National Trends in the Prevalence and Treatment of Depression in Adolescents and Young Adults

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OBJECTIVES: This study examined national trends in 12-month prevalence of major depressive episodes (MDEs) in adolescents and young adults overall and in different sociodemographic groups, as well as trends in depression treatment between 2005 and 2014.

METHODS: Data were drawn from the National Surveys on Drug Use and Health for 2005 to 2014, which are annual cross-sectional surveys of the US general population. Participants included 172,495 adolescents aged 12 to 17 and 178,755 adults aged 18 to 25. Time trends in 12-month prevalence of MDEs were examined overall and in different subgroups, as were time trends in the use of treatment services.

RESULTS: The 12-month prevalence of MDEs increased from 8.7% in 2005 to 11.3% in 2014 in adolescents and from 8.8% to 9.6% in young adults (both \( P < .001 \)). The increase was larger and statistically significant only in the age range of 12 to 20 years. The trends remained significant after adjustment for substance use disorders and sociodemographic factors. Mental health care contacts overall did not change over time; however, the use of specialty mental health providers increased in adolescents and young adults, and the use of prescription medications and inpatient hospitalizations increased in adolescents.

CONCLUSIONS: The prevalence of depression in adolescents and young adults has increased in recent years. In the context of little change in mental health treatments, trends in prevalence translate into a growing number of young people with untreated depression. The findings call for renewed efforts to expand service capacity to best meet the mental health care needs of this age group.
The risk of depression sharply rises as children transition to adolescence.1 In the US National Comorbidity Survey (NCS)-Adolescent Supplement of 2001 to 2004, 11.7% of adolescents 13 to 18 years of age met criteria for a lifetime major depressive disorder or dysthymia.1 Reports of increasing antidepressant medication use by adolescents before the Food and Drug Administration (FDA) 2003 black-box warning2,3 and indirect evidence of increased lifetime prevalence of major depressive disorder in successive birth cohorts4 have raised concerns about increasing prevalence of depression among adolescents. Yet, there is little direct information from the United States on national trends in prevalence of depression in adolescents and young adults.

Studies of trends in depression from other industrialized countries have produced mixed results.5 Although studies based on rating scales of depressive symptoms showed an increasing trend over the past 3 decades,6-13 a 2006 meta-analysis of 26 epidemiologic studies on rates of current depressive disorder among adolescents found no significant change between the mid-1960s and mid-1990s.14 A more recent study15 found a declining prevalence of severe impairment among US adolescents from 1996–1998 to 2010–2012.15 However, this study did not assess trends in specific disorders and was based on parent reports.

Examining temporal trends in prevalence of depression among young people has implications for evaluating whether they have benefited from increasing use of mental health treatments.16 Characterization of national trends in depressive disorders and their treatment could also inform community efforts to improve access to mental health services for young people. In the current study, we used data from the 2005 to 2014 National Surveys on Drug Use and Health (NSDUH) on adolescents and young adults to examine trends in 12-month major depressive episodes (MDEs), controlling for sociodemographic characteristics and substance use disorders. We further examined trends in prevalence of MDEs in different sociodemographic groups and trends in mental health service use among adolescents and young adults with MDEs. The study period covers years following the FDA black-box warning regarding antidepressant use in youth.

Stratified regression analyses are examined for trends in prevalence according to sex, race/ethnicity, age, income group, and substance use disorders. Trends in service use also are evaluated by type of provider, type of setting, use of psychiatric medications, continuation of treatment, and perceived helpfulness of treatments.

METHODS

Sample

The NSDUH is a cross-sectional annual survey of the US population in all 50 states and the District of Columbia sponsored by Substance Abuse and Mental Health Services Administration. It provides nationally representative data on MDE and its treatment among the civilian noninstitutionalized population aged 12 or older. Persons without a household address (eg, homeless persons not living in shelters), active-duty military, and institutional residents are excluded. Interviews are conducted by using computer-assisted interviewing. The NSDUH data collection protocol was approved by the institutional review board at RTI International (Research Triangle Park, NC). NSDUH oversamples adolescents and young adults.

