney Hill's catchment area that are relatively inaccessible to the approved doctor at night. Their use has been greatly discouraged with the new act but in the light of Barrow's figures, additional measures to reduce emergency sections might be sought at Coney Hill Hospital.

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Neglect of the long-term severely mentally ill

DEAR SIRS

Dingwall's survey of some Scottish mental hospitals seemed to indicate a lack of direction in rehabilitation services (*Bulletin*, May 1987, **11**, 158–160). There are many possible factors which may be contributing to this, but an interesting hypothesis concerning the role of staff attitudes has been put forward by Lamb.[1] He commented on the general tendency to neglect the long-term severely mentally ill and attributes this in part to the following:

(a) a basic moral disapproval of dependency and passivity within society which mental health professionals share

(b) professionals' own needs remaining unfulfilled by the care of these patients as degrees of improvement are small

(c) an initial overenthusiasm for rehabilitation with correspondingly unrealistic expectations leading to disillusionment.

Perhaps further examination of staff attitudes towards the most disabled group of patients might contribute towards the improvement of rehabilitation techniques and help the sub-specialty find its direction.

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Rehabilitation teams

DEAR SIRS

I was particularly interested in Dr Dingwalls's article 'Psychiatric Rehabilitation—a lack of direction' (*Bulletin*, May, 1987, **11**, 158–160). In it, he referred to the formation of a Scottish multi-disciplinary body of rehabilitation workers.

In Northern Ireland, we formed such a group two years ago (CHART: acronym for Community/Hospital Association of Rehabilitation Teams). Its main strength has been its multi-disciplinary membership and its provision of an arena for sharing of problem solving and academic interests. Above all, we have utilised the group to exert pressure and express protest in a formal manner with more efficacy achieved than with the individual/unit approach.

Although we could not claim, as our name suggests, to have found a direction, we may have glimpsed a few signposts!

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Community psychiatry

DEAR SIRS

Reading the recommendations for training in community psychiatry (*Bulletin*, June 1987, **11**, 213), I was struck by the statement that the recommendations do not for the most part represent new departures. New departures are precisely what is needed if we are to have a good service a few decades from now.

I believe we now have a large and growing population of people with severe psychiatric handicap who are in minimal or no contact with psychiatric services. How can we remedy this by sticking to what we are doing?

One deficiency that is evident to me is lack of insistence upon experience of long-term follow up. This is undermined by six-monthly rotation, although it need not preclude long-term involvement.

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