PrescQIPP Community Interest Company

Trimipramine

In England, Scotland and Wales, over £8.2 million is spent annually on prescribing trimipramine (NHSBSA (March to May 2022), Public Health Scotland (February to April 2022)).

Medicines optimisation (MO) projects in this area are aimed at reviewing the continued need for trimipramine and switching to an alternative antidepressant which is more cost-effective. Work with the local Integrated Care System (England) or Health Board (Scotland, Wales and Northern Ireland) to produce a joint policy with input from secondary care and mental health services to support the review and switch of patients from trimipramine in primary care.

This bulletin reviews the place in therapy of trimipramine and offers guidance and support materials for organisations considering reviewing the prescribing of trimipramine as a MO project.

This is one of several bulletins providing further information on medicines that should be given a low priority for prescribing on the NHS, are poor value for money, suitable for self-care or for which there are safer more suitable alternatives. This supports the implementation of the NHS England guidance Items which should not be routinely prescribed in primary care.[1]

Recommendations

- Tricyclic antidepressants (TCAs) should not be used first-line for the treatment of depression. Selective Serotonin Reuptake Inhibitors (SSRIs) are recommended by National Institute for Health and Care Excellence (NICE) guidance [NG222] Depression in adults: treatment and management as they are equally effective and have a more favourable risk-benefit ratio.
- Where a tricyclic antidepressant is indicated in accordance with NICE, trimipramine should not be prescribed as it is not considered to be cost effective for prescribing on the NHS.
- Primary care prescribers should not initiate trimipramine for any new patient.
- Produce a joint policy with input from secondary care and mental health services to support the review and switch of patients from trimipramine in primary care.
- Review all existing patients prescribed trimipramine and deprescribe where appropriate, ensure the availability of relevant services to facilitate this change.
  - » Switch to an alternative antidepressant, if patients are under the care of a specialist, involve them in the decision to discontinue or switch treatment.
  - » As with all switches, this should be tailored to the individual patient.
  - » Patients at risk of suicide should be reviewed as a matter of urgency.
- Trimipramine should not be prescribed for an unlicensed indication such as an anxiolytic, for neuropathic pain, fibromyalgia or for its sedative effects as an aid to sleep. Consider discontinuation or switching treatment to a more appropriate alternative in collaboration with an appropriate specialist.
- Ongoing prescribing of antidepressants to prevent relapse should be reviewed at least every six months.

Recommendations

- Trimipramine should not be stopped abruptly unless serious side effects have occurred. The dose should preferably be reduced gradually. The speed of withdrawal should be led by the patient, and guided by the medicines pharmacokinetic profile and duration of treatment. The BNF recommends reducing the dose gradually over a period of four weeks, or longer if withdrawal symptoms emerge (six months in patients who have been on long term maintenance treatment).

Background

Trimipramine is a tricyclic antidepressant. Tricyclic antidepressants block the re-uptake of both serotonin and noradrenaline. They can be divided into those with additional sedative properties and those that are less sedating. Agitated and anxious patients tend to respond best to the sedative compounds, whereas withdrawn and apathetic patients will often obtain most benefit from the less sedating ones. Trimipramine is a tricyclic antidepressant with sedative properties. Tricyclic antidepressants also have varying degrees of antimuscarinic side-effects and cardiotoxicity in overdosage.[2]

Trimipramine is licensed for the treatment of depressive illness, especially where sleep disturbance, anxiety or agitation are presenting symptoms. Sleep disturbance is controlled within 24 hours and true antidepressant action follows within seven to ten days.[3]

The usual dosage in adults is initially 50–75mg daily in divided doses, alternatively initially 50–75mg once daily. The dose should be taken at bedtime and increased if necessary to 150–300mg daily.[2,3] The maintenance dose is 75-150mg daily.[3] In elderly patients' lower doses are required, initially 10–25mg three times a day. The initial dose should be increased with caution under close supervision. Half the normal maintenance dose may be sufficient to produce a satisfactory clinical response. A maintenance dose is 75–150mg daily.[2,3] Trimipramine is not recommended for children.[3]

Trimipramine is available as licensed 10mg and 25mg tablets and 50mg capsules.[2]

For more information see PrescQIPP Bulletin 237. Antidepressants which includes a useful table (table 5) comparing the antidepressant drugs.

National guidance

The NHS England guidance Items which should not be routinely prescribed in primary care includes trimipramine as an item which is clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation. The recommendations are:[1]

- Prescribers in primary care should not initiate trimipramine for any new patient.
- Support prescribers in deprescribing trimipramine where appropriate, ensure the availability of relevant services to facilitate this change.