Overall, 176,245 adolescents aged 12 to 17 and 180,459 adults aged 18 to 25 were interviewed in the NSDUH 2005 to 2014 and their data are available in public use files. The annual mean weighted response rate of the 2005 to 2014 NSDUH was 65.2%17 according to Response Rate 2 of the American Association for Public Opinion Research.18 Of those interviewed, 172,495 (98.9%) adolescents and 178,755 (99.1%) young adults responded to structured interview questions for 12-month MDE and comprised the study samples.

Assessments

Lifetime and 12-month MDE were assessed using a structured interview based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria. Participants were next asked whether they had experienced an episode in the past year. Questions were adapted from the depression section of the NCS-Replication.4 Although the validity of the NSDUH major depressive disorder instrument has not been assessed, the validity of the NCS-Replication in adults and adolescents has been assessed.11,16 In a test-retest reliability study of NSDUH interviews, the κ values for the of past-year MDE ranged from 0.52 in adults to 0.72 in adolescents,19 representing “moderate” to “substantial agreement,” respectively.20

Treatments for depression were assessed by asking whether during the past 12 months participants had seen or talked to a medical doctor or other professional about their depressive symptoms. Types of professionals were aggregated into mental health providers (psychologist, psychiatrist, or psychotherapist; social worker; counselor, other mental health professional), general medical providers (general practitioner or family doctor; other medical doctor; a nurse, occupational therapist, or other health professional), and complementary/alternative medicine
Treatment seeking for any mental health problems was assessed differently in adolescents and young adults. All adolescent participants were asked if they had received care for “emotional or behavioral problems that were not caused by alcohol or drugs.” Similarly, all adult participants were asked if they had received treatment or counseling for “problems with emotions, nerves or mental health,” excluding treatment of alcohol or drug use. We limited the analyses of these questions to participants with 12-month MDE.

Substance use disorder ratings were based on individual diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition on past 12-month abuse and dependence of alcohol, marijuana, and other drugs (including cocaine, hallucinogens, heroin, inhalants, non–medically used prescription pain relievers, sedatives, tranquilizers, or stimulants). Substance use disorders were categorized into alcohol use disorder only, cannabis use disorder (without alcohol use disorder), other drug use disorder (without alcohol use disorder), and any drug use disorder with alcohol use disorder.

Information also was collected on participant age, sex, race/ethnicity, annual family income, student status, parents in the household (for adolescents), employment status (for those aged 14+) and marital status (adults).

**Statistical Analyses**

Analyses were conducted in 3 stages. First, trends in the prevalence of 12-month MDE across the 10 years of NSDUH were assessed by using adjusted binary logistic regression models. The adjusted model included sociodemographic variables and substance use disorders in addition to the survey year variable. Because the association between survey year and 12-month MDE did not appear to be linear in preliminary analyses, the mvrS routine of Stata 14 (Stata Corp, College Station, TX) for regression spline was used to fit the data (see Supplemental Information).

Second, we conducted stratified analyses and interaction tests to examine whether the observed trends in 12-month MDE were consistent across major sociodemographic groups. The transformed predictor variables obtained in the first stage of the analyses were used as predictors in the stratified analyses.

In the third stage, we examined trends in depression treatment overall and by provider type and setting by using binary logistic models. Trends in perceived helpfulness of treatments were similarly assessed. These analyses were limited to respondents with 12-month MDE. In addition to sociodemographics and substance use disorders, these models adjusted for health insurance coverage and receipt of substance use disorder treatment.

All analyses were conducted by using Stata 14, taking into account the complex survey design and sampling weights of NSDUH; α was set at P < .01.

**RESULTS**

Of the 172,495 adolescents and 178,755 young adults who responded to 12-month MDE questions, 15,529 (8.7%) and 15,603 (8.6%), respectively, met criteria for 12-month MDE. Background characteristics by MDE are presented in Supplemental Table 4. In comparison with adolescents without MDE, those with MDE included a disproportionate number of older adolescents, nonstudents, unemployed individuals, adolescents from households with no parents or with single parents, and adolescents with substance use disorders.

