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.

Fifty-eight questionnaires were returned (58/100): 17.2% nurses had never experience physical violence; 44.8% had rarely experienced physical violence; 32.7% had sometimes and 5.1% had often experienced physical violence. No-one said they had never and only 1.7% rarely experienced verbal violence; 55.1% had sometimes and 43.1% often experienced verbal violence. Of injuries, 1.7% had received many; 31% some and 67.2% none. Of these, only 6.9% required treatments and none needed time off work.

The verbal violence most frequently encountered was obscenities, 45.4%; non-specific threats, 35%; threats to the person, 24.8% and sexual harassment, 9.4%. The majority of verbal abuse came from relatives then medical and then psychiatric patients. The opportunity to discuss incidents was had by 56% but only 9% had a support group; 39.2% had received training in physical violence and 30% in verbal violence. In most cases this was a day course or a lecture.

Our results concur with other studies that physical violence is rare in hospitals but verbal assault is extremely common and seems to be a relatively neglected area in training.

Staffing levels and stress in the department may effect violence. An association has been shown between violence and agency staff levels in psychiatric hospitals (Fineberg *et al*, 1988). We support Drs Kidd & Stark in calling for more formal teaching in aggression management. Provision of support for victims of physical and verbal violence appears lacking. A standardised method of recording verbal violence needs to be developed (Palmistierna & Wistedt, 1987). These issues need urgent consideration to improve safety at work and enhance training and hopefully morale of all health workers.

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Ancestral spirits

DEAR SIRS

I enjoyed Jack Piachaud's article 'A Week in Zimbabwe' (*Psychiatric Bulletin*, March 1992, **16**, 164–166), written in his refreshingly direct style. In it he refers to ancestral spirits which guide the practice of medicine, often through a living "medium".

Is it not so that we too are guided, in the developed world, by the spirits of our ancestors? Two of them appeared on the back cover of the yellow journal, in the form of bronze busts of Stengel and Maudsley. In psychoanalysis particularly, one gets the feeling that the closer an eminent analyst has been to the inner circle of Freud's disciples, the more he functions as a "medium" for Freud's ancestral spirit.

The language may be different, but as Dr Piachaud brought out, the human experience is much the same.

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'The madness of George III'

DEAR SIRS

In his review of Alan Bennett's 'The Madness of George III' (*Psychiatric Bulletin*, April 1992, **16**, 249–250) Hugh Freeman rightly points to the conceptual muddle in the play's conclusion which is exemplified by "Ida Macalpine" who declares that the king was "not mad but suffering from porphyria". However, he wrongly traces this to non-medical historians. I am afraid that the real villains of the piece were the distinguished medical historians Macalpine and Hunter who also incorrectly overemphasised the diagnosis of porphyria which has never been proven. It might amuse your readers to read my review of their book from the *British Journal of Psychiatry* (Levy, 1970) which, *inter alia*, puts the case against the diagnosis of porphyria.

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Screening of the over-75s

DEAR SIRS

Further to Dr MacKenzie's article (*Psychiatric Bulletin*, March 1992, **16**, 146–147), I write to describe related work in Manchester. The continuing development of the Department of Old Age Psychiatry in South Manchester includes the introduction of a liaison service to interested general practitioners. As part of this process I am engaged in a project to assess the feasibility of helping GPs to screen their patients, aged 75 and over, for dementia and depression in a reliable and valid way.

At the planning stage of this work 55 local GPs were sent a questionnaire about screening for