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# How Mental Health Professionals Can Address Disparities in the Context of the COVID-19 Pandemic

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The Coronavirus, 2019 (COVID-19) pandemic is an unparalleled crisis, yet also a unique opportunity for mental health professionals to address and prioritize mental and physical health disparities that disproportionately impact marginalized populations. Black, indigenous, and people of color have long experienced structural racism and oppression, resulting in disproportionately high rates of trauma, poverty, and chronic diseases that span generations and are associated with increased COVID-19 morbidity and mortality rates. The current pandemic, with the potential of conferring new trauma exposure, interacts with and exacerbates existing disparities. To assist mental health professionals in offering more comprehensive services and programs for those who have minimal resources and the most profound barriers to care, 4 critical areas are highlighted as being historically problematic and essential to address: (a) recognizing psychology's role in institutionalizing disparities; (b) examining race/ethnicity as a critical variable; (c) proactively tackling growing mental health problems amid the COVID-19 crisis; and (d) understanding the importance of incorporating historical trauma and discrimination in research and practice. Recommendations are provided to promote equity at the structural (e.g., nationwide, federal), professional (e.g., the mental health professions), and individual (e.g., practitioners, researchers) levels.

*Keywords:* mental health professionals, BIPOC, mental health disparities, COVID-19 pandemic

The Coronavirus, 2019 (COVID-19) pandemic has highlighted longstanding, unaddressed inequities in mental and physical health access and outcomes. These disparities became the focus of national attention when reports of elevated COVID-19-related illnesses and mortality rates among Black, indigenous groups, and other people of color (BIPOC) were released. Providers are responding to this crisis by providing critically needed services for clients who are struggling with a broad range of economic, medical, and mental health issues exacerbated by the COVID-19 pandemic (Shullman, 2020). In addition to the increase in services, this pandemic has brought increased attention to some of the long-established policies and practices that have fostered the creation of health disparities that BIPOC cope with daily such as the historical and intergenerational effects of stress and discrimination due to racial/ethnic, gender, and sexual orientation. Mental health professionals must also consider these factors along with the impact of structural inequalities in housing, education, health, workplace positions, and salaries for over 4 centuries that have resulted in marginalized people being overly burdened by public health crises, natural disasters, and pandemics like COVID-19 (Novacek et al., 2020; Purtle, 2012). Disparities in health outcomes are not new, but if they remain in place when this pandemic is contained, the mental health community will have accomplished little. This is the time to provoke change, not a time to return to "normal" (Obama, 2020).

To assist mental health professionals in offering more comprehensive services and programs for those who have the fewest resources and most profound barriers to care, the following four areas are presented to remind providers of some of the roles that psychology has played in history and in practices: (a) recognizing psychology's role in institutionalizing disparities; (b) examining race/ethnicity as a critical variable; (c) proactively tackling growing mental health problems amid the COVID-19 crisis; and (d) understanding the importance of incorporating historical trauma and discrimination in research and practice.

## Owning the Past

Mental health professionals and clinicians at all levels of training and professionalism need to be reminded that the fields of psychology and psychiatry emerged in the late 1800s at a time when there was little attention paid to ongoing factors that could impact the health and mental health of marginalized populations such as racial injustice, discrimination, gender, poverty, and violence in families, communities, and institutions. To the contrary, more attention was paid to supporting the structural systems of oppression (e.g., slavery, the Jim Crow era, Native American genocide, and displacement and the exploitation of migrant labor; Dews, 2014; Wilkins et al., 2013). Many of these historical periods were borne out of or supported by the Eugenics movement. The Eugenics movement, supported by some psychologists, impacted social, educational, housing, immigration, and labor policies to separate and protect people from "undesirables" (Greenwood, 2017; Washington et al., 2016). Eugenics-era policies created suspicion among marginalized populations, causing them to suppress their symptoms and not seek health care due to fundamental mistrust in the government and in health care institutions (Jones, 2015). Efforts initiated by the Centers for Disease Control and Prevention and other public health institutions remained under high suspicion of not being in the best interest or well-being of people of color (Council of National Psychological Associations for the Advancement of Ethnic Minority Interests [CNPAAEMI], 2003). Social welfare policies and public housing for poor and marginalized people were initially intended to serve as assistance for individuals and families, but in fact promoted the separation of families. Underserved populations, including BIPOC, were alienated and disenfranchised from the U.S. health care system (Medlock et al., 2016), the effects of which are still apparent today.

