

# **Behavioral Health Innovations during COVID in Black and Hispanic Communities: Research Findings of a Community Engagement Project**

**Jennifer Baggerly**

University of North Texas at Dallas

**Constance Lacy**

University of North Texas at Dallas

**Samuel Bore**

University of North Texas at Dallas

**Corron Sanders**

University of North Texas at Dallas

**Erica Pounce**

University of North Texas at Dallas

## **Abstract**

In an effort to address behavioral health disparities, the researchers conducted a community engagement research study to identify innovative practices that behavioral health agencies utilized in Black and Hispanic communities during COVID-19. Research methods included community agency input, a targeted survey of 15 behavioral health agencies, and focus groups. The researchers identified innovative practices in eight areas including physical safety, emotional safety, accessibility through technology, accessibility for face-to-face counseling, affordability, leveraging resources, availability, and changes in procedures. The researchers discuss recommendations and implications for social justice action to decrease behavioral health disparities.

*Keywords: COVID, Behavioral Health, Black and Hispanic, community, Innovative strategies*

## **Behavioral Health Innovations during COVID in Black and Hispanic Communities: Research Findings of a Community Engagement Project**

During the COVID-19 pandemic, there were increases in mental health problems as well as numerous counseling barriers and behavioral health disparities for people in underserved Black and Hispanic communities (Ruprecht et al., 2021; Sullivan et al., 2021). Counselors are ethically obligated to follow the American Counseling Association's Multicultural and Social Justice Competencies (MSJC) (Ratts et al., 2015) to improve the behavioral health of diverse communities. MSJC implores counselors to "collaborate with social institutions to remove systemic barriers experienced by marginalized clients" (Ratts et al., 2025, p. 12).

The purpose of this article is to explain how we collaborated with community leaders to identify innovative practices that behavioral health agencies utilized during COVID-19 in underserved Black and Hispanic communities. We will (a) discuss counseling barriers and behavioral health disparities during COVID-19; (b) describe research methods of facilitating community agency input, implementing a targeted survey of 15 behavioral health agencies, and conducting focus groups; (c) report findings of innovative practices in eight areas; and (d) discuss recommendations and social justice implications for systems change.

### **COVID-19 Counseling Barriers and Behavioral Health Disparities**

During COVID-19, mental health problems increased due to fear, grief, traumatic stress, unemployment, food insecurity and social isolation (Liu & Modir, 2020; Ruprecht et al., 2021; Thomeer et al., 2023). Yet, Thomeer et al. (2023) found Black and Hispanic community members had disproportionately higher mental health problems than White individuals. Their study of two nationally representative U.S. surveys, one pre-pandemic and one during the pandemic, revealed that the mental health of Black and Hispanic respondents worsened compared to White participants, particularly with respect to depression and anxiety. Specifically, "in 2020–2021, a larger percentage of Black (41.69%) and Hispanic (44.23%) respondents were categorized as having depression/anxiety compared to White respondents (37.97%;  $p < 0.001$ )" (Thomeer et al., 2023, p. 968) The researchers concluded that this was due to less access to mental health, lower pay and insurance, less job flexibility, more discrimination from mental health care workers, and the compounding of racist events such as George Floyd's murder.

Prior to COVID-19, Black and Hispanic community members faced numerous barriers to counseling such as stigma, finances, geographic access, discrimination, cultural unresponsiveness, and language (Thomeer et al., 2023). During COVID-19, additional barriers were the higher likelihood of COVID-19 exposure; higher likelihood of COVID-19 related death (1.5 per 10,000 for Whites, 4.3 for Hispanics, and 6.8 for Blacks); reduced resources; and financial insecurities (Thomeer et al.).

Black and Hispanic community members also faced more behavioral health disparities during COVID-19 (Johnson-Agbakwu et al., 2022; Maffly-Kipp et al., 2021; Sullivan et al., 2021). Ruprecht et al.'s (2021) study of Chicago residents during COVID found that the Black and Hispanic survey respondents had a significantly lower use of telehealth for mental health services (Black: 9.75% vs. Hispanic: 16.0% vs. White: 30.7%;  $p = 0.001$ ) compared to the White participants, partially due to mental health stigma and limited access. Behavioral health disparities also were attributed to existing racism and implicit bias (Johnson-Agbakwu et al., 2022); shortages in the Black and Hispanic workforce due to the disproportionate impact of COVID-19 (Office of the Assistant Secretary for Planning and Evaluation, 2022), and clinician burnout (Wood, 2021).

