were emailed by sixteen participants from across the globe using letter templates that remain openly available.[5] Fourteen responses (21%) were received, which are also available.[6] Only two responses stated a reason for not adopting RRs and none of the contacted journals changed their policies to offer RRs as of August 2022.

Our experience suggests that there may be a knowledge gap among journal editors regarding the RR format and its wide applicability. Additionally, it is likely that direct, unsolicited outreach has limited capacity to influence journal policies. Journals that offer RRs, such as the *BJGP*, can pave the way for wider adoption in health and medical publishing by sharing their experience of adopting RRs.

Our hack-a-thon involved volunteers, mostly early-career researchers (ECRs), who understand the benefits of RRs and the impact that they could have on the research quality if the format were made widely available. Mobilising other stakeholders in the research ecosystem who have greater agency to promote uptake of RRs, including funders, institutions, and governmental bodies, along with ECRs, will be crucial to achieve change.

Although the scale of the problems regarding research quality and integrity are daunting, making RRs available to researchers is a simple but far-reaching measure that journals can adopt to help improve standards and trust in our system of scientific discovery.

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The serotonin theory of depression and why we use antidepressants

Nada Khan asks what GPs should tell patients when they ask how antidepressants 'work'.[1]

Surely prescribers need to talk honestly with patients, explaining that it is unclear how antidepressants 'work', even for 'depression', and that serotonin has multiple effects – on all physiological systems as well as on feelings of overwhelm, hopelessness, and 'depression'. These effects can include paradoxical suicidality, sexual dysfunction, blunted emotions, digestive problems, fatigue, weird dreams, and compulsions – and other apparently bizarre effects that also affect mood.

Many people are suffering exacerbated physical and mental illness as a consequence of taking antidepressants 'as prescribed', often for many years. I and others have been trying to raise our concerns with GP prescribers through the *BJGP* – such as:

- Stevie Lewis's 'Four research papers I wish my GP had read before prescribing antidepressants':[2] *'As a busy GP, should you wish to learn more through reading current research, which papers give you the best insight into this subject? I would suggest the following four…'*
- Ed White's 'Tapering antidepressants: why do tens of thousands turn to Facebook groups for support?':[3] *'… there is a huge amount of evidence that patients' withdrawal symptoms are often misdiagnosed when trying to stop taking ADs'.*
- My own 'New NICE guideline: antidepressants and chronic pain – chicken or egg?':[4] sounding the alarm that antidepressant problems are actually a definite contributor to 'where we are' and that initial decisions to prescribe them warrant urgent attention – as well as how to address the longer-term dependence issues that are clearly now evident.
- David Misselbrook's *BJGP* article 'Don't get fooled again'[5] picked up on our concerns and asked fellow GPs, *'… were we all too easily bewitched by our need to have the answers? And, fair enough, our desire to help patients, even when the evidence was doubtful or conflicted?'*

Please may I also recommend the 2022 book *Antidepressed* by Beverley Thomson,[6] written in plain language specifically to enable prescribers and patients to engage in the important discussions that need to take place with anyone prescribing or taking, considering prescribing or taking … or indeed trying to 'come off' antidepressants.

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