***The Use of Science to Justify the Inferiority of Non-White Groups.*** For hundreds of years, the mental health professions have used science and the assessment of mental health to justify discriminatory policies against BIPOC, including the creation of diagnostic nomenclature, theories, and psychological tests that offered "proof" of the inferiority of non-Whites and solidified the rationale for racial separation (Tucker, 2009). Historically, psychological diagnoses (e.g., drapetomania, dysaesthesia aethiopica) were created to pathologize expected responses due to separation of families, sexual exploitation, and violence against anyone who resisted oppression to slavery (Cartwright, 1851/2004). In the early to mid 1800s, physicians (e.g., Charles Caldwell) used the field of phrenology to justify biological differences between races, as well as slavery, segregation, and medical experimentation with people of color, against the backdrop of the abolitionist movement (Ktitowsky, 2017; Washington, 2008). Phrenology was also used by

physiologists (e.g., Samuel Morton) to identify skull differences and to allege intellectual deficits of Native Americans to justify their removal from their ancestral lands (Ktitowsky, 2017).

Intelligence tests, widely used and among the most psychometrically validated of psychological tests, were pioneered by the American Psychological Association (APA) and notable psychologists throughout the past century who were proponents of the Eugenics movement (e.g., Goddard, Terman, Cattell; Benjamin, 2009; Brookwood, 2016; Healey, 2018; Tucker, 2009). The tests offered Eugenics a scientific methodology to classify individuals according to their intelligence and emotional maturity and identify purportedly unbiased physiological bases justifying the inferiority of BIPOC (Healey, 2018; Washington et al., 2016). Eugenicists and ethnocentrists supported *racial hygiene*, fearing a decline in the intellectual genetic pool if individuals with low intelligence reproduced (Washington, 2008). They attributed differences in intelligence to biology and race, discounting important differences in environmental conditions and asserted biological superiority when differences by class and race were observed (Martschenko, 2017; Washington et al., 2016). These terms were also found in reports by mental health professionals to justify racial segregation, restricted immigration policies, institutionalization, and the forced sterilization of thousands of impoverished people of color in 31 U.S. states until as recently as 1977 (Greenwood, 2017; Severson, 2011). Intelligence testing has also been used to justify the prohibition of *racial mixing* or interracial marriages (i.e., miscegenation) between Whites and people of color (Greenwood, 2017), a practice that was often illegal and could be punishable by death via lynching (Martschenko, 2017; Washington, 2008). Clinicians used these tests more to confirm notions of inferiority that further marginalized people of color (Medlock et al., 2016; Olsen, 2017; Williams & Mohammed, 2013) than to identify potential talent or to improve the educational or social status of a person of color (Martschenko, 2017).

***Using Racial and Biological Differences to Justify a Hierarchy of Humans.*** Historically false premises that once perpetuated myths about biological differences between African Americans and European Americans (Villarosa, 2019) have reemerged during the COVID-19 pandemic. In the late 1700s, misinformation about African Americans' purported immunity to the yellow fever epidemic in Philadelphia spread and resulted in delays in health care treatment and death among persons of color (Hogarth, 2019). Most recently, the false belief that Black individuals might be biologically immune to COVID-19 stemmed from a low initial number of reported cases earlier on in the pandemic that was later attributed to a lack of testing (Kendi, 2020; Mock, 2020; Poston et al., 2020). This led to questions surrounding the necessity of social distancing mandates, which when coupled with daily fluctuations in COVID-19 information provided to the public resulted in differing interpretations of risks and plans for protection from infection (Pfefferbaum & North, 2020).