To decrease counseling barriers and behavioral health disparities in the future, counselors need to intervene at the institutional, community, and public policy levels (Ratts et al., 2015). Moreno et al. (2020) recommended "disseminating good practices that can result in sustained, efficient, and equitable delivery of mental health-care delivery" after COVID-19 (p. 813). To achieve this outcome, counselors need to know what behavioral health interventions were helpful in Black and Hispanic communities during the COVID-19 pandemic so they can advocate for systems change. Although general strategies used during COVID were increased such

as the utilization of technology (Wood, 2021), telemedicine (Ye et al., 2021), and partnerships with community agencies (Moran et al., 2022), there is limited research on innovative strategies specifically for underserved Black and Hispanic communities. Hence, the purpose of our study.

### **Purpose of Study.**

This study was designed to document emerging innovative practices of community-based behavioral healthcare providers in a large Southwest city of the U.S. during the COVID-19 pandemic in order to improve the mental health care delivery to underserved Black and Hispanic communities. The study was part of a larger project that examined both healthcare and behavioral health care emerging practices in agencies that offer free or low-cost services to underserved people in predominantly Black or Hispanic communities. The study featured in this article focused on behavioral health care. Our research questions were (1) “what was the work format of behavioral health care agency staff during the pandemic,” (2) “what were barriers that behavioral health care clients experienced,” and (3) “what are emerging and innovative approaches conducted by behavioral health care providers during the COVID-19 pandemic within underserved Black and Hispanic communities.”

## **Methods**

To answer these research questions, we conducted a mixed methods study (Timans et al., 2019) that included a quantitative online survey and qualitative focus groups. We used triangulation to increase the trustworthiness of research findings by (1) engaging leaders in behavioral health organizations that operated during COVID-19 to identify innovative strategies they used in underserved Black and Hispanic communities; (2) developing an online survey, based on community leaders’ input, for behavioral health providers in the region; and (3) conducting follow up focus groups to verify and expound upon the survey findings. The Institutional Review Board (IRB) of our university approved our request to conduct the study.

### **Organization Leader Participation: Step One**

As part of a larger study, we conducted purposeful sampling to identify 74 leaders from 37 community-based healthcare and behavioral health care agencies that served underserved low-income individuals in 9 specific zip codes that were predominantly Black or Hispanic communities. We sent emails to invite these organizational leaders to attend an introductory meeting. Between March and April of 2023, twenty-two organizational leaders, approximately 30% of those invited, participated in an introductory meeting.

We asked the agency leaders (e.g., administrator, clinical supervisor, counselor, etc.) to describe changes their agency made during COVID-19 to serve their clients. Then, we asked the leaders to review preliminary survey questions that were based on findings that appeared in the literature. We also asked the leaders to improve the wording of the of the questions, response options, etc., and to identify missing content and questions. Finally, we asked the leaders to request their staff to complete the online survey and to share ideas on how to increase response rates to the survey.

### **Online Survey Instrument: Step Two**

The purpose of the online survey was to identify emerging and innovative approaches implemented by primary care and behavioral health care providers during the COVID-19 pandemic in a major city in the Southwest region of the U.S. First, we reviewed the current literature related to healthcare and behavioral healthcare changes during the pandemic. Second, the research team developed a preliminary 17 question online survey via Qualtrics to gather data on participant demographics, agency information, the format of work during the COVID pandemic (i.e., solely face to face, mostly face to face, equal amount, mostly online, or solely online), client barriers to services during the pandemic (Likert scales and an open-ended question), innovative approaches used during the pandemic (Likert scales and an open-ended question), ideas for innovative approaches post-pandemic, and willingness to participate in a focus group. For example, a 5-point Likert scale (Almost all, Most to Very few) was

used to rate perceptions of which service barriers clients experienced, such as fear of getting COVID, limited finances, long waiting lists, etc. Likewise, a Likert scale (Very Effective to Not effective, or Did not use) was used to rate perceptions of the effectiveness of innovative practices such as teleHealth, zoom meetings for staff, ppe, reduced fees, artificial intelligence for medical records, etc.

Third, we solicited feedback from the 22 agency leaders mentioned above on ways to improve the survey and we later implemented their suggested changes. Fourth, we tested the survey by sending it to two colleagues to ensure the link worked properly. Then, we emailed an invitation to complete the 15 to 20-minute online survey to the 74 individuals representing the 37 agencies and requested that they send the Qualtrics link for the survey to their staff. We called and sent follow-up emails to ask the agency staff to participate. Based on our survey responses, we identified qualitative themes through a process described below.

