General Screening

1 DEPRESSION

Depression 2 questions screen
In the past two weeks, have you been bothered by:
Feeling down, depressed or hopeless?
Having little interest or pleasure in doing things?
If patient answers 'Yes' to any of the questions
→ Depression Guidelines

2 ANXIETY

Anxiety 2 question screen
In the past two weeks, have you been bothered by:
Worry, anxiety or feeling on edge?
Inability to stop or control your worry?
If patient answers 'Yes' to any of the questions

→ Anxiety Guidelines

3 MEDICALLY UNEXPLAINED SYMPTOMS

Medically Unexplained Symptoms (MUS) 2 questions screen
In the past two weeks, have you been bothered by:
Physical symptoms for which you received different medications?
Doctors have not been able to find a medical diagnosis?
If patient answers 'Yes' to BOTH questions
→ MUS Guidelines

4 FIRST EPISODE PSYHOSIS

First Episode Psychosis (FEP) 2 Questions Screen
Recently, have you been bothered by (has your patient been bothered by):
Strange behavior, speech or thoughts?
Strange experiences like hearing voices or seeing things that others cannot see?
If Answer is 'Yes' to any of the questions → FEP Guideline

Depression **Anxiety** **Somatic** **Psychosis**

Clinical Practice Guidelines: Management of Depression in Primary Health Care

Step 1: Recognition, Assessment and initial Management

1.1 Screening for Depression

A. Be Alert to Risk Factors for Depression Patients with high risk for depression

Multiple unexplained symptoms	Chronic physical illness	
Recent major stress or loss	Chronic mental illness	
Repeated visits to PHC	Post-partum	
Chronic Pain	Complaints: sleep, appetite change, weight loss/gain	

B. Screen All patients with risk factors for depression

During the last month, have you often been bothered by: ***– 1. feeling down, depressed or hopeless?***

–2. having little interest or pleasure in doing things?

If Patient Answers 'No' to both questions → Move to Anxiety Guidelines

If Patient Answers 'Yes' to one questions → Continue Screening

1.2 Diagnosis of Depression in Primary Health Care

A. Perform Comprehensive Assessment

Duration of symptoms	At least 3 of the following symptoms for 4 days (hypomania) or 1 week (mania) • Decreased need for sleep • Increased activity or restlessness • Increased talkativeness • Distractibility • Excessive involvement in pleasurable activities that have a high potential for painful consequences • Flight of ideas or the subjective experience that thoughts are racing • Infl ated self-esteem or grandiosity
History of depression and comorbid mental and physical illness	
Past history of mood elevation (Mania) →	
Quality of interpersonal relationship	
Living conditions or Social isolation	

B. Perform PHQ-9

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly Everyday
1. Feeling down, depressed, or hopeless?	0	1	2	3
2. Little interest or pleasure in doing things?	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way?*	0	1	2	3
Add Columns			+	+
Total PHQ-9 Score				
Number of Symptoms in shaded Area				

C. Assess Functional Impairment

10. If you are experiencing any of the problems on this form, how ***difficult*** have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult _____	No functional impairment
	Somewhat Difficult _____	Mild functional impairment
	Very Difficult _____	Moderate functional impairment
	Extremely Difficult _____	Severe functional impairment

