caution and sensitivity, I suggest that the following criteria (in addition to the usual ones) should be used:

(a) Research into black people must address the realities of life for *them* in this country and not make assumptions based on the experiences of white people only.
(b) Research that uses white Eurocentric concepts, such as our present concept of schizophrenia, must allow for the fact that their validity as useful cross-cultural concepts is usually unproven – as is the case with schizophrenia.
(c) The presentation of research must be sensitive to the consequences of racism in society, such as inequalities in (psychiatric) service provision and the relatively excessive numbers of black people being compulsorily detained, and must deal with the likelihood of research findings being used for reinforcing them.
(d) The involvement of psychiatry in social control systems in a context where black people are over-represented in prisons (Home Office Statistical Bulletin, 1986), secure (psychiatric) facilities (McGovern & Cope, 1987) and remand homes (Kettle, 1982) must be addressed, both in research methodology and in the presentation of findings, as an important factor that affects psychiatry's perceptions of black people and *vice versa*.

The adoption of these or similar criteria by (say) the *British Journal of Psychiatry* would, I feel, set a standard for other journals to follow.

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DEAR SIRS

Dr Fernando's comments so misrepresent the balance of the discussion in our paper that it is difficult to know how to proceed with a sensible debate on these important issues.

Perhaps people should be allowed to make up their own minds. Following the additional 'criteria' laid down for editors in this letter, I hope that in future there will be sufficient published data to assist them in doing so.

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Transcultural psychiatry

DEAR SIRS

Dr Cook has made an interesting observation on Dr Littlewood's style of 'transcultural' research. (*Psychiatric Bulletin*, March 1989, **13**, 148). Commenting on his paper on 'cannabis psychosis' (*Psychiatric Bulletin*, November 1988, **12**, 486–488), Dr Cook pertinently questions Dr Littlewood's meaning of 'community initiated research' among ethnic minorities, collaboration, credit and responsibility. It is noteworthy that another paper, 'An indigenous conceptualisation of depression in Trinidad' (1985), later presented to a College meeting as 'An indigenous conceptualistion of depression in the West Indies!' (*Abstracts of the Proceedings of Meetings of the Royal College of Psychiatrists 1988*), has aroused similar feelings among psychiatrists and other mental health workers in Trinidad and the West Indies. In addition, Dr Littlewood's study in Trinidad between 1979–1981 raises the issue of ethics in transcultural research. He mentions no collaborators in his paper, neither is credit or discredit given to anyone. His paper is historically and socio-culturally inaccurate. He has misinterpreted his findings, stating misconceptions as facts. He has extrapolated an unsubstantiated finding from an isolated fishing village on the north coast of Trinidad to the entire country, and then to the West Indies with projections to immigrant groups abroad. With whom does responsibility lie? Is it to natives of the region who are furious about his irresponsible misinterpretations of facts? Is it to local psychiatrists who do not seem to have the same valency as those in Britain, despite being British trained? Or should it be the collaborators in this study that we have located? It is now common knowledge in Trinidad that Dr Littlewood spent 14 of his 16 months here with a cult group on the north coast of Trinidad whose leader, now dead, and many members of the group suffered from schizophrenia.

It is unfair, to our society and to psychiatry that such studies find themselves in the archives, with the authors becoming 'experts'. Studies in transcultural

psychiatry often reflect a relationship between colonisers and colonised. It is especially alarming when findings may be utilised in the psychiatric care of large immigrant population in Britain and other countries. We sincerely hope that future excursions into transcultural psychiatry will be undertaken with approved and ethical collaborations and with the recognition that to observe a cultural mechanism and interpret it are two entirely different things. It is clear that a multitude of images and observations must take place and they must be seen through the eyes of both the observers and participants, as the former can only reveal a partial knowledge of the subject at hand. If the purpose of transcultural psychiatry is to impress upon Europeans the differences between themselves and the rest of the world, then certainly Dr Littlewood will agree, there is no difference between transcultural psychiatry and comparative zoology.

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—— (1988) An indigenous conceptualization of depression in the West Indies. *Abstract of Proceedings of Meetings of the Royal College of Psychiatrists 1988*.

DEAR SIRS

The letter from Dr Maharajh and his medical colleagues contains so many errors of fact and interpretation that I doubt your columns could bear a detailed riposte.

Suffice to note that these psychiatrists label a local Afro-Caribbean religion as 'schizophrenia'. Whose (post) colonialism? Whose schizophrenia?

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Administration of rectal diazepam

DEAR SIRS

I write to let Dr Kearns know that I encounter a similar problem with the administration of rectal diazepam (*Psychiatric Bulletin*, June 1989, **13**, 314). Recently one ATC (Adult Training Centre) Manager wanted an instructor to be taught how to administer rectal diazepam to a client who was going on holiday with the instructor. The family doctor contacted earlier had asked the manager to put his request across to me as the client in question occasionally comes into hospital for respite care and drug monitoring. When I sought the opinion of the Director of Nursing Services, he reminded me that the UKCC code forbids his nurses to pass on this skill to any person who is not a nurse or a trainee nurse.

It was suggested that a community nurse should fulfil this role. In districts where community nurses are thin on the ground and have never made any input into the training centres, it seems unrealistic to rely on them to respond to emergency calls at the training centres. I entirely agree with the suggestion that a clinically trained member of staff be jointly appointed to the training centres.

I did, in consequence, put in a bid for District Joint Finance for the employment of a liaison nurse between the Health Service and the ATC. The following problems that such an appointment would solve were highlighted:

(a) Afternoon tablets for our clients attending the ATC are handed over to the ATC once every three weeks, except where there has been a change of medication. Senior managers in Social Services ask for week's supply at a time, possibly to limit losses due to break-ins at the centres on week-ends. The pharmacy issues these tablets in individual bottles for three weeks, and nurses are not allowed to decant the tablets or remove a week's supply from the three week stock. I feel that such a liaison nurse between the pharmacy and the ATC would make co-ordination much easier.

(b) Following the nurse grading exercise, our nursing auxiliaries refuse to transport tablets to the training centres, even though they accompany clients to these centres. Currently a staff nurse on the ward has to take these tablets to the training centres. Given that trained nurses are very scarce, it seems an unnecessary way of deploying ward staff. A liaison nurse would correct this anomaly.

(c) Slow recovery after a severe fit and status epilepticus are sometimes grounds for sending epileptic patients back home from the training centres. I think that a liaison nurse could give continued guidance on the management of severe epileptics and so reduce the frequency of these impromptu returns to residential units.

(d) Management of the doubly incontinent client poses a problem to instructors at the training centres. A liaison nurse could pass on skills of their management to these instructors.

(e) When our joint funded special needs unit was opened in 1984 at the training centre, I identified a group of clients in the Health Service