**Participants for Online Survey.** The demographics of the 15 behavioral health care agency respondents are as follows. The gender of the respondents was 20% ( $n = 3$ ) male and 80% ( $n = 12$ ) female. The race/ethnicity of the respondents was 33.33% ( $n = 5$ ) African American or Black; 0% ( $n = 0$ ) Latinx or Hispanic; 6.67% ( $n = 1$ ) Asian; 33.33% ( $n = 5$ ) White; 20% ( $n = 3$ ) bi-racial; and 6.67% ( $n = 1$ ) prefer not to answer. The age range was 6.67% ( $n = 1$ ) 18-24; 20% ( $n = 3$ ) 25-34; 20% ( $n = 3$ ) 35-44; 26.67% ( $n = 4$ ) 45-54; 13.33% ( $n = 2$ ) 55-64; and 13.33% ( $n = 2$ ) 65 or older.

**Agencies.** These survey respondents represented 12 different agencies with 80% ( $n = 12$ ) from behavioral health care agencies or private practice and 20% ( $n = 3$ ) from behavioral health hospitals. Approximately 46.67% ( $n = 7$ ) of the agencies reported that 50 to 100% of their clients were low-income, uninsured.

### **Focus Groups: Step 3**

As we stated earlier, we also led focus groups. The purpose of these groups was to (1) conduct member checking to determine if the wording and description of the qualitative themes were accurate or reflective of what respondents had intended; (2) ask focus group participants to elaborate on these emerging practices and to give examples; and (3) discuss the focus group participants' recommendations for implementation of these emerging practices.

We developed focus group questions to review the themes for innovative practices used during the pandemic and to elicit ideas for post-pandemic systems change. Then we made telephone calls to invite the survey participants to attend a one-hour focus group. Since many people were working, both face-to-face and virtual options were provided at two different times for a total of two focus groups, each lasting 90 minutes. A focus group facilitator with a master's degree in social work and graduate course work in focus group facilitation conducted both focus groups comprised of health care and behavioral health care survey respondents who agreed to participate. The focus groups were recorded to ensure that the agenda for the questions developed by the research team were implemented as intended (Krueger & Casey, 2014). The focus group recordings were transcribed using ATLAS.ti Web Version 5.8.0 (2023). During the focus groups, the facilitator did not ask for any specific identifying client data in order to adhere to the Health Insurance Portability and Accountability Act (HIPAA). There were seven focus group participants, two in the first group and five in the second group.

### **Researcher Bias and Positionality**

The biases of researchers during the entire study were discussed among the research team members. The positionality of the research and coding team members were three Black females, one Black male, and one White female. Four of the team members were doctoral level mental health educators and one was a doctoral level public health educator. They all work at a university in an under-resourced Black community and are avid social justice advocates. They acknowledged their belief that Black and Hispanic clients experienced behavioral health disparity, which they saw as unfair and detrimental. They combatted researcher bias by consulting with their university research advisors, systematically reviewing the literature with neutral words such as COVID, Black, Hispanic, and health services, seeking the voice of a wide range of behavioral health providers in the community, using a

computer coding program, having a coding team, and performing member checking (Whittemore et. al., 2001). They did not use self-reflective journaling, which was a limitation of the study.

### Data Analysis

To analyze the quantitative survey data, we used Qualtrics and SPSS to obtain frequencies and percentages. To analyze the qualitative data in response to the open-ended survey questions and focus group transcripts, we followed Braun and Clarke's (2006) thematic analysis procedures to establish trustworthiness. We loaded open-ended survey responses and the Atlas transcriptions into NVivo, color coded similar responses, and identified themes until consensus was met among the five research team members. Specifically, four team members had a doctoral degree in a behavioral health field (i.e., 3 in counseling and one in social work) and one team member had a doctoral degree in public health. Each team member had doctoral level training in qualitative analysis. We conducted two one-hour meetings to discuss the coding process. Nvivo software was used to collect, sort, and code data. The team members independently engaged in open coding to label themes based on description and content. Three team members engaged in focused coding by color coding similar core concepts. Then all team members discussed the themes until consensus was reached. There were no disagreements. To increase the trustworthiness of the results, we sought member checking by asking the seven focus group members to confirm or change the themes and to elaborate on the themes by providing examples. The focus group members agreed with the themes and did not recommend any changes. Their elaboration on the themes are described below.

## Results

In the larger study of both healthcare and behavioral healthcare agencies, there were 47 healthcare and behavioral healthcare professionals that responded to the online survey. In the current study, we focused on responses from 15 behavioral healthcare respondents, who represented 12 behavioral health care agencies or practices and three behavioral health hospitals. The rationale for focusing solely on behavioral health care responses was because the combined data of healthcare and behavioral health care is reported in a separate journal article targeted in the public health discipline. We desired to extend the literature on social justice in the counseling discipline.