Although disparities in COVID-19-related mortality rates are fueled by preexisting conditions that are more prevalent among Black Americans, the role of clinician and implicit bias cannot be overlooked (Healey, 2018; Wyatt et al., 2009). There is evidence that patient group identity can affect clinicians in areas including clinical interviewing, diagnostic decision-making, symptom management, and treatment recommendations (van Ryn et al., 2015). Amid the COVID-19 pandemic, this implicit bias may negatively

impact testing and access to care among BIPOC (Griffith, 2020). The culture of American medicine continues to reflect larger societal beliefs that support racial myths and resulting inequities.

***Mistrust of Physical and Mental Health Practice and Providers.*** Disparities in mental health care access and use are complicated by a longstanding distrust of health care professionals and the health care system among people living in marginalized communities. This is particularly relevant for African Americans, who have a painful history of victimization at the hands of professionals in medicine, psychology, and in research (Kennedy et al., 2007; Steiner, 2018). One prominent example is that of Henrietta Lacks, whose body tissue was taken without her or her family's consent. Her cancer cells, as well as her children's blood samples and medical records, were used in research around the world without their knowledge, leading eventually to the award of two Nobel prizes and corporate financial gain, but marginal compensation to the Lacks family (Harris, 2013). Another example is the Tuskegee Syphilis experiments based in Macon County, Alabama, where participants were denied treatment for syphilis in the context of a 40-year study marked by deception (Gamble, 1997).

Concerns about fears of medical experimentation are likely to reemerge when human vaccine trials begin recruitment for those at most risk for COVID infection. Medical trials have a significant history: Africans were subjected to horrific medical experimentation performed without anesthesia on slave ships (Bachynski, 2018; Villarosa, 2019). In the 1600s, physicians routinely performed involuntary experimentation with enslaved Africans and Native Americans to develop procedures to effectively treat European Americans (Rothman, 2017). When enslaved Africans died, their bodies were used for further experimentation, despite cultural and religious beliefs about the importance of preserving bodies after death (Rothman, 2017). Experimental mishandlings were often downplayed or misrepresented as therapeutic in the medical literature (Washington, 2008). Today, written accounts of these abuses, intended only for the medical community, are chronicled in medical journals, memoirs, and documented oral speeches that were not accessible to lay people and enslaved Africans (Washington, 2008). These candid accounts, written by medical researchers, provide supporting evidence of the extensive and troubling history of enslaved Africans as research subjects that contribute to mistrust that prevails today. Information about vaccine trials and their benefits and risks will need to be carefully articulated, differentiating the experimental nature of these trials from past medical experimentation conducted at the expense of African American communities.

It is necessary to keep the role that the mental health profession has played in institutionalizing disparities at the forefront of our thinking regarding how we move forward to aid in the crisis response to the COVID-19 pandemic. This reckoning with our past will allow us to proceed from a space of humility and desire for change in critical areas that can help foster trust so that we can work collaboratively with individuals to promote well-being in physical and mental health.

## How the Past Affects the Present Pandemic

### Overlooking Race/Ethnicity as a Critical Variable

Although the spread of COVID-19 was widely recognized by mid- to late January 2020, initial reports focused on older adults with preexisting conditions; racial/ethnic data were initially not reported. It was not until early April, 2020 that Federal officials, pressed to release racial demographic data, confirmed what health disparities advocates and researchers feared: The most vulnerable American citizens are disproportionately affected (Berry, 2020). Although high infection and mortality rates of these groups, particularly Black Americans, were presented as breaking news, this state of affairs is not surprising, as this population has long experienced higher rates of chronic diseases that increase COVID-19 mortality, including diabetes, high blood pressure, obesity, and asthma (Chow et al., 2020; Lahut, 2020; Poston et al., 2020). The states that have collected and released race-based data show alarming but predictable trends—Black Americans are dying from COVID-19 complications at significantly higher rates than other groups (Haynes, 2020; Yancy, 2020). This oversight parallels the historic downplaying of race/ethnicity as a critical variable in the field of clinical psychological research (Roberts et al., 2020).

