iour is of any benefit to the patients. It is widely acknowledged that up to half of all cases of depression are not diagnosed in primary care, but depression in primary care is known in general to be mild[1] and, as a result, the significance of undiagnosed depression as a public health problem has been questioned by Coyne.[2] He contends that most cases of missed depression in primary care are so mild that they result in little disturbance of social functioning, and can be categorized with those types of depression that have not been demonstrated to respond to treatment. Moreover, he suggests that these cases would no longer qualify as major depression under the DSM IV criteria, which incorporate impairment criteria into the diagnosis. The use of the Hospital Anxiety and Depression (HAD) threshold score of eight, while having satisfactory sensitivity, is regarded by the originators as a borderline score and is bound to capture patients with the mildest degrees of depression.

While there is some evidence that improving detection rates among general practitioners has a beneficial effect on outcome of depression, other studies have failed to replicate this. In his study, Dowrick suggested that one of the explanations for the negative outcome was a failure to initiate adequate treatment despite a knowledge of recommended dosage schedules.[3] Donoghue reports that up to 88% of depressed patients treated in primary care with tricyclic antidepressants may be underdosed.[4] Patients who are readily recognized by GPs as suffering from depression are likely to have a greater severity of illness, and are therefore more likely to benefit from appropriate treatment. It is probably more important to direct educational campaigns to ensure confident diagnosis of moderate to severe depression and to improve effective dose and duration of treatment.

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Continuing medical education (CME) in mental illness: a paradox for GPs

Sir,

From the perspective of a CME tutor and GP academic, Singleton's and Tylee's revealing article (June *Journal*) was both thought-provoking and disturbing. I would support their conclusion that encouraging learner-centred education in primary care presented various paradoxes: central to this debate is the truism that encouraging learners to define their own learning needs means that they will *only* take up a planned educational package if it is perceived as meeting their requirements. This is a potential source of frustration to those who may feel they have an important message to deliver, be they local cardiologists, AIDs awareness facilitators, or Health Commission managers.

The issue of 'access' in the data given does not address the position of CME tutors who themselves are committed to an andragogic approach, but it may be for this reason that providers of education (in this case, the RCGP Mental Health Fellows) cannot expect CME tutors to be able to guarantee delivery of any programme to their autonomous peers. In addition, I perceive the following factors to be relevant:

- Apparent 'non-cooperation' by CME tutors may have been a consequence of the barriers to implementing innovative educational programmes at a local level: the authors do not present data on this
- There is as yet no coherent approach to CME on a national basis, and CME tutors may vary in their preference for pedagogic or andragogic approaches
- Creating a new network with a declared educational brief, such as the Regional Fellows, is inevitably going to be seen as 'outside' the CME tutor system
- The market research among CME tutors prior to setting up this initiative, which might have allowed more ownership and less 'resistance', seems to have been lacking
- CME tutors may form judgements about educational initiatives based more on origin than content
- Some difficulty may have arisen from local 'competent and enthusiastic teachers' feeling excluded from the Mental Health initiative because their experience was not drawn on or recognized in providing for the programme
- Barriers to taking responsibility for one's own learning go very deep, and personal facilitation may need to precede the uptake of educational packages which require a GP to engage at a self-critical and active level.

It may be that resourcing generic programmes of educational facilitation which are truly learner-centred (portfolio learning, team-based multidisciplinary education) would prove more fruitful than content-oriented campaigns (pedagogy masquerading as andragogy?), and working through local providers and educators may prove a key factor in the success of future educational initiatives.

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Improving the detection of mental illness in general practice

Sir,

Alastair Wright (June *Journal*) summarizes the substantial problem of unrecognized mental illness in general practice and makes a number of suggestions for improving detection rates.[1] One strategy which he does not consider, however, is a greater involvement of other primary care staff. In the district of Epsom an education package designed to improve mental illness detection rates has been provided to both general practitioners and other primary care staff involved in the care of patients. Prior to the introduction of the package we carried out a survey to compare the detection rates of anxiety and depression by general practitioners with those of other primary care staff. More than 2500 patients from 10 practices took part. Each participant was required to rate the patient on a scale of 1–3, with 1 representing no anxiety/depression, 2, mild to moderate anxiety/depression, and 3, severe anxiety/depression requiring treatment. This was compared with the score from a patient self-administered Hospital Anxiety and Depression (HAD) questionnaire.

General practitioners were slightly more likely to make a correct diagnosis of severe anxiety and severe depression, but at the expense of diagnosing anxiety and depression where there was none accord-