### Quantitative Survey Results

**Format of Work during COVID.** The format of how respondents worked with clients from February 2020 to February 2022, divided into four 6-month increments, varied throughout the pandemic. See Table 1. From February 2020-July 2020, 53.33% (n = 8) were working either solely face to face or mostly face to face while 13.33% (n = 2) worked equal face-to-face and online but 33.33% (n = 5) worked either mostly online or solely online. However, by August 2020-January 2021, there was a decrease to only 40.00% (n = 6) who were working either solely face to face or mostly face to face while 13.33% (n = 2) worked equal face-to-face and online but there was an increase to 46.67% (n = 7) who worked either mostly online or solely online. Between February 2021 to July 2021, there was another shift to 33.33% (n = 5) working equal face-to-face and online. By February 2022, work shifted back to 60.00% (n = 9) solely face-to-face or mostly face-to-face.

**Client Barriers.** When asked about the most prominent barriers that many clients had to obtain behavioral healthcare services, 53.33% (n = 8) of respondents marked fear of getting COVID; 53.33% (n = 8) marked limited finances; 46.67% (n = 7) marked misinformation or lack of trust; and 46.67% (n = 7) marked limited staff. See Table 2. When asked to write in other barriers, respondents commented:

- “The greatest barrier was limited hospital staff leading to higher rates of burnout among practitioners and lower quality client care. Long waiting lists were also a frequent complaint.”
- “Most clients either lost a loved one or feared catching the virus. Most were diagnosed with PTSD and were afraid to go to work.”
- “Many clients lost their jobs due to non-essential job duties. Some even didn't have childcare. Families

were forced to be at home. Struggling with the online school environment. Families suffering from lack of communication. Loss. Lots of loss.”

**Effective Strategies.** When asked about effective strategies to meet client needs and reduce health inequities during the pandemic, 73.33% (n = 11) of respondents indicated Zoom/TEAM meetings for staff; 66.67% (n = 10) indicated Telehealth; 46.67% (n = 7) indicated online/paperless forms; 40.00% (n = 6) indicated telephone contact; 40.00% (n = 6) indicated online education/information for clients; and 40.00% (n = 6) indicated Personal Protective Equipment (PPE; e.g., masks). See Table 3 which lists strategies from most effective to least effective. When asked to write about other effective strategies, respondents commented:

- “Networking with the community and being able to refer them over to an agency that can meet their needs.”
- “1. Minimizing contact with the clients. 2. Minimizing treatment team face-to-face weekly meetings 3. Social distancing in sessions and other settings. 4. Suspended family visitation. 5. Placing all new intake clients on Quarantine to prevent possible COVID-19 spread. 6. Conducting a rapid COVID-19 test on all intake clients for potential COVID-19 infection. 7. Conducting periodic tests on clients and staff for suspected/potential cases. 8. Client isolation if tested positive. 9. Staff sick time off if tested COVID positive.”
- “Transportation.”
- “Assisting clients with acquiring private insurance to get medical care.”

## Qualitative Survey Results

We analyzed qualitative data from the online survey. We identified numerous themes of behavioral health emerging practices during COVID that respondents used in Black and Hispanic communities.

**During the pandemic.** Based on written survey comments about effective strategies during the pandemic, seven themes emerged and are organized by similar content as follows.

1. **Physical Safety** during the pandemic was described as using Personal Protective Equipment (e.g., masks and gowns), social distancing, and COVID-19 tests. This theme appeared twice.
2. **Emotional safety** was reported as “check ins,” “client feedback,” and “cultural responsiveness.” This theme appeared once.
3. **Accessibility via technology** was identified as telehealth, online meetings, emails, texting, phone calls, electronic records, electronic education, electronic data gathering, and providing computers. This theme appeared ten times.
4. **Accessibility for face-to-face** was defined as transportation assistance such as gas cards or ride share (e.g., Uber or Lyft). This theme appeared three times.
5. **Affordability via fee adjustment** was delineated as reduced fees or eliminated fees and **funding** by enrolling clients in insurance, obtaining grants, and added resources of food pantry and internet access. This theme appeared three times.
6. **Leverage resources** was described as networking with other agencies and referring to other agencies to connect clients with food banks and other assistance. This theme appeared six times.
7. **Availability via extra staff** was reported as hiring extra staff and **extended hours** via evening hours and being open on the weekends. This theme appeared twice.