Adolescents with MDE also were less

(CAM) providers (eg, a religious or spiritual advisor; alternative healers, such as an herbalist). Participants were next asked if they were currently receiving treatment or counseling. In addition, participants were asked if during the past 12 months they had taken medication that was prescribed for their depression and whether they were taking such medication at the time of interview. Two further questions assessed how much treatment or counseling had helped and how much prescription medication had helped, with responses ranging from “not at all” to “extremely.” Questions regarding treatment of depression were asked only among participants with positive responses to the MDE questions.
likely to be boys than girls and non-Hispanic black than non-Hispanic white (Supplemental Table 4). The sociodemographic correlates of MDE in young adults were somewhat similar to those in adolescents. Compared with young adults without MDE, those with 12-month MDE were proportionately less likely to be men and non-Hispanic black compared to non-Hispanic white and more likely to have a substance use disorder. Young adults with 12-month MDE were also more likely to be unemployed or employed part-time, compared to employed full-time; widowed, divorced or separated, or never married, compared to married or living as married; and less likely to have an annual family income of $20,000 to $75,000, compared to <$20,000 (Supplemental Table 4).

In adolescents, the prevalence of 12-month MDE was stable over the 2005 to 2011 period; however, it gradually increased in later years (Fig 1), growing from 8.7% (2005) to 11.3% (2014) corresponding to a 37% increase in odds (odds ratio [OR] 1.37, 95% confidence interval [CI] 1.27–1.48, \( P < .001 \)). These proportions translate into an increase of more than a half million adolescents with 12-month MDE between 2005 (approximately 2,200,000) and 2014 (approximately 2,700,000). The change was more modest for the young adult group: from 8.8% to 9.6% (OR 1.13, 95% CI 1.05–1.22, \( P = .001 \)).

A spline regression model with 2 basis functions provided the best-fitting model for both adolescents and young adults (see Supplemental Information). These transformed predictors were used in the regression models, the results of which are presented in Table 1.

For adolescents, a similar increasing trend was observed across age, income, and substance use disorder strata (Table 1); however, the trend was somewhat stronger among girls than boys, with the interaction test approaching significance (\( P = .020 \)). Among girls, the prevalence of 12-month MDE increased from 13.1% (2004) to 17.3% (2014); whereas, among boys the prevalence increased from 4.5% (2004) to 5.7% (2014) (Table 1). Furthermore, the increasing trend was smaller and statistically nonsignificant in non-Hispanic black adolescents, although the interaction test for race/ethnicity was not statistically significant (Table 1).

Among young adults, the increasing trend in prevalence of 12-month MDE was limited to those in the 18 to 20 age range (Table 1). The prevalence did not appreciably change in the 21 to 25 age range. The interaction test with age group was statistically significant (\( P < .01 \)). Furthermore, the trend was statistically significant only among the non-Hispanic whites. However, the interaction test with race/ethnicity only approached a trend-level statistical significance (\( P = .012 \)).

The proportion of adolescents with 12-month MDE who received mental health counseling or treatment in the past 12 months for their depression from any type of provider did not significantly change over the 2005 to 2014 period (Table 2). However, a larger proportion of adolescents with 12-month MDE reported care from specialty mental health providers, in private mental health care settings, in inpatient or day treatment settings, and in multiple settings. Furthermore, adolescents with 12-month MDE who had received any treatment or counseling in the past year were more likely in recent years to report being currently in treatment. A larger proportion of adolescents with 12-month MDE also reported receiving prescription medication for their depression in recent years. There was no significant trend in the percentage of adolescents who perceived treatment overall or medication treatment as helpful (Table 2).

There were fewer statistically significant changes in treatment seeking over time among young adults (Table 3). Only the proportion of young adults with 12-month MDE who received depression care from specialty mental health care providers increased significantly over the study period.

**DISCUSSION**

Each year almost 1 in 11 adolescents and young adults have an MDE. The prevalence of these episodes increased between 2005 and 2014. The trend was limited to those in the 12 to 20 age range, and was somewhat more prominent among non-Hispanic whites than minority groups and among adolescent girls than boys.