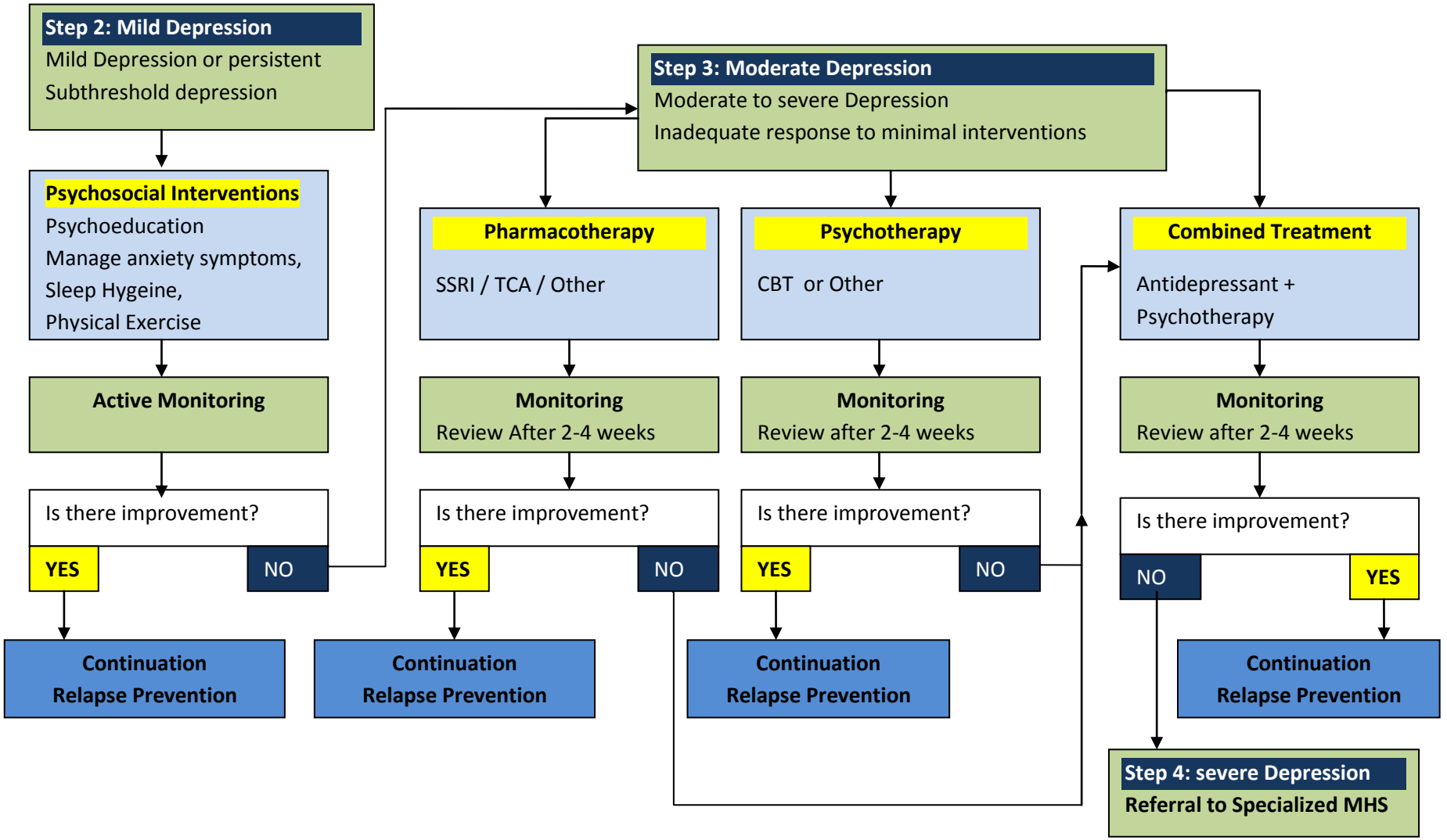
D. Depression severity

PHQ-9 Score	**Functional assessment**	**Symptom Severity**	**Guidelines**
5- 9	No functional impairment	**Subthreshold Depression**	Step 2
10-14	Minimal functional impairment	**Mild Depression**	Step 2
15-20	Mild to severe functional impairment	**Moderate Depression**	Step 2,3
>20	Sever functional impairment	**Severe Depression**	Step 4

1.3 Risk Assessment

A. Perform Risk Assessment			B. Refer High Risk Patients immediately to mental health Specialist services
Suicide: →	**Suicide Risk Assessment**	→	**If Patient presents considerable risk for themselves (suicide, psychosis, severe self-neglect) or others (violence)**
Violence	Do you have thoughts about death or dying?		
	Do you have thoughts that life is not worth living?		
Psychosis	Did you to think that you are better off dead?		
	What about thoughts of hurting or killing yourself?		Share concern with family members Ensure that patient has good social support Provide more support and frequent contact Refer to Specialized mental Health Services
Self-neglect	What have you thought about, have you done anything to hurt yourself?		
	Risk factors for suicide: History of suicide attempt		
Poor Physical health	Social isolation		
	Substance abuse		**Move to → Step 4**
	Hopelessness		
	Significant comorbid anxiety		