**Post-pandemic.** Based on qualitative data of written open-ended comments about enduring trends after the pandemic, the same themes emerged as earlier: physical safety; emotional safety; accessibility via technology, distribution, and transportation; and affordability via fee adjustment, funding, and leveraging resources. One new theme was identified as **Change in procedures**, which was described as changing the meeting location, shorter

appointment times, limited number of guests in the waiting rooms, and marketing via text messaging. This theme appeared four times.

### **Focus Group Verification and Expansion of Results**

Seven respondents participated in the focus groups. These participants first confirmed the results of the theme analysis reported above with no recommended changes and then provided even more examples of emerging practices linked with each theme. An analysis of the focus group responses revealed the following recommendations for implementation of these emerging practices.

**Physical Safety** was described as following CDC protocols and maintaining good hygiene practices even after the pandemic.

**Emotional Safety** was delineated as encouraging staff work-life balance; understanding client triggers of PTSD due to COVID; providing clear expectations to staff; and providing effective strategies to clients.

**Accessibility through Technology** was depicted as demonstrating patience, user friendly communication, and explaining technology, especially for elderly; investing in infrastructure such as smartphones or iPads to loan out; and continuing online services (e.g., Doxy.me).

**Accessibility for Face-to-Face** was reported as recognizing some clients need face-to-face counseling; arranging transportation and creating behavioral health pop-up locations in local churches, charter schools, or other agencies.

**Affordability through Fee Adjustment and Funding** was delineated as adjusting eligibility formulas for fee assistance (e.g., so a family income of \$65,000 would qualify); providing a menu of services to cater to people's needs; and seeking special funding (e.g., grants) for services.

**Leverage Resources** was described as encouraging collaboration among agencies and leveraging relationships with food banks.

**Availability** was defined as working to reduce the stigma of mental health; increasing the number of counselors available; promoting counselor self-care to prevent burnout; and right-sizing workload with efficient staffing.

**Change in Procedures** was reported as following CDC guidelines; offering shorter sessions and virtual meetings; allowing staff to work from home when sick to reduce their use of sick days; and being poised to return to sanitizing and social distancing measures if the virus resurfaces,

## **Discussion**

Our findings offer answers to the research questions about the format of work during the pandemic, client barriers, and emerging and innovative approaches conducted by behavioral health care providers during the COVID-19 pandemic in Black and Hispanic communities. Regarding the format of the providers' work, it was interesting that at the height of the pandemic, 34.18% of the providers were still working either solely face-to-face or mostly face-to-face, even though telehealth was an option. By the end of the pandemic, 51.27% of the providers were working solely face-to-face or mostly face-to-face. This finding may indicate that at least one-third to one-half of clients in the Black and Hispanic communities in this study preferred face-to-face counseling. This result is consistent with other research studies showing that Black and Hispanic clients have a lower use of telehealth for mental health services compared to White respondents (Ruprecht et al., 2021). Therefore, it may be helpful for behavioral health providers to maintain flexibility when assisting persons in Black and Hispanic communities so that face-to-face counseling services are an option in the event of another pandemic.

In this study, respondents indicated the main barriers to obtaining behavioral healthcare during the pandemic were predominantly the fear of getting COVID, limited finances, misinformation or lack of trust, and limited staff. These findings complement those of Thomeer's et al. (2023) who discovered that Black and Hispanic individuals had a higher likelihood of COVID-19 deaths and financial insecurities as well as Wood's (2021) finding

concerning clinician burnout. Further, the current study's result related to misinformation or lack of trust appears to be linked to previously identified discrimination, cultural unresponsiveness, and language barriers (Thomeer et al., 2023). Our findings extend the literature of Benkert et al. (2019) and Ho et al. (2022) by verifying that misinformation and a lack of trust existed during the pandemic in Black and Hispanic communities. If a lack of trust is not addressed properly in behavioral health care systems, it could have severe consequences (e.g., suicidal ideation) for Black and Hispanic clients who may be reluctant to seek needed services. Therefore, behavioral health care providers need to be intentional in their efforts to decrease distrust by providing culturally responsive information about a pandemic. It would be best for this information to be delivered by a professional who reflects the race and ethnicity of the community being served.

When identifying emerging, innovative behavioral healthcare strategies in Black and Hispanic communities during and post-pandemic, our study offers a unique contribution to the counseling literature. In short, a comprehensive approach is needed along many realms, including (1) physical safety; (2) emotional safety; (3) accessibility via technology; (4) accessibility via transportation; (5) affordability via fee adjustment and funding; (6) leveraging resources; (7) availability via extra staff and extended hours; and (8) changes in agency procedures. This comprehensive strategy is needed because clients in Black and Hispanic communities face many barriers in each of these realms (Benkert et al., 2019; Ho, et al., 2022; Johnson-Agbakwu et al., 2022; Liu & Modir, 2020; Ruprecht et al., 2021; Thomeer et al., 2023).

