have left till last. The severity of depressive symptoms declined markedly in all treatment groups, and any differences in clinical efficacy between the specialist treatments and routine general practitioner care were not commensurate with the differences in the length and cost of treatment. This generalisation may not apply to more severely depressed (melancholic) patients, but this requires confirmation in a larger sample of patients. The simplest explanation may be that depressive illnesses treated in primary care are of shorter duration than those referred for outpatient care[15 16] and usually have a good prognosis anyway.[2]

The design of the study must also be considered in the interpretation of the findings on clinical efficacy. It is probable that the independent raters became aware of treatment allocation before patients completed treatment, although it is hard to predict what effects this might have had on the findings. Confirmation of the diagnosis of depressive illness may have improved the effectiveness of routine general practitioner care, because recognition of depressive illness may be associated with a better clinical outcome and increases the likelihood of being offered treatment from general practitioners.[26] Even patients who refused to start or continue treatment had been made aware of the diagnosis of depression and it is unfortunate there were no available data on their clinical progress because these may have provided further information about what, if any, additional benefit treatment itself brought. A major aim of the present study was to measure the routine length of the patient-therapist contact involved in each treatment, and so no attempt was made to standardise therapeutic attention among the treatments. Consequently, it cannot be assumed that any slight advantage for one of the specialist treatments depended on the defining characteristics of the treatment rather than the length of therapeutic attention.[17]

Most patients rated the results of their treatment positively, but few said they would want the same treatment again. Perhaps this reflects a dislike of being depressed or fears about the possibility of future episodes. Such fears are realistic because most outpatients who recover from an episode of depression will suffer a recurrence of illness within two years despite continuation treatment with antidepressant drugs.[27] Depressed patients treated by cognitive behaviour therapy may be less likely to relapse than patients treated with antidepressant drugs alone over one[28] and two[29] years after the index episode. The potential longer term benefits of social work counselling have not been assessed. If social work counselling or cognitive therapy helps patients to cope more effectively with the problems that led to their depression this may prevent further episodes of depression. Until we have measured relapse rates after treatment our cost-benefit analysis is incomplete.

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Correction

Workload of general practitioners before and after the new contract

Several errors occurred in this paper by David Hannay *et al* (7 March, p 615). In the fifth sentence of the results section of the abstracts the figures for the time spent on general medical service duties are incorrect and should be 40·5 h in 1990 *v* 42·5 h in 1991. Two errors occur in table IV: in the second column the first figure should be 124, not 1124; and in the final column the asterisk should refer to the third value down (0·001), not the fourth.