Adjusting the analyses for sociodemographic and household factors that have been previously found to be associated with adverse mental health outcomes in...
**TABLE 1**

Trends in 12-Month MDEs in Adolescents (n = 172,495) and Young Adults (n = 178,755) in the United States, Stratified According to Major Sociodemographic Groups

<table>
<thead>
<tr>
<th>Year</th>
<th>All adolescent participants</th>
<th>Age, y</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>Family Income, $</th>
<th>12-mo Substance Use Disorder</th>
<th>Alcohol Use Disorder</th>
<th>Cannabis Use Disorder</th>
<th>Other Drug Use Disorder</th>
<th>Drug Use Disorder With Alcohol Use Disorder</th>
<th>No Substance Use Disorder</th>
</tr>
</thead>
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<tr>
<td>2005</td>
<td>8.7</td>
<td>8.0</td>
<td>8.2</td>
<td>8.4</td>
<td>8.0</td>
<td>8.0</td>
<td>8.3</td>
<td>9.3</td>
<td>9.9</td>
<td>10.6</td>
<td>9.9</td>
</tr>
<tr>
<td>2006</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>9.3</td>
<td>9.3</td>
<td>9.9</td>
<td>10.6</td>
<td>9.9</td>
</tr>
<tr>
<td>2007</td>
<td>8.3</td>
<td>9.0</td>
<td>8.4</td>
<td>9.3</td>
<td>8.5</td>
<td>8.5</td>
<td>8.6</td>
<td>9.9</td>
<td>9.9</td>
<td>10.6</td>
<td>9.9</td>
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<tr>
<td>2008</td>
<td>8.4</td>
<td>9.1</td>
<td>8.0</td>
<td>8.4</td>
<td>9.0</td>
<td>9.0</td>
<td>9.1</td>
<td>8.5</td>
<td>9.9</td>
<td>10.6</td>
<td>9.9</td>
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<tr>
<td>2009</td>
<td>8.0</td>
<td>9.1</td>
<td>8.5</td>
<td>8.5</td>
<td>8.7</td>
<td>8.7</td>
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<td>8.9</td>
<td>9.9</td>
<td>10.6</td>
<td>9.9</td>
</tr>
<tr>
<td>2010</td>
<td>8.0</td>
<td>9.1</td>
<td>8.3</td>
<td>8.5</td>
<td>8.7</td>
<td>8.7</td>
<td>9.9</td>
<td>8.9</td>
<td>9.9</td>
<td>10.6</td>
<td>9.9</td>
</tr>
<tr>
<td>2011</td>
<td>8.3</td>
<td>9.3</td>
<td>8.3</td>
<td>8.5</td>
<td>9.0</td>
<td>9.0</td>
<td>8.9</td>
<td>8.9</td>
<td>9.9</td>
<td>10.6</td>
<td>9.9</td>
</tr>
<tr>
<td>2012</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>2013</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
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</tr>
<tr>
<td>2014</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
</tbody>
</table>

**Note:** All values are percentages. Significance levels are based on Wald tests and are reported as exact two-tailed p values. Significant p values are indicated in bold.

**Main Effect:** Wald test

**Interaction:** Wald test

**All adolescent participants:**
- Age, y: 12–13
- 14–15
- 16–17
- Sex: Girls
- Boys
- Race/Ethnicity: Non-Hispanic white
- Non-Hispanic black
- Hispanic
- Non-Hispanic other
- Family income, $:
  - <20,000
  - 20,000–49,999
  - 50,000–74,999
  - 75,000+
- 12-mo substance use disorder: Alcohol use disorder
- Cannabis use disorder
- Other drug use disorder
- Drug use disorder with alcohol use disorder
- No substance use disorder

**All young adult participants:**
- Age, y: 18–20
- 21–25
- Sex: Women
- Men
- Race/Ethnicity: Non-Hispanic white
- Non-Hispanic black
- Hispanic
- Non-Hispanic other
- Family income, $:
  - <20,000
  - 20,000–49,999
  - 50,000–74,999
  - 75,000+
- 12-mo substance use disorder: Alcohol use disorder
- Cannabis use disorder
- Other drug use disorder
- Drug use disorder with alcohol use disorder
- No substance use disorder