To decrease behavioral health disparities for clients in Black and Hispanic communities during a pandemic, it would seem important for behavioral health providers to advocate for systems change in their organizations. Not only is it an ethical duty for counselors to foster fairness and equality (American Counseling Association, 2014), but it is a key multicultural and social justice counseling competency to promote equity in systems (Ratts et al., 2015). The following recommendations may help counselors in doing so.

### **Recommendations for Systems Change**

While each agency must consider the needs of their specific clientele, our findings lead to some recommendations to remove systems barriers and promote innovative behavioral health practices for marginalized clients in Black and Hispanic communities.

1. During a pandemic, behavioral health agencies can prepare their staff to work mostly online but also have the flexibility to meet face-to-face with clients while following CDC recommendations.
2. During a pandemic, agencies can be intentional when providing culturally responsive information to address the fear of clients contracting a disease. This information should be delivered by people who reflect the race and ethnicity of the community being served.
3. Agencies can increase the trustworthiness of their services by considering the strategies mentioned below. In an effort to promote counselors' social justice advocacy, we have linked these strategies to the domains of the ACA Advocacy Competencies (Lewis et al., 2003). We will identify if these strategies are at the micro, mezzo, or macro level and if they are a direct systems intervention or collaboration with client community groups.
  - a. **Physical Safety** can be explicit by ensuring each staff person is wearing PPE, offering free masks at check-in counters, placing hand sanitizing containers throughout the building, and signs stating the frequency of sanitation. In light of ACA Advocacy Competencies, physical safety is at the mezzo-level of systems advocacy in that counselors are addressing an environmental barrier for Black and Hispanic clients. Physical safety in health is particularly important given the peripheral trauma from the Tuskegee study of untreated

syphilis in Black men (Alsan, et al., 2019). Black and Hispanic clients need reassurance that their physical safety is paramount.

b. **Emotional safety** can be promoted through intentional check-ins via phone calls, emails, and texts, asking for verbal and anonymous written client feedback, and behavioral health providers stating their intentions to be culturally responsiveness and open to their clients' guidance. Emotional safety also is at the mezzo-level of systems advocacy in that counselors are understanding the cultural contexts of their clients as well as their own cultural identity in relation to Black and Hispanic clients. In their phenomenological study of counselors as social justice advocates, Sinclair et al. (2024) also identified diversity and culturally responsive trainings for staff to be at the mezzo-level of advocacy.

c. **Accessibility via technology** (e.g., telehealth, electronic intake forms, electronic education) can be offered, step-by-step directions provided, and tablets or smart phones can be loaned out as needed. Providing accessibility to technology is at the ACA Advocacy Competencies micro-level of client empowerment by sharing resources and tools with Black and Hispanic clients.

d. **Accessibility** can be facilitated by offering services in local churches or community centers and arranging transportation through gas cards or ride shares (e.g., Uber or Lyft). Accessibility is at the mezzo-level of community collaboration by partnering with community centers and Churches to meet common concerns of access to mental health for Black and Hispanic clients.

e. **Affordability** can occur by reducing fees or eliminating fees (e.g., consider hosting counseling interns or associates), assisting with insurance enrollment, and seeking grant funding. Affordability is at both the micro-level of client advocacy when enrolling clients with insurance and the mezzo-level of systems advocacy when removing barriers and providing resources. Affordability also could be at the macro-level of collective action or social/political advocacy by contacting legislators regarding improving insurance coverage (e.g., Medicaid paying counseling associates to provide counseling).

f. **Leverage resources** by networking with other agencies (e.g., onsite food distribution), referring to other agencies (e.g., YMCA), and offering free internet access. Leveraging resources is at the mezzo-level of community collaboration by developing alliances for other groups working for change. Sinclair et al. (2024) also reported that community partnerships at the mezzo-level of advocacy were helpful when addressing systemic marginalization.

g. **Availability** can be increased by hiring extra staff and offering extended hours in the evening and weekends. Availability is at the mezzo-level of direct systems change by identifying environmental factors that impede Black and Hispanic clients' access to services. This is particularly important in lower income areas where clients may have multiple jobs without flexible schedules.

h. **Change in procedures** can occur by modifying the meeting location (e.g., closer to community transportation), shortening appointment times, limiting the number of guests in waiting rooms, and marketing via text messaging. Change in procedures also is at the mezzo-level of direct systems change. Counselors could be flexible in providing services other than the traditional in office 60-minute session. In addition, they could limit the number of family members in the waiting room to ensure safety. Although many Black and Hispanic clients may have a collectivistic value of bringing many family members to an appointment, it may be more

important to maintain physical safety to not contract a disease by limiting the number of family members at an appointment.