To prioritize health equity, it is paramount that the public health officials standardize, collect, and make available existing race and ethnicity data in a timely manner. These data are central to understanding health care inequalities and ensuring optimal health and fairness for all (Maybank, 2020). There are opposing views on the necessity of collecting race-based data within the U.S. government. However, in mid-April, 2020, the Congressional Black Caucus introduced legislation, *The Equitable Data Collection and Disclosure on COVID-19 Act*, to ensure that the Department of Health and Human Services would begin to collect and post essential demographic data such as race, ethnicity, sex, age, and socioeconomic and disability status, daily on the Centers for Disease Control and Prevention website along with COVID-19-related testing, treatment, and outcomes (Atkins, 2020; Pressley, 2020). As of early June, 2020, states were required to report COVID-19 data by race and ethnicity, which is essential for the identification of community needs and the best ways to allocate vital resources (Shelton, 2020).

### Mental Health Disparities and the Likely Impact of COVID-19

The lack of attention paid to the mental health needs of BIPOC, who are disproportionately represented in risk for mental illness (American Psychiatric Association, 2017b), continues today. Further, due to various historical, linguistic, and cultural factors, BIPOC often experience psychological symptoms that are undiagnosed, underdiagnosed, or misdiagnosed (APA, 2017b; Skosireva et al., 2014; Wyatt, 2009). High rates of deep poverty, unemployment, and social isolation are consistently linked to increased risks for mental illness, trauma exposure, and poor health outcomes (APA, 2017c, 2019; Deluca et al., 2020; Gopalkrishnan, 2018; Reger et al., 2020). Although untreated mental illness is not associated with higher criminality, BIPOC as well as those living in poverty are most likely to experience homelessness and incarceration before they receive effective treatment (American Psychiatric Association, 2017b; Dreyer, 2020; Greenberg & Rosenheck, 2008; Lurie et al., 2015). Disparities are also fueled by stigma associated with mental illness, lack of insurance, unaffordable treatment, and culturally irrelevant practices stemming from a scarcity of clinicians trained to address the needs of ethnically diverse populations who speak languages other than English (American Psychiatric Association, 2017b; Shushanksy, 2017; Weiner, 2020). Those who have long experienced barriers to mental health access, treatment, and quality care will likely experience exacerbated

disparities and mental health risks, given increased stress and uncertainty surrounding the COVID-19 pandemic (Greenberg & Rosenheck, 2008; Novacek et al., 2020; Shushanksy, 2017; Walravens, 2020). Further, emerging data suggests that COVID-19 may be associated with increased anxiety and depression by way of impacts to the central nervous system (Speth et al., 2020); therefore, the direct and indirect impacts of the COVID-19 pandemic are critical to understand when considering the mental health impacts on vulnerable individuals.

For BIPOC who have experienced both historical and contemporary practices of enforced separation of family members, physical distancing mandates may be regarded with fear and suspicion (Garcia & Hellerstein, 2020; Kendi, 2020). For BIPOC, virus-related anxiety, coupled with mandates to socially isolate, may increase psychological distress (Novacek et al., 2020). Moreover, social support and church-going have been shown to be protective factors against depression for Black Americans (Taylor et al., 2005); thus, physical distancing could increase risk for mental health issues by limiting access to loved ones and to a worship community. Those who are already emotionally vulnerable may experience increased suicidal ideation, substance abuse and self-medication, and interpersonal violence (Deluca et al., 2020; Galea et al., 2020; Pfefferbaum & North, 2020; Reger et al., 2020).