Management of Depression in Primary health Care: Step 2-4



Step 2 Subthreshold and mild Depression

2.1 General Measures

A. Manage comorbidity of Depression with Anxiety	
Perform Screen for Anxiety Disorders	Depression with anxiety symptoms → Treat Depression first Depression AND Anxiety Disorder → Treat Anxiety Disorder
B. Offer Advise on Sleep Hygiene	
	Establishing regular sleep and wake times Avoiding excess eating, smoking or drinking alcohol before sleep Creating a proper environment for sleep Taking regular physical exercise if possible 45-60 min three times a week
C. Active Monitoring 'Watchful Waiting'	
For people who may recover with no formal intervention, -people with **mild depression** who do **not want** an intervention -people with **subthreshold depressive symptoms** who **request** an intervention:	-Discuss the presenting problem(s) and any concerns -Arrange a further assessment, normally within 2 weeks -Provide information about depression -Make contact if the person does not attend appointments.

2.2 Drug Treatment

A. Do not use antidepressants for subthreshold or mild Depression EXCEPT in:

Conditions for using antidepressants	1) Past history of moderate or severe depression
Or	2) Subthreshold Depression present for at least 2 years
Or	3) Subthreshold or mild depression persisting after other interventions
Or	4) Mild Depression complicating treatment of physical illness
----------	If Any of the above → **Move to Step 3**

2.3 Psychological Interventions

A. Provide Psychoeducation about Depression	
A.1-Information about Depression	**Pamphlet**
A2.-Self Management:	Make time for pleasurable activities Spend time with people who can support you Practice relaxation Make simple goals and steps
A.3-Physical Exercise:	Advise patient to stay physically active Start some sort of sports activity like walking or jogging Join a course of aerobics with a trained practitioner
B. Provide brief psychological treatment	**Supportive counseling**
	Problem Solving Technique
	Provided by a trained practitioner 6-8 , 30 minutes sessions over 9-12 weeks Based on evidence that Depression is associated with life problems

Step 3: Moderate Depression

3.1 Choosing Treatment

A. Choose treatment	**Choice of intervention should be influenced by the:**
	Duration of the episode and trajectory of symptoms Previous illness course and response to treatment Likelihood of adherence and potential adverse effects Person's preference Course and treatment of any chronic physical health problem

3.2 Choosing psychotherapy

A. Provide a course of Cognitive Behavior Therapy (CBT)	Should be provided by a trained therapist

	61-20 sessions once per week over 3-4 months For moderate to severe depression: 2 sessions per week in the first month

3.3 Choosing Antidepressant Drug

A. Discuss choice of antidepressant with patient: Delayed action of antidepressants Side effects and discontinuation symptoms Interactions with concomitant medication or physical illness Efficacy and tolerability of any antidepressants previously taken	Refer to **Guidelines for using antidepressants**
B. Starting Antidepressant Treatment	Refer to **Guidelines for using antidepressants**
C. Combining and Augmenting antidepressants	Refer to **Guidelines for using antidepressants**

3.4 Combining psychological and drug treatment

A. If a person's depression has not responded to either pharmacological or psychological interventions, consider combining antidepressants with CBT.

3.5 Referral to Specialized Mental Health Services

If a person's depression has not responded to various augmentation and combination treatments, consider referral to a specialist practitioner or service.

3.6 Continuation and Relapse Prevention

A. Full Remission

Encourage a person who has benefited from taking an antidepressant to continue medication for at least 6 months and inform them that:	1 this greatly reduces the risk of relapse 2 antidepressants are not associated with addiction	

B. If risk of relapse is significant or there is a history of recurrent depression

Discuss choice of treatment with the person, and base choice on previous treatment history and the person's preference

1.	**Continuing medication** Advise use of antidepressants for at least2 years at optimal dose if: 1) the person has had two or more recent episodes of depression which caused significant functional Impairment **After 2 years** Re-evaluate treatment regularly.	2.	**Augmenting medication** Augmentation should be done under supervision of a Psychiatrist - Do not use lithium alone to prevent recurrence	3.	**Psychological interventions** Provide individual CBT for people who have relapsed despite antidepressants and for people with a significant history of depression and residual symptoms despite treatment.