The rationale for inclusion in this guidance was the price of trimipramine is significantly more expensive than other antidepressants and cost effective alternatives are available.[1]

NICE guideline [NG222] Depression in adults: treatment and management states:[4]

- Take into account toxicity in overdose when prescribing an antidepressant medication for people at significant risk of suicide.
- Tricyclic antidepressants are dangerous in overdose, although lofepramine has the best safety profile.
- Do not routinely start treatment with tricyclic antidepressants, except lofepramine, as they are associated with the greatest risk in overdose.[4]

The guideline recommends all the following first-line treatment options for less severe depression. These are listed in order of recommended use, based on the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors:[4]

- Guided self-help – Including structured cognitive behavioural therapy (CBT), structured behavioural activation (BA), problem solving or psychoeducation materials. These can be delivered in person, by telephone, or online.
- Group CBT
- Group BA
- Individual CBT
- Individual BA
- Group exercise
- Group mindfulness and meditation
- Interpersonal psychotherapy
- SSRI antidepressants
- Counselling
- Short-term psychodynamic psychotherapy (STPP).

The guideline does not recommend that antidepressant medication is routinely offered as first-line treatment for less severe depression, unless that is the person's preference. When an antidepressant is to be prescribed, the first-line pharmacological treatment should be an SSRI in a generic form.[4] Toxicity in overdose should be considered when choosing an antidepressant for people at significant risk of suicide. Out of the tricyclic antidepressants, lofepramine has the best safety profile.[4]

If switching a patient to a SSRI, consider that SSRIs are associated with an increased risk of bleeding, especially in older people or in people taking other drugs that have the potential to damage the gastrointestinal mucosa or interfere with clotting, for example aspirin, non-steroidal anti-inflammatory drugs (NSAIDs), anticoagulants and antiplatelets. Consider prescribing a gastroprotective drug in older people who are also taking NSAIDs or aspirin.[5]

Antidepressant medication is usually taken for at least six months. For less severe depression this may include some time after symptoms remit. Benefit should be felt within four weeks. Discuss with people that continuation of treatment (antidepressants or psychological therapies) after full or partial remission may reduce their risk of relapse and may help them stay well. Reach a shared decision on whether or not to continue a treatment for depression based on their clinical needs and preferences. Consider the potential risks of continuing with antidepressants long term, and how these balance against the risks of depression relapse. These include:[4]

- Possible side effects, such as an increased bleeding risk or long term effects on sexual function.
- Difficulty stopping antidepressants.

Review treatment for people continuing with antidepressant medication to prevent relapse at least every six months. At each review monitor mood, side effects, any medical, personal, social or environmental factors that may affect their risk of relapse and discuss with them if they wish to continue treatment or if they wish to stop antidepressant treatment.[4]

NICE Guideline [NG134] Depression in children and young people: identification and management recommends that tricyclic antidepressants should not be used for the treatment of depression in children and young people.[6]

The Scottish Medicine Consortium (SMC) do not have a review of trimipramine, and the Scottish Intercollegiate Guidelines Network (SIGN) currently do not have guidance on the pharmaceutical management of depression.[7,8] The Northern Ireland Department of Health (NI DH) have included trimipramine in their Deprescribing: Limited Evidence List and Stop List. Trimipramine is included in the limited evidence list and must not be routinely prescribed. It is recommended that prescribing is reviewed to ensure it is used only in the approved circumstances. The rationale for inclusion is that the cost of trimipramine is significantly more expensive than other antidepressants.[9]

The British Association for Psychopharmacology (BAP) guidelines states that the choice of antidepressant drug should be matched to individual patient requirements as far as possible, taking into account likely short-term and long term effects. In the absence of special factors, choose antidepressants that are better tolerated and safer in overdose. There is most evidence for SSRIs which, together with other newer antidepressants, are first line choices. Older tricyclic antidepressants should generally be reserved for situations when first-line drug treatment has failed.[10]

NICE guideline NG215 Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults covers general principles for prescribing and managing withdrawal from dependence-forming medicines and antidepressants in primary and secondary care.[11]

Clinical effectiveness

There is little to choose between the different classes of antidepressant drugs in terms of efficacy, and tricyclic antidepressants have similar efficacy to SSRIs. Tricyclic antidepressants are more likely to be discontinued because of side-effects and toxicity in overdosage is also a concern. SSRIs are less sedating and have fewer antimuscarinic and cardiotoxic effects. SSRIs are recommended as one of the first-line options for less severe and severe depression in NICE guideline [NG222], but should not be routinely offered first-line, unless that is the person's preference.[2,4]