During the COVID-19 pandemic, reports of domestic violence and child abuse have decreased, as safer at home mandates result in limited options for victims to distance themselves from their abusers and children are not able to interact with their teachers and other mandated reporters at school (Santhanam, 2020). Schools, community centers, centers of faith, parks, and other public spaces that served as safe havens have been restricted or closed for prolonged periods of time (Galea et al., 2020; Reger et al., 2020). Although abuse incidents are known to increase after natural disasters, due to exacerbated levels of stress and financial instability, insufficient documentation of these incidents impedes effective identification and response efforts (Santhanam, 2020). However, given the elevated stress conferred by the pandemic in general, it is likely that child abuse and interpersonal violence rates have risen despite fewer reports, a circumstance that is concerning and will demand the attention of mental health professionals.

Increased rates of mental health symptoms due to COVID-19 are coupled with physical distancing mandates that exacerbate barriers to treatment. Research documents the negative effects of untreated mental health symptoms, including exposure to violence and alcohol and substance use (National Institute on Drug Abuse [NIDA], 2020). Self-medication of mental health symptoms includes using drugs that are smoked or inhaled (e.g., crack, heroin, methamphetamine, marijuana, tobacco) that negatively impact lung function and increase the risk of chronic lung disease that drives COVID-19 mortality and morbidity (NIDA, 2020), while also increasing suicide, overdose, and interpersonal violence-related deaths. Mental health treatment, currently inaccessible in person, may be restricted to those with access to phone or online platforms (Reger et al., 2020; Scheiber et al., 2020; Wind et al., 2020). Low-income individuals may be especially disadvantaged by these restrictions in access to care during the pandemic.

### The Importance of Incorporating Historical Trauma and Discrimination in Research and Practice

Mental health providers typically do not receive training in how to address the mental and physical consequences of historical trauma and discrimination due to race/ethnicity, sexual orientation, or gender. Research has established that trauma can be transmitted across generations, unfavorably impacting marginalized groups and communities that share a history of subjugation, persecution, or group trauma (Mohatt et al., 2014; Wyatt, 2009). Historical trauma negatively impacts both mental and physical health, yet its significance to mental health remains inadequately addressed (Grills et al., 2016). Although the historical trauma literature originated from research describing the plight of children of Holocaust survivors (Kellerman, 2001), the term has also been applied to Indigenous groups that include Black, Latinx, and Native Americans (American Psychiatric Association, 2017a; Mohatt et al., 2014). Although mental health professionals are called on to understand the role of racism and unequal power dynamics in research and clinical settings (Medlock et al., 2016; Szymanski & Stewart, 2010; Williams et al., 2018, 2019), the impact of historical trauma on the recovery process among BIPOC is not adequately addressed or supervised in practice (Grills et al., 2016). To effectively meet the needs of BIPOC, providers must have academic, training, and continuing education opportunities to assess and treat survivors of historical trauma.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, criteria for trauma specifies, "exposure to actual or threatened death, serious injury or sexual violence" (Holmes et al., 2016; Jones & Cureton, 2014, p. 261). Racial, historical, and discriminatory trauma may not meet this definition of trauma, nor does it meet the criteria for a billable diagnosis, posing yet another barrier to treatment. Rates of posttraumatic stress disorder are elevated among African Americans (Himle et al., 2009), yet clinicians who are aware of the impact of historical trauma and discrimination are left without a pathway to diagnose and provide treatment for affected BIPOC (Comas-Díaz et al., 2019; Moffic, 2015; Williams et al., 2018). Mental health and primary care providers receive limited training on historical trauma and discrimination and how to address it in the therapeutic process (Grills et al., 2016). For example, the generational effects of slavery continue to be evident both in currently racist institutions, seen in practices such as redlining, as well as in the descendants of enslaved people themselves. Interventions such as Emotional Emancipation Circles (Grills et al., 2016) make explicit these effects and empower participants with historical knowledge, understanding, and an active and engaged community.