### **Implications**

The implications for social justice action, based on our study's findings and recommendations, are as follows. First, since Black and Hispanic community members faced more behavioral health disparities during COVID (Johnson-Agbakwu et al., 2022; Maffly-Kipp et al., 2021; Ruprecht et al., 2021; Thomeer et al., 2023), counselors need to act as social justice advocates by collaborating with behavioral health agencies in Black and Hispanic communities to identify and remove systemic barriers (Lewis et al., 2003), particularly during a pandemic. Such collaboration could help decrease implicit bias that impacts behavioral health systems (Johnson-Agbakwu et al., 2022) by amplifying the lived experiences of providers working in Black and Hispanic communities, as we did in our study. For example, rather than assuming Black clients did not want counseling since many did not show up during the pandemic, behavioral health providers can consider ways to mitigate clients' lack of trust, logistical barriers, and threats to their social identity (Kahn & Money, 2022).

Second, counselors need to advocate for behavioral health agencies to use a comprehensive approach that addresses the complex interactions of clients' physical safety, emotional safety, affordability, accessibility, and availability. This approach may help remove multiple barriers such as the fear of contracting a disease, limited finances, misinformation, lack of trust, and limited access. When counselors enact their social responsibility by advocating for this comprehensive approach, they can help decrease behavioral health disparities in Black and Hispanic communities during and post pandemics (Johnson-Agbakwu et al., 2022; Moreno et al., 2020; Sullivan et al., 2021; Wood, 2021).

Third, our recommendations may help to increase Black and Hispanic clients' use of mental health services in their communities both now and in the event of another pandemic. Our recommendations provide concrete steps for social justice action. Finally, behavioral health agencies must be flexible in changing their systems to accommodate clients and employees in Black and Hispanic communities. This flexibility will help maintain the consistency of behavioral health services in these communities so that clients can stabilize their own mental health.

### **Limitations and Future Directions**

Like all studies, our study had several limitations. First, since we used purposeful sampling rather than randomized sampling of organizational leaders in a specific geographical area, our results may not necessarily apply to other geographical areas and cannot be generalized to all Black and Hispanic communities. Second, the reliability and validity of the online survey we developed were not established, beyond being guided by the literature and community leaders. Third, our results were based on self-report and recollections of behavioral health providers and did not represent the perceptions of clients or actual data obtained from agencies. Fourth, we did not utilize self-reflective journals during the study to examine our personal assumptions and clarify our belief systems, thereby limiting the rigor and trustworthiness of our project. Finally, the effectiveness of our recommended innovative practices has not been established.

Based on these limitations, future research should use randomly sample behavioral health providers who work in Black and Hispanic communities during a pandemic. It also should administer outcome assessments that are valid and reliable and gather data directly from clients in Black and Hispanic communities who have received behavioral health services during the pandemic. Additionally, future research should measure the effectiveness of the practices we have recommended. The implementation of such studies could help to decrease the behavioral health disparities in Black and Hispanic communities during a pandemic and promote systems change.

## Conclusion


In an effort to address behavioral health disparities, our study aimed to identify barriers and emerging innovative behavioral health strategies used in Black and Hispanic communities in a large Southwestern city of the U.S. during the COVID-19 pandemic. We discovered that the barriers for clients were the fear of getting COVID, limited finances, misinformation or lack of trust, and limited staff. We also found emerging, innovative behavioral healthcare strategies encompassed (1) physical safety, (2) emotional safety, (3) accessibility via technology, (4) accessibility via transportation, (5) affordability via fee adjustment and funding, (6) leveraging resources, (7) availability via extra staff and extended hours, and (8) changes in agency procedures.


Our study embraced community collaboration, which represents the ACA Advocacy Competency (Lewis et al., 2003) domain of Collective Action to support Black and Hispanic groups. We encourage behavioral health leaders and providers to be social justice advocates by following our recommendations in the eight areas mentioned above. Doing so could potentially reduce behavioral health disparities both now and during another pandemic. Accomplishing this outcome has important implications for promoting systems change for behavioral health in Black and Hispanic communities.


### Author Note

Grant funding provided by Texas Health Resources. Correspondence concerning this article should be addressed to Jennifer Baggerly, University of North Texas at Dallas, 7300 University Hills Blvd., Dallas, TX, 75028. Email: Jennifer.baggerly@untDallas.edu.

