

05 - Clinical guidance

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566 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 5 Depression in children and adolescents Diagnostic issues Approximately 15% of young people experience depression by age 18 years and these young people often have significant functional impairment and risk of harm.¹ Compared with depressed adults, young people with depression tend to experience more irritability, loss of energy, insomnia and weight change, and less anhedonia and concentration problems.² These symptoms can overlap with and appear similar to other disorders or can be minimised and incorrectly attributed to typical teenage development, making diagnosis challenging. Assessments should therefore be undertaken by clinicians who understand developmental variations and can accurately identify depression in young people.³ Clinical guidance For mild depression in children and adolescents, the UK National Institute for Health and Care Excellence (NICE) guidelines⁴ and American Academy of Child and Adolescent Psychiatry (AACAP) practice parameter³ recommend that supportive care or psychological intervention should be considered as first-line treatment, and that antidepressant medication should not be prescribed. For moderate to severe depression in young people, these same guidelines recommend offering psychological therapy, either alone or in combination with antidepressant medication. In addition, the AACAP practice parameter recommends that antidepressant medication alone could be considered, particularly if the presentation is severe and the patient is unable to engage in talking therapy, if psychological interventions are not available or if this is the patient's and family's preference. These guidelines were informed by research evidence for the effectiveness of selective serotonin reuptake inhibitors (SSRIs) in treating depression in young people. For example, a seminal large UK National Institute of Mental Health (NIMH) funded randomised controlled trial (RCT) - the Treatment of Adolescents With Depression Study (TADS)⁵ - found a fluoxetine response rate of 61% over the acute (12-week) phase, which was significantly higher than the placebo response rate of 35%, giving a number needed to treat (NNT) of 4.5 Subsequent systematic reviews and meta-analyses, which include this trial and others, have provided further evidence demonstrating that SSRIs are effective at improving symptoms and functioning, and are largely acceptable treatments for depression in young people. However, several individual studies and systematic reviews studies report less certain effects⁶⁻¹⁰ and a 2021 Cochrane review described antidepressant effects as 'small and unimportant'.¹¹ The current evidence base is unclear about whether SSRI medications alone, psychological therapy alone or combined treatment is most effective for treating depression in children and adolescents. TADS found that fluoxetine alone or in combination with cognitive behavioural therapy (CBT) might accelerate treatment response, and that adding CBT might decrease adverse effects including suicidality, so enhancing the safety of fluoxetine.^{5,12} However, other studies have not replicated this finding,^{13,14} including the Adolescent Depression Antidepressants and Psychotherapy Trial (ADAPT), which found no

benefit in combining fluoxetine with CBT over fluoxetine alone.15 A network

Revision #1

Created 2026-01-04 20:16:30 UTC by Omar Ayman

Updated 2026-01-04 20:16:31 UTC by Omar Ayman