About 10 to 20% of patients fail to respond to tricyclic and related antidepressant drugs and inadequate dosage may account for some of these failures. It is important to use doses that are sufficiently high for effective treatment but not so high as to cause toxic effects. Low doses should be used for initial treatment in the elderly. Studies have shown that tricyclic antidepressants are not effective for treating depression in children.[2]

Safety

Trimipramine is contraindicated in acute porphyrias; arrhythmias; during the manic phase of bipolar disorder; heart block; immediate recovery period after myocardial infarction; severe liver disease; during breast feeding and hypersensitivity to trimipramine or any of the excipients.[2,3] It may be advisable to monitor liver function in the patients on long term treatment with trimipramine.[3]

Caution is required in cardiovascular disease; chronic constipation; diabetes; epilepsy; history of bipolar disorder; history of psychosis; hyperthyroidism (risk of arrhythmias); increased intra-ocular pressure; patients with a significant risk of suicide; phaeochromocytoma (risk of arrhythmias); prostatic hypertrophy; susceptibility to angle-closure glaucoma; urinary retention. Treatment should be stopped if the patient enters a manic phase.[2] Like other tricyclic antidepressants, trimipramine may dose-dependently prolong QT interval. Caution should be taken in patients receiving drugs known to prolong QT interval (e.g. Class IA and III antiarrhythmics, macrolides, fluoroquinolones, some antifungals, some antipsychotics), induce hypokalemia (e.g. hypokalemic diuretics, stimulant laxatives, glucocorticoids, tetracosactides) or bradycardia (e.g. beta-blockers, diltiazem, verapamil, clonidine, digitalis).[3]

The BNF contains a full list of interactions. Concomitant administration with buprenorphine/opioids may result in serotonin syndrome, a potentially life-threatening condition. Symptoms of serotonin syndrome may include mental-status changes, autonomic instability, neuromuscular abnormalities, and/

or gastrointestinal symptoms. If serotonin syndrome is suspected, a dose reduction or discontinuation of therapy should be considered depending on the severity of the symptoms. If concomitant treatment of buprenorphine/opioids or other serotonergic agents (such as SSRIs, SNRIs, MAOIs, lithium, triptans, tramadol, linezolid, L-tryptophan, and St John's Wort - Hypericum perforatum preparations) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases.[3] Tricyclic antidepressants potentiate the central nervous depressant action of alcohol.[3]

Trimipramine should not be used in pregnancy especially during the first and last trimesters unless there are compelling reasons, and the potential benefit outweighs risk. There is no evidence from animal work that it is free from hazard.[2,3] Adverse effects such as withdrawal symptoms, respiratory depression and agitation have been reported in neonates whose mothers had taken trimipramine during the last trimester of pregnancy.[3] Trimipramine is contraindicated during lactation.[3]

The BNF and SPC have detailed information on the side-effects of trimipramine which are reduced by titrating slowly to the minimum effective dose (every two to three days). Elderly patients are particularly susceptible to many of the side-effects of tricyclic antidepressants especially agitation, confusion and postural hypotension; low initial doses should be used, with close monitoring, particularly for psychiatric and cardiac side-effects.[2,3]

Signs of overdose include dry mouth, coma of varying degree, hypotension, hypothermia, hyperreflexia, extensor plantar responses, convulsions, respiratory failure, cardiac conduction defects, and arrhythmias.[2] Dilated pupils and urinary retention also occur. Acute overdosage may be accompanied by hypotensive collapse, convulsions coma, QT interval prolongation, torsades de pointes and may result in a fatal outcome.[3] Metabolic acidosis may complicate severe poisoning; delirium with confusion, agitation, and visual and auditory hallucinations are common during recovery. Limited quantities of tricyclic antidepressants should be prescribed at any one time because their cardiovascular and epileptogenic effects are dangerous in overdosage.[2]

Withdrawal effects may occur within five days of stopping treatment with antidepressant drugs; they are usually mild and self-limiting, but in some cases may be severe.[2] Symptoms may occur on abrupt cessation of therapy and include insomnia, irritability and excessive perspiration.[3] The risk of withdrawal symptoms is increased if the antidepressant is stopped suddenly after regular administration for eight weeks or more.[2] The dose should preferably be reduced gradually. The speed of withdrawal should be led by the patient, and guided by the medicines pharmacokinetic profile and duration of treatment.[4] The BNF recommends reducing the dose gradually over a period of four weeks, or longer if withdrawal symptoms emerge (six months in patients who have been on long term maintenance treatment).[2]

The use of tricyclic antidepressants in elderly patients is potentially inappropriate (STOPP criteria):[2]

- If prescribed in those with dementia, narrow angle glaucoma, cardiac conduction abnormalities, prostatism, or history of urinary retention (risk of worsening these conditions).
- If initiated as first-line antidepressant treatment (higher risk of adverse drug reactions than with SSRIs or SNRIs).