Step 4: Complex and Severe Depression

Refer patients with Complex or Severe Depression to Specialized Mental Health Services

Suicide risk,
Severe functional impairment,
Psychotic symptoms,
Poor physical condition,
Poor social support system

2 Generalized Anxiety Disorder

Step 1: Recognition and Diagnosis of Anxiety Disorders

1.A Screening for Anxiety Disorders in PHC centers

Identify common presentations of anxiety in PHC

Fatigue, insomnia, chronic pain	Consider both depression and anxiety disorders as they commonly coexist
Frequent visits with multiple symptoms	For example a patient with irritable bowel syndrome + headaches + back pain
Cardiovascular symptoms	Palpitations, chest pain, faintness, flushing, sweating
Respiratory symptoms	Shortness of breath, hyperventilation, dyspnoea
Gastrointestinal symptoms	Choking, lump in throat, dry mouth, nausea,vomiting, diarrhoea
Neurological symptoms	Dizziness, headache, paraesthesia, vertigo
Musculoskeletal symptoms	Muscle ache, muscle tension, tremor, restlessness

Use the Two Question Screen for Anxiety

Patients identified at risk for anxiety disorder should be screened with the following two questions:

In the past two weeks, have you been bothered by:
1– Feeling anxious, nervous or on edge?
2– Being unable to stop or control worry?

If Patient answers **Yes** to one of the questions → continue screening
If the patient answers **No** to both questions → Anxiety Disorder is highly unlikely

If a patient presents with a panic attack in the emergency room, he or she should:

– be asked if they are already receiving treatment for panic disorder – undergo the minimum investigations necessary to exclude acute physical problems
– not usually be admitted to a medical or psychiatric bed
– be referred to PHC for subsequent care
– be given appropriate written information about panic attacks and why they are being referred to primary care

Symptoms of Panic Attack

(1) palpitations, pounding heart. or accelerated heart rate
(2) sweating (3) trembling or shaking (4) sensations of shortness of breath or smothering (5) feeling of choking (6) chest pain or discomfort (7) nausea or abdominal distress
(8) feeling dizzy, unsteady, lightheaded. or faint
(9) derealization (feelings of unreality) or depersonalization (being detached from oneself) (10) fear of losing control or going crazy (11) fear of dying
(12) paresthesias (13) chills or hot flushes

1.B Diagnosis of Anxiety Disorders

A.Obtain History

Factors triggering symptoms

Cognitions related to symptoms

Associated symptoms

B.Assess Severity of Anxiety Symptoms

During the last 2 weeks, how often have been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling Nervous, anxious or on edge?	0	1	2	3
Not being able to stop or control worry?	0	1	2	3
Worrying too much about different things?	0	1	2	3
Trouble relaxing?	0	1	2	3
Being so restless that it is hard to sit still?	0	1	2	3
Becoming easily annoyed or irritable?	0	1	2	3
Feeling afraid as if something awful might happen?	0	1	2	3
Add Columns			+	+
Total Score				

C.Assess functional impairment

If you are experiencing any of the problems on this form, how ***difficult*** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult		**None**
Somewhat Difficult		**Mild**
Very Difficult		**Moderate**
Extremely Difficult		**Severe**

D.Assess Severity of Anxiety Disorder

0-5	No Impairment	Minimal anxiety	No Treat
6-10	Mild	Mild anxiety	Step 2
11-15	Moderate	Moderate anxiety	Step 3
16-21	Severe	Severe anxiety	Step 4

E. Identify physical conditions that mimic or are associated with Anxiety

1 Medical conditions

Thyrotoxicosis
alcohol or drug withdrawal
hypocapnia due to hyperventilation
Anaemia
Hypoglycaemia
hypoxia or hypercapnia due to intermittent respiratory disorders
poor pain control
vertigo due to vestibular disorders.