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TABLE 1 Continued

<table>
<thead>
<tr>
<th>Percent of Participants in Each Survey Year Meeting Criteria for 12-mo MDEs</th>
<th>Main Effect&lt;sup&gt;a&lt;/sup&gt;,&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Interaction&lt;sup&gt;c&lt;/sup&gt;</th>
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</thead>
<tbody>
<tr>
<td>Other drug use disorder</td>
<td>24.8</td>
<td>19.4</td>
</tr>
<tr>
<td>Drug use disorder with alcohol use disorder</td>
<td>18.3</td>
<td>21.0</td>
</tr>
<tr>
<td>No substance use disorder</td>
<td>7.1</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Data source: The 2005–2014 NSDUH.
<sup>a</sup> Adjusted for age, sex, race/ethnicity, income, student status, presence of parents in household and substance use disorders in analyses for adolescents and for age, sex, race/ethnicity, income, marital status, employment, student status, and substance use disorders in analyses for young adults.
<sup>b</sup> Adjusted Wald F test for the predictors from the logistic regression model. In these models, 12-mo MDE was parameterized by a regression spline with 2 basis functions and 1 knot automatically selected at position 8 on the predictor variable (corresponding to year 2012) in adolescents and a regression spline with 2 basis functions and 1 knot automatically selected at position 3 (corresponding to year 2007) in young adults (see Appendix 1 for detail).
<sup>c</sup> Based on adjusted Wald F test for the interaction of each variable with the predictors from the spline regression model.
<sup>d</sup> Interaction tests examine variations in trend among subgroups and cannot be computed for whole group.
<table>
<thead>
<tr>
<th>Participant Groups</th>
<th>Survey Year</th>
<th>Test of Temporal Trend</th>
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<tbody>
<tr>
<td>Treatment seeking for any mental health problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of provider seen for depression care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty mental health</td>
<td>30.0 29.1 30.6 29.3 27.3 29.5 30.6 30.5 30.2 34.3 1.14 0.96–1.36 .043</td>
<td></td>
</tr>
<tr>
<td>General medical</td>
<td>10.2 10.4 12.3 11.3 9.7 10.5 11.5 10.3 9.8 11.7 1.14 0.77–1.40 .740</td>
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<tr>
<td>CAM</td>
<td>3.9 7.4 6.0 6.5 4.1 5.5 6.6 5.3 4.3 5.7 0.80 0.49–1.30 .227</td>
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<tr>
<td>Any type of provider</td>
<td>34.3 36.1 36.1 34.4 32.4 35.8 36.0 35.0 34.2 38.6 1.14 0.95–1.34 .127</td>
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<tr>
<td>Treatment setting for depression care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private mental health care provider</td>
<td>21.3 23.7 23.7 22.7 18.0 22.8 21.5 23.2 24.3 28.0 1.33 1.08–1.64 &lt;.001</td>
<td></td>
</tr>
<tr>
<td>Mental health clinic</td>
<td>8.1 7.6 7.6 7.4 6.6 7.8 7.7 7.7 8.5 10.8 1.39 1.00–1.93 .010</td>
<td></td>
</tr>
<tr>
<td>Day treatment</td>
<td>3.6 4.1 4.4 3.0 3.1 3.6 5.3 5.3 5.3 5.8 1.58 1.05–2.44 .006</td>
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<tr>
<td>Inpatient</td>
<td>3.1 2.8 3.0 3.3 3.6 3.1 3.4 3.2 3.5 5.5 1.78 1.15–2.90 .001</td>
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<tr>
<td>Residential</td>
<td>2.1 2.3 1.5 1.3 1.5 1.7 2.1 2.8 1.9 3.2 1.81 0.92–3.58 .242</td>
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<tr>
<td>In home</td>
<td>5.5 6.7 6.3 7.4 5.4 5.7 6.0 7.5 5.6 7.9 1.25 0.85–1.82 .132</td>
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<tr>
<td>School counseling</td>
<td>a</td>
<td></td>
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<tr>
<td>Multiple settings</td>
<td>11.4 12.9 12.7 12.7 10.6 12.4 12.5 14.2 14.1 17.1 1.52 1.15–2.00 &lt;.001</td>
<td></td>
</tr>
<tr>
<td>Use of prescription medication for depression</td>
<td></td>
<td></td>
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<tr>
<td>Currently receiving treatment or counseling</td>
<td>16.5 14.8 17.8 15.5 14.1 16.2 15.3 15.8 16.9 20.0 1.31 1.02–1.68 .006</td>
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<tr>
<td>Currently taking prescription medication</td>
<td></td>
<td></td>
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<tr>
<td>Treatment or counseling helpful</td>
<td>32.9 35.2 33.9 36.7 36.4 36.6 38.1 37.9 36.1 36.1 1.10 0.88–1.47 .367</td>
<td></td>
</tr>
<tr>
<td>Prescription medication helpful</td>
<td>47.2 45.9 43.9 44.3 43.4 44.1 44.0 47.1 43.6 37.7 0.84 0.56–1.26 .261</td>
<td></td>
</tr>
</tbody>
</table>