Patient and carers should be advised that trimipramine may impair performance of skilled tasks (e.g. driving) and the effects of alcohol are enhanced with trimipramine.[2]

Patient factors

Trimipramine can be taken in divided doses or as a once daily dose at bedtime. The SSRIs which are better tolerated and are safer in overdose should be considered first-line for treating depression and are all once daily dosing, so no significant patient factors are foreseen.[2]

Costs and savings

In England, Scotland and Wales, over £8.2 million is spent annually on prescribing trimipramine (NHSBSA (March to May 2022), Public Health Scotland (February to April 2022)).

A 10% reduction in trimipramine through deprescribing in appropriate individuals could release annual savings of £820,000 across England, Wales and Scotland.

Switching 25% of patients from trimipramine to sertraline would save £2.04 million per annum, this equates to £2,886 per 100,000 patients across England, Wales and Scotland.

Switching 25% of patients from trimipramine to lofepramine would save £1.99 million per annum, this equates to £2,817 per 100,000 patients across England, Wales and Scotland.

As with all switches, individual patient circumstances need to be borne in mind. However, assistance from practice nurses, practice pharmacists, PCN pharmacists, support from your local prescribing teams and the input of relevant specialist teams, where appropriate, it is hoped that practices will participate in switching to a safer alternative and realising the cost savings. The table below shows the cost of trimipramine compared to other medicines used for the treatment of depression in primary care.

Table 1: Trimipramine and commonly prescribed antidepressants price comparison – Drug Tariff August 2022[12]

*Table compares cost of 28 tablets, but usually more than one trimipramine tablet daily will be prescribed so costs are likely to be higher. Usually the SSRIs are one tablet/capsule daily.[2]

Antidepressant	Cost per 28 tablets/capsules
*Trimipramine 10mg tablets	£179.18
*Trimipramine 25mg tablets	£200.50
*Trimipramine 50mg capsules	£217.50
Citalopram 10mg tablets	£0.75
Citalopram 20mg tablets	£0.84
Citalopram 40mg tablets	£0.96
Escitalopram 5mg tablets	£1.01
Escitalopram 10mg tablets	£1.03
Escitalopram 20mg tablets	£1.26
Fluoxetine 10mg capsules	£33.85
Fluoxetine 10mg tablets	£57.61
Fluoxetine 20mg capsules	£0.72
Fluoxetine 30mg capsules	£2.20
Fluoxetine 40mg capsules	£1.68
Fluoxetine 60mg capsules	£1.84
Fluvoxamine 50mg tablets	£7.98
Fluvoxamine 100mg tablets	£19.58
Mirtazapine 15mg tablets	£1.08
Mirtazapine 30mg tablets	£1.07
Mirtazapine 45mg tablets	£1.32
Paroxetine 10mg tablets	£2.15
Paroxetine 20mg tablets	£1.20
Paroxetine 30mg tablets	£1.41
Paroxetine 40mg tablets	£14.50

Antidepressant	Cost per 28 tablets/capsules
Sertraline 25mg tablets	£15.18
Sertraline 50mg tablets	£0.96
Sertraline 100mg tablets	£1.10
Venlafaxine 37.5mg modified release capsules	£5.25
Venlafaxine 37.5mg modified release tablets	£6.16
Venlafaxine 37.5mg tablets	£0.85
Venlafaxine 75mg modified release capsules	£2.86
Venlafaxine 75mg modified release tablets	£2.43
Venlafaxine 75mg tablets	£1.15
Venlafaxine 150mg modified release capsules	£4.10
Venlafaxine 150mg modified release tablets	£3.64
Venlafaxine 225mg modified release capsules	£47.11
Venlafaxine 225mg modified release tablets	£31.36
Vortioxetine 5mg tablets	£27.72
Vortioxetine 10mg tablets	£27.72
Vortioxetine 20mg tablets	£27.72

Chart 1: Trimipramine and commonly prescribed antidepressants price comparison – Drug Tariff August 2022[12]