2 Drugs

Bronchodilators
insulin and oral hypoglycaemic agents
SSRI* antidepressants
Corticosteroids
Thyroxine

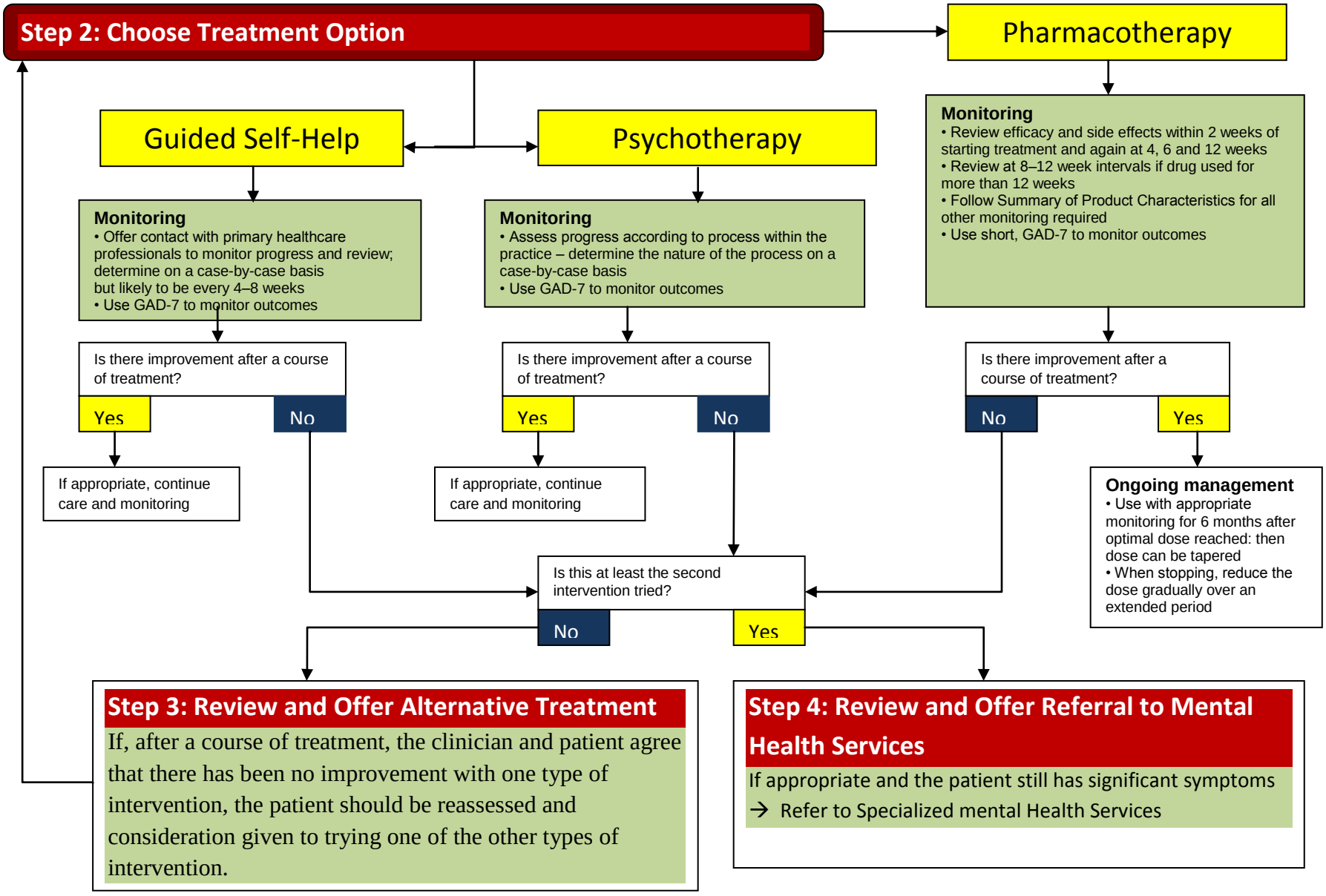
selective serotonin reuptake inhibitor

3 Evaluate comorbidity

Depression
Screen for Depression in all patients with an anxiety disorder
If a patient with anxiety also has Depression → Treat Anxiety First
Substance Abuse
Screen for Substance Abuse
Refer to Mental health

