in the community, third-sector and statutory organisations, can all contribute.

For general practice and primary care this will certainly require different training and more resources. The experience for all could be quite different: an individual with 'stress' booking straight into their choice of groups run by Improving Access to Psychological Therapies (IAPT) services; a patient with psychosis booking their follow up with the practice-based community psychiatric nurse through GP receptionists; a third-sector practitioner liaising with a GP to discuss the mutually accessible online shared plan for an individual with psychosis; a GP calling a psychiatrist to discuss reducing doses of antipsychotic medication for a patient the psychiatrist had seen as a one off at the practice; the practice-based IAPT practitioner providing cognitive behavioural therapy for anxiety as part of the aftercare plan following community-based alcohol detoxification. All possible with a small shift in allocation of NHS resources.

Richard Byng,

Professor in Primary Care Research and GP with a Special Interest in Mental Health, Plymouth University, Plymouth.
E-mail: richard.byng@plymouth.ac.uk

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Digital mental health services in general practice

Claire Harding and colleagues have highlighted the potential of digital interventions in general practice and the need for NHS accredited or 'kitemarked' apps, but also raise questions about the need for evidence of their safety and efficacy.[1]

They state that *' ... there is broad consensus in the field that traditional randomised controlled trials are not fit for purpose with digital interventions (largely because services develop and expectations change faster than trials can be run) ... '*. We acknowledge that good interventions take time to develop and test, but do not agree that this is a reason to abandon evidence-based practice. Users and commissioners should expect robust evidence before choosing to invest time or resources in such interventions.

For simple health information on the web, common sense 'kitemarking' may be sufficient. However, for interventions aimed at behaviour change, randomised controlled trials are warranted, regardless of whether they are delivered digitally. Rapid changes in services are not sufficient reason to negate this necessity, as well-developed interventions can be adapted to new delivery systems.

Miriam Santer,

Clinical Lecturer, University of Southampton, Southampton.
E-mail: m.santer@soton.ac.uk

Hazel Everitt,

Clinical Lecturer, University of Southampton, Southampton.

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Endometriosis in secondary care

As a hospital gynaecologist I may not be the best person to comment on your article[1] but these are my thoughts. Symptoms that could be due to endometriosis are extremely common in both primary care and the hospital gynaecology clinic. With the exception of women who are currently trying to conceive, it is perfectly reasonable to treat these symptoms hormonally. The earlier Royal College of Obstetricians and Gynaecologists guideline as well as the more recent European guideline you quote, both recommend treating symptoms with either the combined contraceptive pill, an ovulation suppressing progesterone-only pill, or the Mirena® interauterine system. Women referred to hospital because of the supposed importance of early diagnosis may be disappointed to be offered precisely those treatments if they attend a consultant clinic.

Stewart Pringle,

Consultant Gynaecologist, South Glasgow University Hospitals, Glasgow.
E-mail: stewartpringle@netscape.net

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