YES

Should young people be given antidepressants?

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Depression and obsessive-compulsive disorder cause considerable distress in young people. These disorders affect emotional, educational, and social development. To deny these vulnerable groups the possibility of receiving antidepressants would be to withhold one of the few evidence based treatments available to them.

There are genuine reasons to question their use. Nevertheless, the evidence indicates that the benefits of these drugs outweigh the risks when used in the appropriate clinical context. I shall focus on the use of selective serotonin reuptake inhibitors (SSRIs) because this is the group of antidepressants for which the evidence in young people is strongest[1] and it is the use of these drugs in depression that has been most controversial.

The criticisms of research into SSRIs include an exaggerated description of efficacy, selective reporting of measures, short follow-up periods, poor reporting of adverse effects, and underplaying the large placebo effects.[2] Participants were mostly recruited by advertising and self referral[3] and common comorbidities, including suicidality, were excluded.[4] In the first half of the decade there was also selective publication of studies with more positive results.[5]

However, objective meta-analysis of the studies shows a significant benefit over placebo for some SSRIs.[1 5] It is not surprising then that the Medicines and Healthcare Regulatory Authority[6] and the National Institute for Health and Clinical Excellence (NICE)[1] both concluded that SSRIs can be used for the treatment of depression in young people. Recent studies without many of the earlier methodological flaws—for example, the adolescent depression antidepressant and psychotherapy trial (ADAPT)[7]—have added further evidence to support the use of SSRIs in treating depression.

So, if the drugs work, what about the risks? Earlier publications tended to play down the risks, particularly that of increased suicidality. When this came to light there was an understandable flurry of adverse publicity. However, a meta-analysis that included previously unpublished studies showed the benefits outweighed the risks, at least for fluoxetine.[5] A more recent meta-analysis confirms an increase in suicide related events in young people with depression taking SSRIs compared with placebo, but the difference is small (4.8% *v* 3%) and there have been no suicides in any of the studies to date.[4] Two studies found a decrease in suicidality with fluoxetine during treatment.[7 8] Overall, although there is an increase in suicidality, the risk is small and can be reduced further by careful monitoring.

Are there other treatments for depression in young people that make the use of antidepressants unnecessary? There is some evidence for the efficacy of psychological treatments such as cognitive behaviour therapy, interpersonal therapy, and family therapy, but the effects are small. The treatment for adolescents with depression study (TADS) suggested that cognitive behaviour therapy alone was no different from placebo and was a significantly poorer treatment than SSRIs alone.[8] NICE, partly in consideration of evidence from TADS that suggested cognitive behaviour therapy combined with SSRI reduced suicidal behaviour, supported the use of psychological therapy as first treatment of moderate or severe depression but was clear that fluoxetine should be offered if the young person does not respond.[1]

Two studies reported since the publication of the NICE guideline have shown no benefit for combined treatment over SSRIs alone.[9 10] In patients with moderate to severe depression ADAPT found no added value in combining cognitive behaviour therapy with fluoxetine.[7] These studies support the case for fluoxetine alone being the treatment of choice for more severe depression.

Antidepressants are also used to treat obsessive-compulsive disorder. NICE included 14 randomised controlled trials in its analysis of the efficacy of SSRIs for obsessive-compulsive disorder in young people.[11] It concluded that the evidence supported the use of SSRIs and recommended fluvoxamine or sertraline, which have been licensed for this disorder. It found no significant increase in suicidal behaviour but, because of remaining uncertainty about risk, recommended cognitive behaviour therapy as the first line treatment. NICE also recommended the use of the tricyclic antidepressant clomipramine if SSRIs are ineffective.

Worrying methodological errors, publication bias, and omissions of evidence in the conduct and reporting of some SSRI trials have rightly alarmed the medical profession and the public. However, careful and objective review of the evidence shows that antidepressants have a place in treating young people with depression or obsessive-compulsive disorder. Parents and young people need to be told the risks and benefits, given advice, and be supported in choosing an evidence based treatment. Removing antidepressants from this choice would take away one of the few potentially effective interventions for these disabling conditions.

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