F.Identify Specific Anxiety Disorder

Management of Anxiety in Primary health Care: Step 2-4



Step 2: Treatment of Anxiety Disorders in Primary Health care

2.A Choosing treatment

Discuss treatment options with patient: The available treatment options should be discussed with the patient. Selection of one intervention should be a shared decision between doctor and patient. - **Guided Self-help** OR - **Psychological interventions** OR - **Pharmacological intervention**

2.B Guided Self-help

1.Provide Psychoeducation

Important messages for patients with Anxiety Disorders

Anxiety disorders are common and chronic conditions

1) the cause of considerable distress and disability
2) often unrecognized and untreated
3) If left untreated they are costly to both the individual and society.

A range of effective interventions is available to treat anxiety disorders, including medication, psychological therapies and self-help.

Individuals do get better and remain better.

Involving individuals in an effective partnership with health care professionals, with all decision-making being shared, improves outcomes.

Access to information, including support groups, is a valuable part of any package of care

2.Physical exercise

Advise patient to start a structured physical exercise

3.Stress Reduction and Relaxation techniques

Deep Breathing Exercise:

Teach and demonstrate to the patient Deep (abdominal) breathing exercise

Provide written pamphlet

Progressive Muscular Relaxation (PMR):

Teach and demonstrate to the patient PMR

Provide written pamphlet

Advise patient to practice regularly at home

Problem solving technique (PST):

Teach and demonstrate to the patient the PST technique.

Advise patient to practice PST with daily problems

2.C PPsychologicalInterventions

Cognitive Behavior Therapy (CBT)

CBT Should be used in all anxiety disorders

Should be delivered by a trained practitioner

Consist of 1 hour weekly sessions over 3-4 months

Brief CBT should be integrated with guided self-help

2.D Pharmacological interventions

A.Antidepresant Medication

Refer to **Guidelines for Using Antidepressants**

B.Other medications

Beta Blockers: Used to reduce physical manifestations of anxiety

Benzodiazepines: Should NOT be used for routine treatment of panic and anxiety disorders. If used for anxiety disorder the duration should not exceed a few days

2.E Monitor progress

3 Medically Unexplained Symptoms

Step 1: Recognition and initial Management

Identify patients at risk Somatization

Risk factors for somatization

Predisposing Factors: Age: adult > 30, Gender: Female, Education: lower scale

Triggering Factors: physical trauma, chronic illness, emotional conflicts

Maintaining Factors: illness behavior, iatrogenic factors: repeated medications and investigations

Screen for MUS

Use the following checklist to screen for MUS

In the past two Weeks, How often did you experience any of the following physical symptoms?	Never	Sometimes	More than half the days	Nearly every day		Never	Sometimes	More than half the days	Nearly every day
Headache?	0	1	2	3	Fatigue?	0	1	2	3
Dizziness or fainting?	0	1	2	3	Palpitation?	0	1	2	3
Chest pain?	0	1	2	3	Menstrual problems?	0	1	2	3
Back pain?	0	1	2	3	Nausea? Indigestion?	0	1	2	3
Muscle pain?	0	1	2	3	Abdominal pain?	0	1	2	3
Joint pain?	0	1	2	3	Sleep problems?	0	1	2	3
Tingling or loss of sensation?	0	1	2	3	Diarrhea? Constipation?	0	1	2	3
Weakness in parts of your body?	0	1	2	3	Dyspnea?	0	1	2	3
Add Columns			+	+			+	+	+
Total									
Number of Symptoms in shaded Area									

2. If you are experiencing any of the problems on this form, how ***difficult*** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult _____

