The most recent practice parameter for the American Academy of Child and Adolescent Psychiatry for depressive disorders in children and adolescents (Birmaher et al., 2007) is listed as historical and not considered to be current. Many recommendations were similar in style to the American Psychiatric Association's practice guideline, focusing on general considerations such as confidentiality, screening, evaluation, phases to include in treatment (i.e., acute and continuation, possibly maintenance), and prevention. It also included some specific treatment recommendations. For children with a brief or uncomplicated depression, it recommended case management, support, and psychoeducation. For children with more complicated depression or who do not respond to supportive psychotherapy, further treatment with psychotherapy or antidepressant medication was recommended. Regarding moderate depression, it recommended either interpersonal psychotherapy or cognitive-behavioral psychotherapy. For severe depression, antidepressant medication is also recommended alone until the child can begin psychotherapy or in combination with psychotherapy from the start. A combination of antidepressant medication and psychotherapy was recommended for children that do not respond to monotherapy of either medication or psychotherapy.

The American Academy of Child and Adolescent Psychiatry's guideline recommendation for interpersonal psychotherapy or CBT is similar to the American Psychological Association guideline's recommendation for interpersonal psychotherapy (adapted for adolescents) or CBT treatment. The American Academy of Child and Adolescent Psychiatry guideline also cautiously recommends certain antidepressant medications (selective serotonin reuptake inhibitors) and suggests combination of treatment may be warranted with more severe clinical presentations. The APA guideline recommendations, however, do not address combination treatment of psychotherapy and antidepressant medication for children/adolescents. However, it should be noted that the Treatment of Adolescent Depression (TADS) study is the largest study to date examining adolescents with persistent and impairing major depression. This study compared CBT as a standalone intervention to antidepressant medication (fluoxetine), the combination of CBT and medication, and a placebo sugar pill across 13 sites and included over 400 adolescents (March et al., 2004). The study concluded that combination treatment of fluoxetine and CBT resulted in significantly better outcomes than CBT or fluoxetine alone (March et al., 2004). A more recent evidence-based update examined psychosocial interventions for the treatment of child and adolescent depression (Weersing, Jeffreys, Do, Schwartz, & Bolano, 2016). This study concluded that both CBT and interpersonal psychotherapy are well-established interventions (though they have limited evidence for racially diverse youth), with evidence of efficacy in multiple trials by independent investigative teams. However, the conclusion is tempered by the smaller number of studies for interpersonal psychotherapy adapted for adolescents (IPT-A) and the concern that the effects of CBT may be diminished when applied to populations with more comorbidity and diversity of ethnicity and socioeconomic status, and when compared to active treatments (Weersing et al., 2016). While informative, the panel did not find these studies to yet warrant recommendations regarding combined treatment for children and adolescents and desires more comparative effectiveness and combined treatment research.

The guideline for treating depression in adults from the Kaiser Permanente Care Management Institute (2012) recommends either antidepressant medication or psychotherapy (cognitive-behavioral therapy, interpersonal psychotherapy, or problem-solving therapy) as first line treatments for patients whose major depressive disorder is mild to moderate, with consideration given to patient and clinician preferences, medication side effects, and cost. A combination of antidepressant medication and psychotherapy (cognitive-behavioral therapy, interpersonal psychotherapy, or problem-solving therapy) is recommended for patients with chronic or severe major depressive disorder. According to that guideline, the following medication classes can be used as first line treatment: tricyclics, selective serotonin reuptake inhibitor (SSRI), serotonin–norepinephrine reuptake inhibitor (SNRI), norepinephrine reuptake inhibitor (NRI), or dopamine agonist, based on patient and clinician preferences, medication side effects, and cost. The Kaiser guideline does not recommend for or against St. John's Wort (hypericum) for mild to moderate major depressive disorder but recommends against St. John's Wort for severe major depressive disorder. The Kaiser guideline recommends consulting with specialized behavioral health providers for those patients with suicidal ideation, plans, intent, or previous suicide attempts.

The Kaiser guideline goes on to discuss second line treatments for those patients who continue to have symptoms after first line treatment. These second line treatment recommendations include an examination of adherence to treatment, and options such as combining treatments, increasing antidepressant dosage, and switching treatments. The Kaiser guideline recommends against augmenting with pindolol but does not recommend for or against providing atypical antipsychotics or inositol or folate as second line treatments.

APA's guideline also recommends that certain treatment approaches might be considered or applied first (i.e., psychotherapy or pharmacotherapy for adults) and then suggests other options (i.e., complementary and alternative treatments for adults) if the first options are not available or acceptable. Both the APA and Kaiser guidelines recommend consideration of patient culture, values and preferences, and medication side effects. The APA guideline was frequently unable to recommend a specific antidepressant medication over another treatment due to insufficient evidence, though did recommend a combination of antidepressant medication and psychotherapy versus antidepressant medication alone in some cases.

The focus of the Veteran's Affairs/Department of Defense (2016) guideline is on adults with major depressive disorder being treated in the Veteran's Affairs/Department of Defense setting. Recommendations from this guideline include the domains of identification, assessment and triage, treatment setting, and management. The management recommendations for adults are the closest in content scope to APA's guideline. First line psychotherapy treatments recommended by the guideline for mild to moderate major depressive disorder include: acceptance and commitment therapy, behavioral therapy/behavioral activation, cognitive-behavioral therapy, interpersonal psychotherapy, mindfulness-based