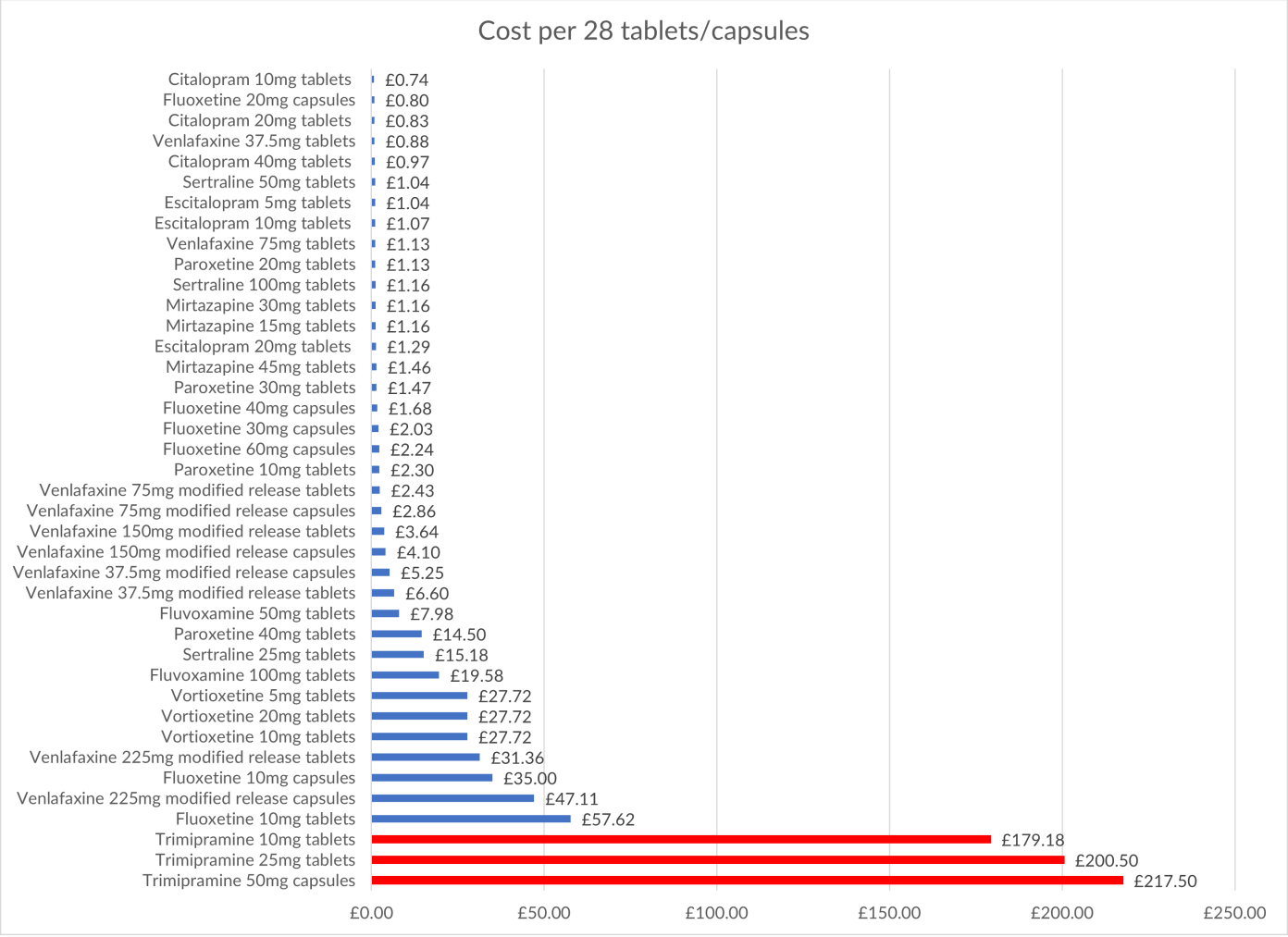
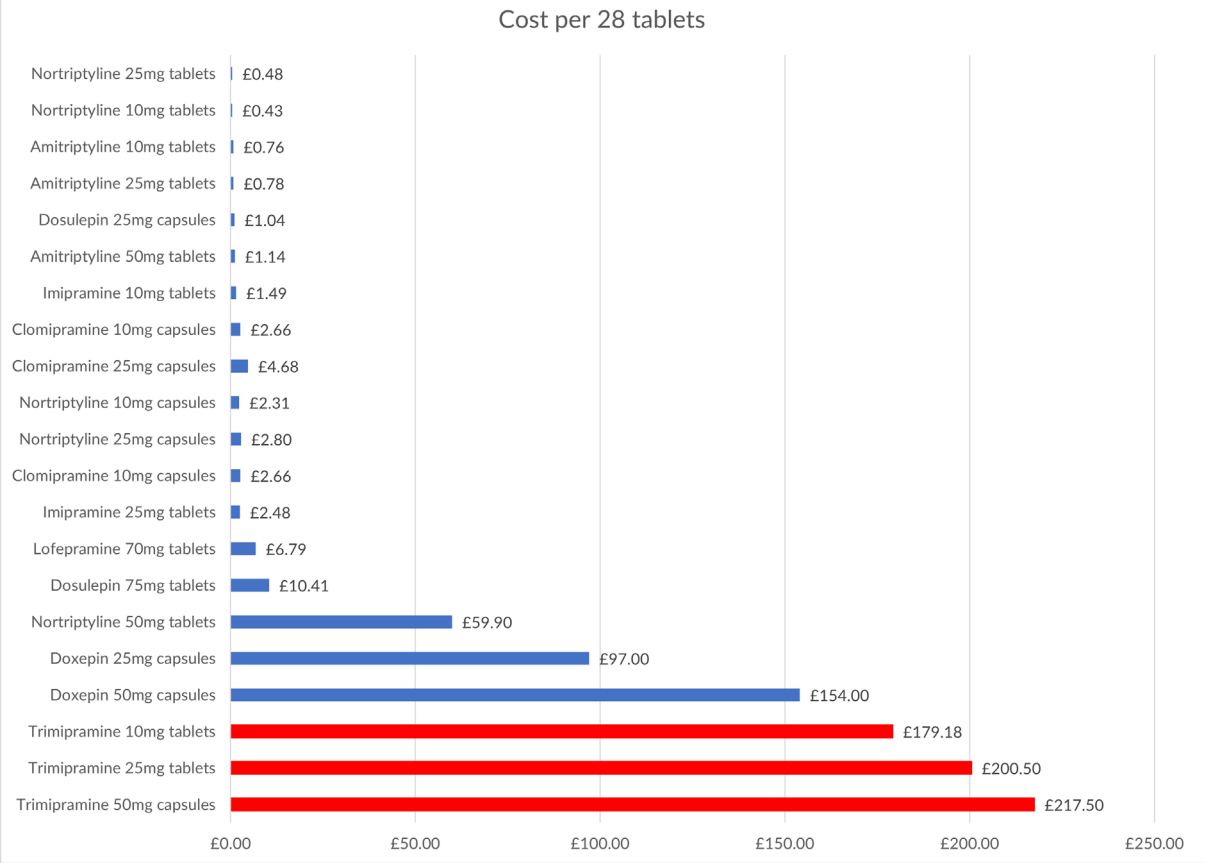