Experiences of discrimination and other forms of trauma should be routinely included in clinical interviews and research examining the effects of trauma (Loeb et al., 2018), and screeners that assess for these experiences should be adopted in primary care and mental health settings (Chin et al., 2020; Liu et al., 2015; Myers et al., 2015).

### Next Steps for Mental Health Professionals

The COVID-19 pandemic highlights the deep-rooted historical and structural inequities that disproportionately impact BIPOC. A return to the norm is simply not enough for the marginalized; this global crisis is an opportunity to initiate long overdue structural changes that will address health disparities and promote health

equity for all. To do this, mental health providers must also be willing to confront how they have been complicit in the formation of these inequalities and lead efforts to confront and remedy them at the structural (e.g., nationwide, federal), professional (e.g., the psychology industry), and individual (i.e., the practitioner/researcher) levels.

## Structural-Level Recommendations

Mental health professionals must advocate for Federal wraparound programs similar to the established Ryan White HIV/AIDS programs to increase access to health care and mental health parity during and after COVID-19. Such programmatic efforts will provide the holistic and integrated care needed for underserved populations by way of addressing barriers related to cost and provider availability (Novacek et al., 2020; Weiser et al., 2015). These efforts could not only provide needed mental and physical health care for complications that arise as a result of contracting and recovering from COVID-19 but could also provide broader wellness programming that enhances recovery and resiliency, such as nutrition, stress management, and exercise, all areas likely to be negatively impacted by COVID-19.

As providers are increasingly using telehealth interventions in the midst of the COVID-19 crisis, providers should advocate for its cost effectiveness, coverage, and continuance postpandemic to increase access and promote retention in mental health treatment for marginalized groups (Novacek et al., 2020). Mental health professionals need to advocate for multidisciplinary mental health teams and multisector collaborations and essential services for BIPOC, not only for basic needs that have been adversely affected by the interaction of systemic inequalities and the pandemic (e.g., food, housing, transportation), but assisting in the therapeutic process as well (Dunseith, 2020). Partnerships across a range of sectors are necessary to address more pronounced gaps in care and to address physical/mental health disparities at various levels of influence (Brown et al., 2019). All of the above recommendations can be better tailored if informed by accurate data.

In health crises such as the COVID-19 pandemic, disaggregated data by race/ethnicity are essential when determining how to focus these efforts to meet the needs of the most vulnerable. This information is vital because it saves lives and informs where resources are directed. Finally, disparities in funding to BIPOC scientists needs to be addressed. Mental health professionals need to advocate for BIPOC to receive funding for mental health disparities research, including the effects of COVID-19 on mental health. In a recent study on major research grants (RO1 mechanism) awarded by the NIH, Black American scientists were found to be 13% less likely to be awarded National Institutes of Health (NIH) grants compared with White American scientists (Ginther et al., 2011; Hoppe et al., 2019); this disparity may be due in part to differences in research topics proposed. African American scientists are more likely to submit community- or population-level work as opposed to basic science proposals, the latter of which has higher funding rates (Hoppe et al., 2019).

## Professional-Level Recommendations

To commit to structural changes in the system, the mental health profession must examine its history and current practices that reflect the racism that exists in society today (Eatkin, 2000). Although the APA has established advocacy efforts to both bring attention to and mitigate disparities through its Health Disparities Program (Keita, 2012) and Political Action Committee (APA, 2017e), health and mental health disparity outcomes, inexorably linked (APA, 2017d; Ohrnberger et al., 2017), nonetheless persist. Although the mental health care workforce has become more diverse, there continues to be a lack of representation of BIPOC among professional mental health providers including social workers, therapists, psychologists, and physicians, which serves as a barrier to effective treatment and reduces BIPOC willingness to entertain the possibility of an academic career in mental health (Association of American Medical Colleges, 2019; Lin et al., 2018). Approximately half (44.8%) of licensed psychologists in the United States work in independent practice settings, primarily providing services to (96%) White populations (Hamp et al., 2016). Despite the fact that a large proportion of the population identifies as BIPOC, only 52.7% of psychologists indicate that they feel well-prepared to provide services to diverse populations. Those who report being knowledgeable about working with diverse populations cite academic (i.e., peer-reviewed journals, books, and colleagues) sources of this information (Hamp et al., 2016), rather than training or professional experiences.

