However, the College Membership will not help our academic furtherance on returning to India. Keen as I am to avoid the pitfall of "generalisation", I must state that it is unlikely to be the same for doctors from other countries such as Nigeria and Pakistan.

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Normalisation and psychiatry

DEAR SIRS

We write to inform you of a recently completed study which compared two of our traditional rehabilitation wards at Claybury Hospital with a project based on normalisation principles. This project was located on the edge of the hospital campus and comprised three former staff houses, each with three patients, with a fourth adjoining house serving as a staff base.

We evaluated our rehabilitation wards and the normalisation project on a wide range of measures covering behavioural functioning, staff attitudes, patient satisfaction, ward management practices, quality of life as well as a measure of the extent to which all three facilities performed against normalisation criteria on the PASS-3 assessment. No significant differences were found in the level of behavioural functioning of the three groups. Patients in the normalisation project obtained significantly higher quality of life scores on the Life Experiences Checklist. They also had higher satisfaction scores. Staff in the normalisation project visited the community with their patients much more frequently than those on the rehabilitation wards. They also reported greater role clarity, and had a more psychological approach to patient care as noted by their Attitudes Towards Treatment Questionnaire scores.

These positive findings suggest that the model of residential care that this project is based on may be suitable for patients needing rehabilitation training. As residents all live in ordinary houses, independent living skills are taught in a naturalistic domestic setting. There is no need to establish complicated kitchen rotas as on rehabilitation wards. The model we have developed combines some of the best principles derived from a normalisation philosophy, such as the idea of providing ordinary housing, with positive supportive psychiatric nursing care. Medical back-up was only one hour per week of a registrar's time, with occasional consultant support. This is dramatically lower than medical input to the rehabilitation wards. We now feel that this model may merit a comparison against a hospital hostel unit.

Interested readers are welcome to write to the senior author for a more extended report of this work.

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The first RSUs

DEAR SIRS

A correction to 'Referrals to an out-patient forensic psychiatry service' by J. A. Hambridge (*Psychiatric Bulletin*, April 1992, **16**, 222–223), where it is stated "Although it (the NWRHA) has had a forensic service for a considerable time, it is only in the last *three* years that an RSU has been established and functioning".

In fact, Elton Ward at Prestwich Hospital, Manchester opened on 20 September 1976 (*15* years ago), the second interim RSU in the country – the first opened in August 1976 at Rainhill Hospital, St Helens. The permanent RSU at Prestwich, the Edenfield Centre, was opened by Robert Kilroy Silk (then MP and Chairman of the Parliamentary Penal Affairs Committee) on 5 July 1986, almost *six* years ago. Incidentally we had a clinical psychologist in post (Amanda Reid) from the first day of the IRSU in 1976.

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Teaching of aggression management

DEAR SIRS

We read with interest the article by Drs Kidd & Stark on violence and junior doctors working in psychiatry (*Psychiatric Bulletin*, March 1992, **16**, 144–145). We recently conducted a questionnaire survey of nurses at an accident and emergency conference to ascertain current observations and procedures on violence within the accident and emergency departments around the country.