Table 2: Tricyclic antidepressant price comparison – Drug Tariff August 2022[12]

Antidepressant	Cost per 28 tablets
Amitriptyline 10mg tablets	£0.68
Amitriptyline 25mg tablets	£0.68
Amitriptyline 50mg tablets	£1.01
Clomipramine 10mg capsules	£3.16
Clomipramine 25mg capsules	£5.98
Clomipramine 50mg capsules	£9.95
Dosulepin 25mg capsules	£1.03
Dosulepin 75mg tablets	£10.57
Doxepin 25mg capsules	£97.00
Doxepin 50mg capsules	£154.00
Imipramine 10mg tablets	£1.37
Imipramine 25mg tablets	£1.93
Lofepramine 70mg tablets	£6.86
Nortriptyline 10mg capsules	£2.31
Nortriptyline 10mg tablets	£0.63
Nortriptyline 25mg capsules	£2.80
Nortriptyline 25mg tablets	£0.69
Nortriptyline 50mg tablets	£59.90
Trimipramine 10mg tablets	£179.18
Trimipramine 25mg tablets	£200.50
Trimipramine 50mg capsules	£217.50

Chart 2: Tricyclic antidepressant price comparison – Drug Tariff August 2022[12]



Switching options

Stopping or switching may be challenging as patients prescribed trimipramine are likely to be complex patients that have tried many different antidepressants previously and have been taking trimipramine for many years. Work with the local Integrated Care System (England) or Health Board (Scotland, Wales and Northern Ireland) to produce a joint policy with input from secondary care and mental health services to support the review and switch of patients from trimipramine in primary care. The NHS Change Model may also support implementation. This is a framework for any project or programme that is seeking to achieve transformational, sustainable change.[13]

A trial discontinuation of trimipramine should be considered if long term maintenance is no longer considered necessary. Explain to the person that it is usually necessary to reduce the dose in stages over time (called 'tapering') but that most people stop antidepressants successfully. Advise them that withdrawal symptoms do not affect everyone and can vary in type and severity between individuals. Symptoms may include:[4]

- Unsteadiness, vertigo or dizziness
- Altered sensations, e.g. electric shock sensations
- Altered feelings, e.g. irritability, anxiety, low mood, tearfulness, panic attacks, irrational fears, confusion, or very rarely suicidal thoughts
- Restlessness or agitation
- Problems sleeping
- Sweating
- Abdominal symptoms, e.g. nausea
- Palpitations, tiredness, headaches, and aches in joints and muscles.

