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Mental Health Disparities Among College Students of Color

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A B S T R A C T

Purpose: Understanding the mental health needs of students of color is a growing priority on college and university campuses nationwide. This study aims to capture the state of mental health among students of color, including the prevalence of mental health problems and treatment utilization.
Methods: The sample is comprised of 43,375 undergraduate and graduate students at 60 institutions that participated in the survey-based Healthy Minds Study from 2012 to 2015. These data include over 13,000 students of color; we look separately at African-American, Latinx, Asian/Asian American, and Arab/Arab American students. Data are analyzed at the individual level using bivariate and multivariate modeling to elucidate variations across race/ethnicity. We examine symptom prevalence (measured by validated screens such as the Patient Health Questionnaire-9 for depression), help-seeking behaviors, and related factors (including knowledge and stigma).
Results: Across race/ethnicity, we find modest variation in symptom prevalence and larger variation in service utilization. Overall, treatment use is lower among students of color relative to white students, even when controlling for other variables in regression models. Asian/Asian American students have the lowest prevalence of treatment, at only 20% among those with apparent mental health conditions. Attitudes related to mental health treatment also vary significantly and help to explain the primary findings.
Conclusions: College students of color represent a disparities population based on greater levels of unmet mental health needs relative to white students. This paper takes an important step toward understanding these needs and points to implications for future research and practice.

IMPLICATIONS AND CONTRIBUTION

This study describes the prevalence of mental health problems and treatment utilization among college students of color. Results indicate that students of color represent a disparities population based on greater unmet mental health needs relative to white students.

Mental health and mental health service utilization are important issues to examine in the increasingly diverse landscape of U.S. higher education. There are over 17 million students enrolled in colleges and universities across the country (representing roughly half of young adults nationwide), with about 40% being students of color [1]. College populations have a special significance for mental health policy given that nearly 75% of mental illnesses have first onset by the mid-20s [2], and mental health in early adulthood is linked to important outcomes, including economic productivity [3]. There is also a growing body of evidence demonstrating a

Abbreviations: HMS, Healthy Minds Study; PHQ-9, Patient Health Questionnaire-9; GAD-7, Generalized Anxiety Disorder 7-item scale; NSSI, non–suicidal self-injury; OR, odds ratio; CI, confidence interval

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connection between mental health and college degree completion [4–6]. The national 6-year bachelor's graduation rate is less than 60% [1], and rates are significantly lower among African-American and Latinx students [7]. Understanding and addressing the mental health needs of racially diverse students is essential to supporting their success and creating equity in other dimensions, including persistence and retention.

College students of color remain an understudied population with regard to mental health. Some studies have found a higher prevalence of depression and anxiety among students of color, as well as higher levels of functional impairments relative to white students [8], while others have found that symptoms do not vary [9]. Numerous studies suggest that mental health treatment is lower among students of color [9–12], with many pointing to higher levels of stigma, particularly among Asian [11,13] and African-American students [13].

However, much of this evidence is drawn from studies conducted on single campuses, many of which have small sample sizes, typically comprised only of undergraduates [9,13–15]. The only multicampus study in this area that we are aware of [10] used data collected in 1997–1998. There is a pressing need for large, multicampus studies that can speak to the mental health needs of today's diverse student populations.

The present study aims to contribute key findings related to the prevalence of mental health and service utilization across both undergraduate and graduate students' racial and ethnic identities, drawing from one of the largest campus-based surveys, the Healthy Minds Study (HMS). Previous studies using HMS data have revealed a high prevalence of mental health problems [8] and significant unmet need [16], but little has been done to explore differences by race. The goal of this research is to improve understanding of the mental health needs of students of color in order to promote equity.

Methods

Study design

Data: HMS is an annual web survey examining mental health, service utilization, and related factors among undergraduate and graduate students. In the present study, we analyze three waves of data (2012–2015), which include 60 institutions. Colleges and universities elect to participate in HMS; there are no exclusion criteria for institutional enrollment. Study sites are diverse across campus characteristics, including institutional type, geography, and selectivity.

Data were collected using Qualtrics software. HMS was approved by the Institutional Review Boards on all campuses. A National Institutes of Health Certificate of Confidentiality provided further protections.

Recruitment and informed consent: At each institution with ≥4,000 students, our study team recruited a random sample of 4,000 degree-seeking students from the full population; at smaller institutions, we recruited all students. Student sample files containing information used for recruitment (e.g., name, email address) and nonresponse analyses were obtained from the Registrar at each site. Students had to be at least 18 years old to participate; there were no other exclusion criteria. Students were recruited via email. To incentivize participation, students were informed of their eligibility for one of several prizes totaling $2000 annually (10 $100 and two $500 gift cards per wave). Upon clicking a personalized link in the email, students were presented with an informed consent page and had to agree to the terms of participation before entering the survey. The overall response rate across years was 21%.

To adjust for potential differences between responders and nonresponders, we constructed sample probability weights. We obtained administrative data from participating institutions, including gender, race/ethnicity, academic level, and grade point average. We used this data to construct response weights, equal to 1 divided by the estimated probability of response, using a logistic regression to predict the likelihood of response associated with each variable.

Measures

Detailed information about each measure is included in the Appendix (Table A1).

Mental health: We examine eight binary measures of mental health: (1) *flourishing*; (2) *depression*; (3) *anxiety*; (4) *eating disorders*; (5) *non–suicidal self-injury* (*NSSI*); (6) *suicidal ideation*; (7) *any mental health problem*; and (8) *impairment*. We focus on binary measures because most of these measures have been validated based on standard cutoffs.

(1) To estimate the proportion of students who are *flourishing*, we use the eight-item Flourishing Scale [17], which has been shown to have high convergence with similar scales [18]. The scale is designed to assess major aspects of social–psychological functioning, including relationships, self-esteem, purpose, and optimism. Scores range from 8 to 56, with higher scores indicating higher well-being. This scale does not have a recommended cutoff; rather a score of ≥48 was selected because it best matches rates of flourishing in other scales (e.g., the Mental Health Continuum [19]) in U.S. college populations.

(2) We examine symptoms of *depression* using the Patient Health Questionnaire-9 (PHQ-9) [20,21]. The PHQ-9 has been validated as internally consistent and highly correlated with clinical diagnosis [20–23], including among people of color [24]. We used the standard cutoff of ≥1.

(3) Symptoms of *anxiety* are measured by the Generalized Anxiety Disorder 7-item (GAD-7) scale [25], which has been used in racially diverse samples [25,26]. We used the standard cutoff of ≥10, which has been shown to have high sensitivity and specificity [25]. In 2012, HMS included a different anxiety screen, so that year is excluded from our analyses of anxiety (N = 20,343 students from 2012 excluded).

(4) Symptoms of *eating disorders* are assessed using the five-item SCOFF [27]. Scores range from 0 to 5, with ≥2 constituting a positive screen. Prior studies have determined this cutoff to be sensitive and specific [27,28]. Unlike the PHQ-9 and GAD-7, there have been no validation studies of the SCOFF specifically among people of color. The SCOFF was added to HMS in 2013; as such, our measure of eating disorders also excludes the 2012 sample.

(5) The following item, developed for HMS, is used to assess *NSSI*: "This question asks about ways you may have hurt yourself on purpose, without intending to kill yourself. In the past year, have you ever done any of the following