Somewhat Difficult _____

Very Difficult _____

Extremely Difficult _____

Diagnosis of MUS

Mild	Few symptoms + mild impairment	Manage in PHC
Moderate	Multiple symptoms + moderate impairment	Manage in PHC + psychiatric consultation
Severe	Multiple symptoms + Severe impairment or psychotic Sx	Refer to Psychiatrist

Biopsychosocial Assessment	
Perform medical assessment	Patients should be offered the same professional treatment as any other person seeking health care Perform full medical examination Avoid unnecessary treatment or diagnostic intervention
Psychosocial assessment	Perform full psychological assessment: Cognitive factors, Emotional stressors Social assessment: Patient family, social relations
Diagnosis of Somatization Disorders	Evaluate for Medical condition Evaluate for Psychiatric Conditions -Screen for Depression –> Depression guidelines -Screen for Anxiety Disorders → Anxiety Guidelines
Step 2: Management of mild MUS in Primary Health Care	
Encourage Self-management of MUS	
Provide psychoeducation	Psychoeducational material Stress management skills Problem solving skills Physical activity
Biopsychosocial approach to manage moderate MUS	

Build alliance	Using client centered approach: build therapeutic relationship with patient
Exculpation	Avoid blaming the patient for the symptoms
Convincing Explanation	Give a convincing explanation based on physiology of symptoms

Step 3: Management of Moderate MUS in Primary Health Care

Management of persistent MUS

Reattribution model for managing MUS in PHC	1. Feeling understood: The doctor elicits physical symptoms, psychosocial problems, mood state, beliefs held by patient about the problem, relevant physical examination and investigations. 2 Broadening the agenda: The doctor summarizes the physical and psychosocial findings, and negotiates these findings with the patient. 3 Making the link: The doctor then gives an explanation relating the physical symptoms to psychosocial problems of lifestyle in terms of a link in time or physiology. 4 Negotiating further treatment: The doctor arranges follow-up or treatment of symptoms, psychosocial problems or mental disorder.
Consider treatment with psychotropic medication	Use antidepressants for chronic or persistent MUS: Usually TCAs are effective, but use SSRIs to reduce side effects Avoid habit forming medications: Avoid benzodiazepines Start with smaller doses and increase slowly, watch for side-effect Treat any co-existing psychiatric disorder
Administrative arrangements	Be proactive rather than reactive. Agree on a course with fixed, scheduled appointments with 2–6-week intervals and avoid consultations on demand. If the patient has a job, avoid giving sick leave if at all possible. Try to become the patient's only physician and minimize the patient's contact with other healthcare professionals, doctors on call and alternative therapists. Inform your colleagues of your management plans and develop contingency plans for when you are not accessible. Inform the patient's nearest relative and try to co-opt a relative as a therapeutically. If necessary, arrange support or supervision for yourself.

Step 4: Management of Complex and Severe MUS in mental Health Services	
Referral to Specialized Mental health Services	
Refer Patients with Complex MUS to Specialized mental Health Services	Inadequate response to PHC interventions Psychotic Symptoms Social Isolation

4 Early Detection of First Episode Psychosis in Primary Health Care

Step 1: Recognition and Assessment

1.1 Screening for First Episode Psychosis

A. Be Alert to Risk Factors for psychosis

Risk Factors	**Age: 80% of First Episode Psychosis occur in young people between 18 and 30 years of age**
	Gender: More common in males
	Family history: Positive family history of Schizophrenia, Bipolar Disorder, or Psychotic Depression
Social Functioning	**Problems in relationship with friends and family**
Cognition	**Poor concentration and memory**
Mood	**Feeling depressed, anxious or irritable**
Drug Use	**Abuse of tranquilizers, opioids etc**
Ideas of Suicide	**Suicidal thoughts or attempts**

B. Use screening questions to detect early symptoms

- Have you felt that something odd might be going on that you cannot explain?
- Have you been feeling that people are talking about you, watching you or giving you a hard time for no reason?
- Have you been feeling, seeing or hearing things that others cannot?
- Have you felt especially important in some way, or that you have powers that let you do things that others cannot?

