transmission; and 2) inadequate supplies of FFPs left many HCWs inadequately protected against inhaling aerosols containing SARS-CoV-2.[3] Reviewed studies demonstrated that: 1) hospital patients, visitors, and HCWs were at increased risk of infection; 2) seropositivity was higher among staff working in supposedly low-risk areas; and 3) HCWs who perform AGPs or work in ICUs were protected, with lower prevalence of infections being attributed to better air exchange rates and provision of FFPs.[3] This evidence together with higher infectivity around the time of symptom onset and the emergence of readily transmitted variants warrant that RCGP guidance should be reviewed and updated as a matter of priority. Practices should review their risk assessments and controls for managing airborne exposures. Practices must also consider personal susceptibility[5] and ensure that individual HCW clinical vulnerability (personal risk factors such as age, ethnicity, sex, health, and immune status) is assessed so that each HCW is provided with the correct PPE that recognises both workplace and personal risks.

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**Competing interests**

Paul J Nicholson is co-author of the editorial cited as reference 3.

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## Yonder: antidepressant withdrawal

It is disappointing that, in an issue of the *BJGP* devoted to mental health, the only mention of the increasingly recognised problem of antidepressant dependence is in reference to an article published elsewhere.[1]

I have been in practice long enough to recall the Defeat Depression campaign of the 1990s. I recently came across some of the material distributed to GPs in support of this campaign,[2] which was supported by both the Royal College of Psychiatrists (RCPsych) and the Royal College of General Practitioners (RCGP), as well as the pharmaceutical

industry. We were told that the then-new SSRIs were safe, effective, and non-addictive, they corrected a chemical imbalance in the brain, and that GPs were massively under-recognising and undertreating depression. The professional consensus emerged that it was good practice to prescribe to anyone who had 'biological symptoms of depression' for 2 weeks or more. The studies backing these assertions covered a standard 8–12 weeks.

Now we are faced with huge prescription numbers, driven at least in part by long-term prescribing, for which there is a very flimsy evidence base. Many people have developed discontinuation symptoms when stopping these drugs, been told by their doctors that these represent a relapse of their original condition, and can now count the years over which they have been dependent on prescribed drugs.

The RCPsych has moved its position, as evidenced by its recent publication *Stopping Antidepressants*,[3] endorsed by the RCGP. This is welcome after years of denial from both Colleges that there was a significant problem with SSRI withdrawal. The recent past-president of the RCPsych recently told *Telegraph Magazine*, *'that prescription figure is high. However, most antidepressants are started by GPs.'*[4]

This is important now. Not only are there large numbers of people who need help in coming off their medications, but we also risk adding to their number if the stress and exhaustion of COVID-19 and its aftermath are also subjected to the seemingly irresistible pressure to medicalise human distress.

General practice, and the RCGP in particular, needs to resist the urge to defensiveness, learn the lessons of experience,[5] and show leadership in addressing this problem.

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# Correction

In the editorial by Greenhalgh T and Rosen R, Remote by default general practice: must we, should we, dare we? *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/bjgp21X715313, the following details have been added: Funding: This work was funded by the UKRI COVID-19 Emergency Fund (grant reference: ES/V010069/1).

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