Explain that withdrawal symptoms can be:[4]

- Mild and may appear within a few days of reducing or stopping antidepressant medication, and usually go away within one to two weeks
- More difficult sometimes, with symptoms lasting longer (in some cases several weeks, and occasionally several months)
- Severe sometimes, particularly if the antidepressant medication is stopped suddenly.

When stopping a person's antidepressant medication take into account:[4]

- The pharmacokinetic profile (for example, the half-life of the medication as antidepressants with a short half-life will need to be tapered more slowly) and the duration of treatment.
- Slowly reduce the dose to zero in a step-wise fashion, at each step prescribing a proportion of the previous dose (for example, 50% of previous dose).
- Consider using smaller reductions (for example, 25%) as the dose becomes lower.
- If, once very small doses have been reached, slow tapering cannot be achieved using tablets or capsules, consider using liquid preparations if available.
- Ensure the speed and duration of withdrawal is led by and agreed with the person taking the prescribed medication, ensuring that any withdrawal symptoms have resolved or are tolerable before making the next dose reduction.
- Take into account the broader clinical context such as the potential benefit of more rapid withdrawal if there are serious or intolerable side effects (for example, hyponatraemia or upper gastrointestinal tract bleeding).

- Take into account that more rapid withdrawal may be appropriate when switching antidepressants
- Recognise that withdrawal may take weeks or months to complete successfully.

Where antidepressant treatment is still indicated, SSRIs are better tolerated and are safer in overdose than other classes of antidepressants and should be considered first-line for treating depression.[2,4] If an SSRI isn't appropriate and an alternative tricyclic antidepressant would be a more suitable alternative, there are more cost-effective TCAs than trimipramine available.[1] Table 2 and chart 2 compare the cost of tricyclic antidepressants, but the following also should be considered when switching:[2]

- Amitriptyline hydrochloride, clomipramine hydrochloride, dosulepin hydrochloride and doxepin have sedative properties.
- Imipramine hydrochloride, lofepramine, and nortriptyline have less sedative properties.
- Lofepramine has a lower incidence of side-effects and is less dangerous in overdosage but is infrequently associated with hepatic toxicity.
- Imipramine hydrochloride is also well established, but has more marked antimuscarinic side-effects than other tricyclic and related antidepressants.
- Amitriptyline hydrochloride and dosulepin hydrochloride are effective but they are particularly dangerous in overdosage and are not recommended for the treatment of depression; dosulepin hydrochloride should be initiated by a specialist.

Bear in mind that tricyclic antidepressants are associated with the greatest risk in overdose of all antidepressant classes and an increased likelihood of the person stopping treatment because of side effects.[4]

The following advice is available from the NICE Clinical Knowledge Summary on depression: How should I switch from one antidepressant to another?[5]

In general:

- When switching from one antidepressant to another, be aware of the need for gradual and modest increases of dose, interactions between antidepressants, and the risk of serotonin syndrome when combinations of serotonergic antidepressants are prescribed. Features of serotonin syndrome include confusion, delirium, shivering, sweating, changes in blood pressure, and myoclonus.
  - » Most severe cases of serotonin syndrome involve an monoamine oxidase inhibitors (including moclobemide) and an SSRI.
- Abrupt withdrawal should generally be avoided when switching from one antidepressant to another.
- Cross tapering is usually preferred. However, in some instances it may be possible to withdraw the current antidepressant and start the new antidepressant on the next day, for example when switching from one SSRI to another SSRI or a SNRI; the exception to this is fluoxetine.

When switching from a tricyclic antidepressant to a different tricyclic or to another type of antidepressant:[5]

- Cross-tapering with a tricyclic antidepressant is inadvisable with paroxetine and fluvoxamine, if necessary it should be done very cautiously.
- Clomipramine is a potent inhibitor of serotonin reuptake and serotonin syndrome is more likely if co-administered with an SSRI or SNRI, cross-tapering is not recommended except under specialist supervision.