Data source: The 2005–2014 NSDUH.

AOR, adjusted OR. ORs and AORs were estimated in binary logistic regressions with the variable of survey year transformed to a variable ranging from 0 (for 2005) and 1 (for 2014). Thus, AORs represent change in odds over the whole study period. Variables of age, sex, race/ethnicity, student status, family income, parents' presence in the household, substance use disorders, substance use treatment and any health insurance were included in the models.

a Questions regarding school counseling in NSDUH changed in 2009. As a result, data on school counseling for years 2005-2008 were not included in the analysis of temporal trends for this type of care.

b Includes any combinations of private mental health provider, mental health clinic, day hospital, inpatient, residential, and in-home settings.

c Among participants who received any counseling or therapy for depression in the past year.

d Among participants who took any prescription medication for depression in the past year.
have been efforts by a number of professional bodies, most notably the American Academy of Pediatrics Task Force on Mental Health, to promote diagnosis and management of depression and other common mental disorders in pediatric settings and to provide resources for practice enhancements, such as diagnostic guidelines. With the wider adoption of the medical home model under the Affordable Care Act, integrative approaches to depression treatment in pediatric primary care will likely increase.

The increasing use of inpatient and day treatment settings over the 2005 to 2014 period may reflect greater intensity of treatment of adolescents. These trends may be related to enhanced mental health coverage in recent years after parity legislation, which may also explain greater continuity in treatment in more recent years. However, these findings need to be corroborated in future studies, especially with regard to increased inpatient treatment that was most prominent in 2014.

The findings should be interpreted in the context of several limitations. Most notably, the study was based on self-reports by adolescents and may not correspond with parent, teacher, or clinical assessments. Variations in sources of information would likely affect estimates of prevalence of disorders, but are unlikely to affect temporal trends. Furthermore, self-reports may be more sensitive that parental reports for capturing internalizing disorders such as depression. A second limitation is that NSDUH assessed only MDE. Temporal trends in prevalence of other common mental disorders in these age groups may be different. The findings should be interpreted in the context of these limitations.

## CONCLUSIONS

In the context of these limitations, this study provides useful information for practice enhancements, such as diagnostic guidelines, with the wider adoption of the medical home model under the Affordable Care Act, integrative approaches to depression treatment in pediatric primary care will likely increase.