Although providers' formal education may include information about how to work with underserved populations and/or the effects of structural inequalities, students' training experiences often do not include working with community populations of individuals who are disproportionately more likely to live in deep poverty and are therefore more likely to be impacted by COVID-19 (APA, 2018, 2019, 2020). Additionally, language and cultural barriers experienced by clients and mental health providers add barriers to effective care (American Psychiatric Association, 2017b; APA, 2017b, 2017c); there remains a lack of mental health professionals who can deliver services in clients' native languages. For instance, Latinx/Hispanic populations constitute the largest racial/ethnic minority group in the United States, constituting almost 18% of the population. However, in a national survey, only 5.5% of psychologists indicated that they can provide services in Spanish (Smith, 2018). The most frequently reported treatment areas reported by these clinicians included anxiety, depressive, and trauma and stressor-related disorders, illnesses disproportionately experienced by BIPOC (Myers et al., 2015), providing the opportunity for mental health professionals with community training to meet the needs of these populations (Hamp et al., 2016). An assessment should be conducted to evaluate how clinicians are trained to include enhanced diversity and bias training at the graduate and internship training levels, postdoctoral level, and at the licensure level through continuing education requirements (APA, 2020). How this material is implemented in supervision, classes, administrative activities, or in research needs to be evaluated (APA, 2018).

To address disparities and improve relations with BIPOC, it is important to partner with community-based organizations, such as churches and local nonprofit organizations, as well as community stakeholders, to help build bridges. This would not only help increase trust of mental health providers, which is a barrier to treatment (Kennedy et al., 2007; Wyatt, 2009), but also allow for the expansion of research activities outside of the laboratory into more naturalistic settings, increasing the diversity of samples, and

ultimately increasing the generalizability of research findings (Hamilton et al., 2020; Wyatt et al., in press). In addition, these partnerships and enhanced connections with communities of color will assist in the development and dissemination of race-conscious interventions that effectively meet the needs of marginalized groups.

Training programs should also emphasize advocacy in accordance with existing APA efforts, including (a) advocating for the provision of phone-only services, (b) encouraging support for COVID-19 related research, (c) lobbying for universal physical and mental health care and/or Medicare options to cover health costs, and (d) informing law makers of COVID-19-related mental and behavioral health needs. In addition, coursework on the effects of social determinants of mental and physical health, as well as formal training opportunities with community populations, should be required (Compton & Shim, 2015; Siegel et al., 2018). Including advocacy training as part of graduate education and training programs would better prepare emerging practitioners in the field to understand the issues facing BIPOC as well as feel supported and confident in their abilities to work with those most disenfranchised. Partnering with other health care disciplines will amplify efforts to advocate for policies that help reduce poverty, better prevent and manage chronic diseases, and promote socioeconomic well-being of disenfranchised groups (Thorpe et al., 2017). Emphasizing mental health professionals' role as advocates for health equity and parity should be included in continuing education requirements for licensure. Without advocacy, BIPOC living in marginalized communities will be exposed to ever widening disparity gaps. Licensing requirements and continuing education must address the historical issues that have impacted the field and contributed to the present-day disparities.

