However, routine blood thyroxine estimates on this admission revealed a total thyroxine of greater than 270 (reference range 58–107), and a diagnosis of thyrotoxicosis was made. He was treated initially with propranolol, but later required iodine[131] therapy and neomercazole to achieve euthyroid status. Lithium was discontinued on discovering his thyroid level, but haloperidol was required to control his hypomanic symptoms, and he was later recommenced on lithium following consultation with his physicians. He has since required thyroxine replacement to maintain normal levels, and at an eight year follow-up he has had minor mood swings only which have not required hospital admission.

The relationship between lithium therapy and concomitant thyrotoxicosis remains unclear. Männistö (1980) reviewed 9 of the 11 cases reported so far, and concluded, while lithium may have been a causative agent, there were usually contributing factors (previous thyrotoxicosis, goitre or thyroiditis). He noted that in at least one of the cases reported a reduction of lithium or termination of lithium therapy had unveiled a hidden thyrotoxicosis. The development of thyrotoxicosis during lithium therapy is an unexpected event and may easily be overlooked, especially as the symptoms of this disorder, for example, over-activity and insomnia, resemble those of hypomania. These diagnostic difficulties may be further compounded by co-existing mental handicap.

This case reminds us of the need to remain alert to the possibility of thyrotoxicosis as a rare complication of lithium therapy.

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Overseas doctors

DEAR SIRS

Although Drs Matthew, O'Dwyer and Zafar have made some pertinent points with regards to the Royal College examination for overseas doctors (*Psychiatric Bulletin*, 1991, **15**, 699–700; 1992, **16**, 231–232), they have overlooked the fundamental fact that "overseas doctors" are *not* a homogenous group (*Psychiatric Bulletin*, 1992, **16**, 232). Two of the most important issues at play here are the stage in the overseas doctor's postgraduate career at home before entering British training, and the status of Membership in the home country. As an Indian psychiatrist on the Overseas Doctors Training Scheme (ODTS) I would like to address both these issues, especially as my country is one of the largest contributors of overseas doctors to the NHS.

With the cessation of double sponsorship, successfully applying for the ODTS or passing PLAB are the only viable and practical options commonly available for Indian doctors to work in the UK. Very few Indian postgraduates in psychiatry will be motivated enough to prepare for PLAB, and hence, the ODTS is much the preferred alternative. One of the eligibility criteria for ODTS is a minimum of two years of experience in the home country. However, few candidates will seriously consider breaking off training in India after two years, because most of our academic institutions require continuity in training to be able to take up an Indian psychiatric degree. Therefore, almost all Indian trainees on the ODTS have an Indian DPM and/or MD in psychiatry. This is of paramount importance as the College Membership is *not* recognised in India and doctors returning with British degrees, but having no postgraduate home country qualifications, face enormous difficulties (Patel & Araya, 1992).

To be eligible for "long leave", one has to have been in service for a substantial period, and hence, attained considerable seniority. Not only would few such individuals want to start as senior house officers in the UK, the Overseas Liaison Committee is also likely to hesitate before accepting such senior candidates as trainees in view of the personal dissatisfactions inherent to such situations. Barring the odd instance, the rest of us are supposed to have secure positions on returning home. From a practical point of view, these are unlikely to materialise, whether we have the Membership or not, because most of us have not preserved a continuity in service which is essential for academic medical progress in India. Moreover, our British experience will not be accredited.

The question which begs an answer then is why we come here at all? Apart from varying personal and material reasons, the primary purpose would be to gain specialty and research experience (Gandhi *et al*, 1992), and, as Drs Mann and Caldicott have rightly concluded, not necessarily to acquire the College Membership. The ODTS is, therefore, an excellent scheme for everybody, because while guaranteeing us specialty experience, it also serves the philosophy of *Achieving a Balance*.

And yet, the majority of us will be very disappointed if we return without the Membership. To enumerate a few of the reasons: ego satisfaction; easier absorption into academic medical systems of other countries and international organisations; doubling of consultation fees in Indian private practice; our piquant cultural expectations of acquiring "foreign degrees".

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.