### Table 3: Trends in Treatment Seeking in Young Adults With 12-Month MDEs in the United States (n = 15603)

<table>
<thead>
<tr>
<th>Participant Groups</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>AOR</th>
<th>99% CI</th>
<th>P</th>
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<tbody>
<tr>
<td>Treatment seeking for any mental health problems</td>
<td>28.2</td>
<td>24.9</td>
<td>25.6</td>
<td>25.2</td>
<td>29.2</td>
<td>27.1</td>
<td>28.9</td>
<td>29.0</td>
<td>28.8</td>
<td>29.7</td>
<td>1.13</td>
<td>0.92–1.39</td>
<td>.131</td>
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<td>Type of provider seen for depression care</td>
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<td>Specialty mental health</td>
<td>30.8</td>
<td>29.1</td>
<td>27.2</td>
<td>27.5</td>
<td>29.7</td>
<td>31.7</td>
<td>31.9</td>
<td>32.6</td>
<td>35.4</td>
<td>34.1</td>
<td>1.26</td>
<td>1.03–1.53</td>
<td>.003</td>
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<td>General medical</td>
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<td>23.4</td>
<td>22.8</td>
<td>21.1</td>
<td>22.5</td>
<td>22.7</td>
<td>20.7</td>
<td>23.4</td>
<td>19.1</td>
<td>22.4</td>
<td>0.91</td>
<td>0.75–1.10</td>
<td>.206</td>
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<td>CAM</td>
<td>10.2</td>
<td>7.8</td>
<td>7.8</td>
<td>8.7</td>
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<td>9.0</td>
<td>8.1</td>
<td>8.8</td>
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<td>9.8</td>
<td>1.06</td>
<td>0.74–1.53</td>
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<tr>
<td>Any type of provider</td>
<td>44.8</td>
<td>43.2</td>
<td>41.2</td>
<td>40.5</td>
<td>43.5</td>
<td>45.8</td>
<td>44.0</td>
<td>46.5</td>
<td>45.6</td>
<td>46.1</td>
<td>1.15</td>
<td>0.94–1.35</td>
<td>0.84</td>
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<tr>
<td>Use of prescription medication for depression</td>
<td>30.9</td>
<td>29.7</td>
<td>29.4</td>
<td>27.9</td>
<td>31.5</td>
<td>31.8</td>
<td>30.1</td>
<td>31.2</td>
<td>31.2</td>
<td>31.8</td>
<td>1.09</td>
<td>0.90–1.32</td>
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<td>Currently receiving treatment or counseling</td>
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<td>39.5</td>
<td>45.0</td>
<td>43.0</td>
<td>48.1</td>
<td>46.4</td>
<td>48.1</td>
<td>41.8</td>
<td>45.2</td>
<td>52.9</td>
<td>1.25</td>
<td>0.95–1.64</td>
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<td>Currently taking prescription medication</td>
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<td>68.8</td>
<td>72.1</td>
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<td>69.4</td>
<td>64.1</td>
<td>65.1</td>
<td>73.3</td>
<td>1.34</td>
<td>0.94–1.89</td>
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<td>Treatment or counseling helpful</td>
<td>40.4</td>
<td>32.2</td>
<td>34.6</td>
<td>37.1</td>
<td>40.2</td>
<td>39.0</td>
<td>39.6</td>
<td>39.9</td>
<td>40.4</td>
<td>40.3</td>
<td>1.19</td>
<td>0.91–1.54</td>
<td>.091</td>
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<td>Prescription medication helpful</td>
<td>45.8</td>
<td>43.4</td>
<td>52.5</td>
<td>48.1</td>
<td>49.3</td>
<td>49.3</td>
<td>49.8</td>
<td>47.2</td>
<td>47.9</td>
<td>51.1</td>
<td>1.15</td>
<td>0.83–1.51</td>
<td>.267</td>
</tr>
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</table>

Data source: The 2005–2014 NSDUH. AOR, adjusted OR. ORs and AORs were estimated in binary logistic regressions with the variable of survey year transformed to a variable ranging from 0 (for 2005) and 1 (for 2014). Thus, AORs represent change in odds over the whole study period.

a Among participants who received any counseling or therapy for depression in the past year.

b Among participants who took any prescription medication for depression in the past year.

c Among participants who received any counseling or therapy for depression in the past year. Helpful was defined as reporting that treatment or counseling helped “a lot” or “extremely.”

d Among participants who took any prescription medication for depression in the past year. Helpful was defined as reporting that prescription medication helped “a lot” or “extremely.”

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information on temporal trends in 12-month MDE and treatment of depression based on large and nationally representative samples of adolescents and young adults. Prevention, early detection, and treatment of depression and other common mental disorders in these age groups are major goals of public mental health initiatives. Yet adaptation and broad implementation of effective treatment and prevention programs remains a challenge. The growing number of depressed adolescents and young adults who do not receive any mental health treatment for their MDE calls for renewed outreach efforts, especially in school and college health and counseling services and pediatric practices where many of the untreated adolescents and young adults with depression may be detected and managed.

**REFERENCES**


**ABBREVIATIONS**

- CAM: complementary/alternative medicine
- CI: confidence interval
- FDA: Food and Drug Administration
- MDE: major depressive episodes
- NCS: National Comorbidity Survey
- NSDUH: National Survey on Drug Use and Health
- OR: odds ratio

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HHS Publication No. SMA 09-4425


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Ramin Mojtabai, Mark Olfson and Beth Han

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