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doi: 10.1192/bjp.200.1.81a

Author's reply: Thank you to Drs Scott-Orr and Mela for their interest. It seems to me that there are two issues here. First, should the law be discriminatory between patients with a physical illness and those with a mental illness? I think not and I'm pleased to say the United Nations Convention on the Rights of Persons with Disabilities (2006), to which the UK is a signatory, supports this view. The convention obligates States to (among many other things) 'take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities'. To explain this further, the UN High Commissioner for Human Rights said,[1]

'Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished . . . This should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.'

Second, should the law (for everyone) favour patient autonomy, medically determined best interest or a mixture?

In other words, either everyone, with the capacity to make the decision, should be permitted to 'die (or rot) with their rights on' or nobody should. Or the authority to overrule capacitous refusal could be based on a neutral factor such as risk to other people. It should not be dependent on the stigma associated with certain terminology (a mental illness diagnosis).

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doi: 10.1192/bjp.200.1.82

Family psychoeducation for major depression: randomised controlled trial

The paper by Shimazu *et al*[1] adds robustness to already existing evidence for the role of family psychoeducation in psychiatric disorders. The study has sound methodology (i.e. randomised controlled trial) with adequate masking, in addition to being the first ever study to examine the effect of family psychoeducation for major depressive disorder. The authors describe the possible limitations of the study honestly. A source of funding (Grant-in-Aid for Scientific Research, Ministry of Health, Labour and Welfare, 2004) is also mentioned. However, there are some issues which should be further looked into. The aim was to examine family psychoeducation in the maintenance treatment of depression.

However, the patients included were either on continuation or maintenance treatment. Patients who are in partial remission cannot be considered as being in a continuation/maintenance phase.[2] Also it was not mentioned how many patients had single or recurrent episodes (patients with single episodes need not receive maintenance phase treatment). Any other psychiatric comorbidity (substance misuse or personality disorder) in the participants was not mentioned, even though it has treatment implications. The health status and intellectual functioning of the primary family member included in the study was not mentioned, although these might compromise their active participation in psychoeducation sessions. The authors are silent on the ethical clearance of the study. For four caregivers psychoeducation sessions were done in the individual's home and not in group sessions, which were not included in the final analysis and not part of the methodology mentioned – this could also have had an effect on the efficacy of the study. Remission was defined by the authors as a Hamilton Rating Scale for Depression (HRSD) score <6, but the normal score is mentioned as <7.[3] The authors have not mentioned the reason for keeping a low score of HRSD in the study. Last, it could be a printing mistake, in the last line of Table 1 it is mentioned that high expressed emotion (as per FMSS) was seen in seven patients in the intervention group and none in the control group, but the results mention that it is seen in six patients in the intervention group and ten in the control group.

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doi: 10.1192/bjp.200.1.82a

Author's reply: We thank Patra & Subodh for their interest in and their very thorough reading of our study.[1] Most of their questions are factual ones and we are grateful that we have been given an opportunity to clarify them. First, whether to call further treatment of patients in partial or full remission after the fully syndromatic episode, as in our study, continuation/maintenance treatment is a terminological issue and not a medically substantive one. And we think our usage of the terms is in consonance with the majority of psychiatrists of the world, as for example done by Paykel *et al* in their famous study of cognitive therapy to prevent relapse after acute episode of major depression.[2]

https://doi.org/10.1192/bjp.200.1.82a Published online by Cambridge University Press