Table 2: Switching from a tricyclic antidepressant (except clomipramine)[5]

Switching to:	
TCA (except clomipramine)	Direct switch possible
SSRI (citalopram, escitalopram, paroxetine or sertraline)	Gradually reduce the dose of tricyclic to 25–50mg daily or half the usual dose Start SSRI then slowly withdraw tricyclic over next five to seven days
SNRI (duloxetine, venlafaxine)	Cross-taper cautiously starting with low dose SNRI
Fluoxetine	Halve dose of tricyclic Add fluoxetine and then slowly withdraw tricyclic
Mirtazapine	Cross-taper cautiously
Moclobemide	Taper then stop tricyclic, then wait for one week then start moclobemide
Reboxetine	Cross-taper cautiously
Trazodone	Halve dose of tricyclic, add trazodone and then slowly withdraw tricyclic

For more information see PrescQIPP Bulletin 237. Antidepressants which provides information to support the evidence based, safe and cost-effective choice of antidepressants. Guidance is provided on the prescribing, review and monitoring of antidepressant therapy. Other supporting resources available include a visual data pack, antidepressants patient information leaflet, antidepressant pathway algorithm, initiation and monitoring antidepressant guidance, antidepressant patient information leaflet, audit and a PowerPoint presentation.

Mental health crisis helplines[14]

Patients should be encouraged to contact helplines if in crisis and need to talk to someone who is trained, ready to listen and not judge.

Samaritans	• People can discuss anything that is upsetting them • 24 hours a day, 365 days a year • Call 116 123 (free from any phone), email jo@samaritans.org or visit some branches in person • The Samaritans Welsh Language Line 0808 164 0123 (7pm–11pm every day)
SANEline	• If experiencing a mental health problem or supporting someone else • Call 0300 304 7000 (4pm–10pm every day)
National Suicide Prevention Helpline UK	• Offers a supportive listening service to anyone with thoughts of suicide • Call 0800 689 5652 (6pm-3.30am every day)

Campaign Against Living Miserably (CALM)	• For people who are struggling and need to talk • Call 0800 58 58 58 (5pm–midnight every day) • Webchat service available
The Mix	• For people under 25 • Call 0808 808 4994 (4pm-11pm every day) • Request support by email using this form on The Mix website • Use their crisis text messenger service • Webchat service available (4pm-11pm every day)
Papyrus HOPELINEUK	• For people under 35 and struggling with suicidal feelings or concerned about a young person who might be struggling • Call 0800 068 4141 (9am-midnight every day) or text 07860 039 967, email pat@papyrus-uk.org
Nightline	• For students the Nightline website has details of university or college offering a night-time listening service • Nightline phone operators are all students too
Switchboard	• For people who identify as gay, lesbian, bisexual or transgender • Call 0300 330 0630 (10am–10pm every day), email chris@switchboard.lgbt or use their webchat service (available from 1pm) • Phone operators all identify as LGBT+
Community Advice and Listening Line (C.A.L.L.)	• Mental health helpline offering a confidential listening and support service for people living in Wales. • Call 0800 132 737 (24 hours a day, 365 days a year). • Text 'help' to 81066.
Helplines Partnership	• The Helplines Partnership website has a directory of UK helplines • Mind's Infoline can help to find services for support • If outside the UK, the Befrienders Worldwide website has a tool to search by country for emotional support helplines around the world
Urgent mental health helplines (England only)	• People living in England can call a local NHS urgent mental health helpline for support during a mental health crisis • Anyone can call these helplines, at any time • These helplines offer similar support to a crisis team • The NHS website has more information on urgent mental health helplines, including how to find your local helpline.

Summary

Trimipramine is a tricyclic antidepressant, there is little to choose between the different classes of antidepressant drugs in terms of efficacy. Tricyclic antidepressants have similar efficacy to SSRIs but are more likely to be discontinued because of side-effects and toxicity in overdosage. SSRIs are less sedating and have fewer antimuscarinic and cardiotoxic effects.[2]

The NHS England guidance Items which should not be routinely prescribed in primary care includes trimipramine as a product which is clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation.[1] NICE guideline [NG222] Depression in adults: treatment and management recommends not routinely starting treatment with tricyclic antidepressants, except lofepramine, as they are associated with the greatest risk in overdose.

An SSRI in a generic form is recommended as one of the first-line option for less severe and severe depression when considering prescribing an antidepressant, however antidepressant medication should not routinely offered as first-line treatment for less severe depression, unless that is the person's preference.[4]

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Additional PrescQIPP resources

Briefing	https://www.prescqipp.info/our-resources/bulletins/bulletin-311-trimipramine/
Implementation tools	
Data pack	https://data.prescqipp.info/?pdata.u/#/views/B311_Trimipramine/FrontPage?:iid=1

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