### Author ORCID iDs

Jennifer Baggerly Email Jennifer.baggerly@untDallas.edu  0000-0002-2519-4089

Constance Lacy Email Constance.Lacy@untDallas.edu  0009-0003-9187-3228

Corron Sanders Email Corron.Sanders@untDallas.edu  0009-0001-8258-6839

### Declaration of Interest Statement

The authors declare no conflicts of interest in relation to this work.

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**Table 1**  
*Format of Work during COVID*

<b>Timeframe</b>	Solely Face-to-Face		Mostly Face-to-Face with Some Online		About Equal Face-to-Face and Online		Mostly Online with Some Face-to-Face		Solely Online	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Feb 2020 - July 2020	5	33.33	3	20.00	2	13.33	4	26.67	1	06.67
Aug 2020 - Jan 2021	4	26.67	2	13.33	2	13.33	4	26.67	3	20.00
Feb. 2021 - July 2021	5	33.33	1	06.67	5	33.33	2	13.33	2	13.33
Aug. 2021 - Jan. 2022	5	33.33	2	13.33	5	33.33	2	13.33	1	06.67
Feb. 2022 - Present	6	40.00	3	20.00	2	13.33	4	26.67	0	0

*Note.* Percentages across rows equal 100% to show different formats within one timeframe.

**Table 2**  
*Barriers Clients Experienced*

<b>Barriers</b>	Many Clients		Some Clients		None	
	<i>n</i>	%	<i>N</i>	%	<i>n</i>	%
Fear of getting COVID*	8	53.33	6	40.00	1	6.67
Limited finances (more of a problem than before COVID)	8	53.33	6	40.00	1	6.67
Misinformation or concerns about vaccinations or lack of trust	7	46.67	7	46.67	1	6.67
Limited number of staff due to COVID	7	46.67	5	33.33	3	20.00
Limited availability or access of meds, supplies, or vaccines	7	46.67	5	33.33	3	20.00
Lack of transportation (more of a problem than before COVID)	7	46.67	1	6.67	7	46.67
Having COVID	6	40.00	7	46.67	2	13.33
Government restrictions/lock downs	6	40.00	7	46.67	2	13.33
Long waiting lists (more of a problem than before COVID)	6	40.00	4	26.67	5	33.33
Job loss	5	33.33	7	46.67	3	20.00
Lack of childcare	5	33.33	5	33.33	5	33.33
Language barriers	2	13.33	8	53.33	5	33.33
No internet access**	2	13.33	6	40.00	7	46.67

*Note.* Percentages across rows equal 100%

\*Most prominent barrier; \*\*Least prominent barrier

**Table 3**  
*Effective Strategies*

Strategies	Effective		Somewhat Effective		Not Effective		Did Not Use	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Zoom/TEAM meetings for staff*	11	73.33	2	13.33	1	6.67	1	6.67
Telehealth or TeleCounseling (Zoom, Doxy.me)	10	66.67	5	33.33	0	0.00	0	0.00
Online/paperless forms	7	46.67	4	26.67	0	0.00	4	26.67
Telephone contact	6	40.00	5	33.33	2	13.33	2	13.33
Online education/info for clients	6	40.00	6	40.00	0	0.00	3	20.00
Personal Protective Equipment (masks, gloves, gowns, etc.)	6	40.00	6	40.00	1	6.67	2	13.33
Texts to clients	5	33.33	5	33.33	1	6.67	4	26.67
Partnerships & Collaboration	5	33.33	2	13.33	0	0.00	8	53.33
Communication software (CareSignal, CareMessage, etc.)	4	26.67	2	13.33	0	0.00	9	60.00
Artificial Intelligence or talk to text for medical records	3	20.00	0	0.00	0	0.00	12	80.00
Plexiglass or plastic dividers	3	20.00	3	20.00	2	13.33	7	46.67
Deliver supplies or medications to clients	3	20.00	2	13.33	1	6.67	9	60.00
Reduced frequency of services	3	20.00	3	20.00	2	13.33	7	46.67
Reduced fees	3	20.00	3	20.00	1	6.67	8	53.33
Drive through or in car services	1	6.67	2	13.33	0	0.00	12	80.00
Pop Up Clinics or Distribution Centers	1	6.67	2	13.33	0	0.00	12	80.00
Community canvassing/door-to-door	1	6.67	0	0.00	1	6.67	13	86.67
Reduced duplicate efforts by staff or restructured	1	6.67	3	20.00	1	6.67	10	66.67
Hired temporary or "floating staff"***	0	0.0	2	13.33	1	6.67	12	80.00

Note. Percentages across rows equal 100%

\*Most effective strategy; \*\*Least effective strategy