Step 2 : Referral to Specialized Mental Health Services

2.1 Management of FEP in Primary Health Care

A. Refer Patient to Mental Health Specialist for Diagnosis and Management

Guidelines for Using Antidepressant Drugs in Primary Health Care

1. Starting Antidepressant Treatment

A. Normally choose an SSRI in generic form

SSRIs are associated with an increased risk of bleeding: Consider prescribing a gastroprotective drug in older people who are taking non-steroidal anti-inflammatory drugs (NSAIDs) or aspirin.

Fluoxetine, fluvoxamine and paroxetine have a higher propensity for drug interactions.

people who also have a chronic physical health problem: consider using citalopram or sertraline as these have a lower propensity for interactions.

Paroxetine: higher incidence of discontinuation symptoms.

B. Take into account toxicity in overdose for people at risk of suicide

Be aware that:

The greatest risk in overdose is with tricyclic antidepressants (TCAs).

C. When prescribing drugs other than SSRIs, take into account:

The increased likelihood of the person stopping treatment because of side effects, and the consequent need to increase the dose gradually TCAs

D. When prescribing antidepressants for older adults:

Prescribe at an age-appropriate dose taking into account physical health and concomitant medication. Monitor carefully for side effects.

Discuss with patient:

The gradual development of the full antidepressant effect	Potential side effects and drug interactions
The importance of taking medication as prescribed	The risk and nature of discontinuation symptoms
The need to continue beyond remission	The fact that addiction does not occur.

2. Review response after 2-4 weeks

A. No response is seen after 2 weeks	→	Check that drug is being taken as prescribed Check for side effects: Mange side effects Continue for 2 more weeks and evaluate respose
B. Minimal response observed after 2-4 weeks Despite that the drug is taken as prescribed Minimal side effects	→	increasing the dose in line with the summary of product characteristics (SPC) if there are no significant side effects **Or** – switching to another antidepressant (see below) if there are side effects or if the person prefers.
C. Poor Response after 3-4 weeks Inadequate Response, OR significant Side Effects, OR Patient prefers another drug	→	Consider switching to another antidepressant

3. Switching to another antidepressant

If no response to antidepressant within 2-4 weeks

Switch to a different SSRI

4. Combining antidepressants

Should be done under supervision of psychiatrist

The specific cautions, contraindications and monitoring requirements for some drugs

Switch to TCA		MAOIs, such as phenelzine, combined antidepressants and lithium augmentation of antidepressants should normally be prescribed only by specialist mental health professionals

Antidepressant discontinuation/withdrawal symptoms

Inform patients about discontinuation/withdrawal symptoms Stopping antidepressants abruptly can cause discontinuation/withdrawal symptoms. To minimize the risk of discontinuation/withdrawal symptoms when stopping antidepressants, the dose should be reduced gradually over an extended period of time. Mild discontinuation/withdrawal symptoms: reassure the patient and monitor symptoms. Severe discontinuation/withdrawal symptoms: consider reintroducing the antidepressant (or prescribing another from the same class that has a longer half-life) and gradually reducing the dose while monitoring symptoms.	→	**Information for Patients using antidepressants:** – although antidepressants are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly – they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms. – the most commonly experienced discontinuation/withdrawal symptoms are ***dizziness, numbness and tingling, gastrointestinal disturbances (particularly nausea and vomiting), headache, sweating, anxiety and sleep disturbances***

INTERACTIONS

NSAIDs (Non-steroidal anti-inflammatory drugs	Do not offer SSRIs Use gastroprotective medications
Warfarin or Heparin	Do not Offer SSTIs
Aspirin	Use SSRIs with caution – if no suitable alternatives can be identified, offer gastroprotective medicines together with the SSRI
Drugs for Migraine 'triptan'	Do not offer SSRIs Offer mirtazapine, trazodone, mianserin or reboxetine
MAOIs (monoamine oxidase inhibitors)	Do not normally offer SSRIs Offer mirtazapine, trazodone, mianserin or reboxetine
Theophylline, clozapine, _ methadone or tizamidine _	Do not normally offer fluvoxamine Offer sertraline or citalopram