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.

HARI D. MAHARAJH
THERESA ANN CLARKE
GERARD HUTCHINSON

*St Ann's Hospital*
*Port of Spain*
*Trinidad*

*References*

LITTLEWOOD, R. (1985) An indigenous conceptualization of reactive depression in Trinidad. *Psychological Medicine*, **15**, 275–281.

—— (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?

ROLAND LITTLEWOOD

*University College &*
*Middlesex School of Medicine*
*London W1N 8AA*

## *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