Although most APA-approved mental health training programs describe diversity in training and in didactic learning as well as supervision in research, there is no program that specifically addresses the needs of mentors of trainees and faculty whose backgrounds represent groups that are diverse and marginalized. It is assumed that faculty members with doctorates can mentor trainees or faculty from diverse backgrounds, processing and addressing race, gender and sexual orientation related experiences that trainees and young faculty may be reluctant to disclose, yet which may interfere with their ability to feel a part of the system and receive needed assistance (Wyatt et al., 2009, 2019). When a trainee or faculty fails to succeed, it is rarely understood as a failure in the support system around that person; rather, it is deemed a failure of the person's ability to "make it." There are Mentoring the Mentors workshops available to professionals in academic settings where mentors are the focus. These workshops are designed to develop the skills to facilitate conversations about "imposter syndrome," implicit and explicit biases, the value of code-switching in White-dominated settings, and identifying internalized racism in people of color, among other important issues (Wyatt et al., 2019). Through videos and role playing, mentors learn how to develop new skills of communication around the race/ethnicity of the trainee or faculty member who represents diverse populations. Universities and institutions should require all faculty to learn to mentor diverse trainees and early career researchers and educators.

## Individual-Level Recommendations

In addition to advocacy at both the structural and industry levels, personal responsibility and buy-in as professionals is essential to take ownership of these goals and act in accordance with them. Awareness of APA-led advocacy efforts (i.e., APA's Psychology Advocacy Network and Advocacy training) should be emphasized in education and training programs (APA, 2017a). Mental health professionals are uniquely positioned to use their expertise to address stress and distress experienced by medical professionals and patients coping with the COVID-19 pandemic (Shullman, 2020). Clinicians can lead these efforts by providing services that address a broad spectrum of mental health needs, including stresses related to unemployment, interpersonal violence, and mental health (e.g., depression, anxiety, posttraumatic stress disorder, substance use disorders; Shullman, 2020).

To accomplish this, mental health professionals must strive for continual growth in the area of cultural humility. This commitment to understanding issues such as racism, discrimination, and historical trauma will aid in the development of clinical practice that is inclusive, safe, and promotes the understanding and validation of the lived experience of patients (D'Anna et al., 2018). Mental health professionals must also acknowledge and understand the history of the profession and the role it has played in the formation of disparities. This level of awareness and humility may act to cultivate rapport with clients that experience apprehension or distrust of the therapeutic process. Such an environment will encourage healing within the relationship between patient and provider.

Interventions designed to minimize health and mental health risks must account for critical vulnerabilities (e.g., housing, food, and transportation instability) that increase mental health problems, lead to research study attrition, and reduce intervention gains (Hamilton et al., 2020). Additionally, clinicians must be aware of an individual's personal history of trauma, as it can negatively impact treatment use, engagement, and adherence, as well as trust and communication with providers (Green et al., 2016; Saha et al., 2011). Mental health providers must be willing to develop relationships with community leaders, faith leaders, community stakeholders, and others who are not traditional partners of the mental health community to ascertain how one could best meet the needs of these communities through dedicated work. Such working relationships help foster trust between the profession and underrepresented groups (Hall et al., 2002; Kelch-Oliver & Smith, 2014). Collaborations between mental health clinicians and other colleagues will increase their effectiveness when confronted by the disparities experienced by their clients (Dreyer, 2020). These structural-, professional-, and individual-level changes could help best serve most vulnerable to the negative impacts of the COVID-19 pandemic.

## Conclusion

In sum, the catastrophic impacts of COVID-19 serve as an important juncture for the mental health professions to make long overdue changes at the structural, professional, and individual levels. With the nation stopped in its tracks and its people especially attuned to inequities, it would be remiss to let this moment pass without fighting for structural change. This is a call to action

for the discipline to put mental and physical health equity at the forefront of the national conversation to help create a tomorrow that is better than yesterday's norms. For every crisis that occurs, no matter how tragic, one can also see an opportunity for change. The mental health professions have not done enough to fully understand how to assess individual differences and the many paths to success and well-being that exist. There is no better time than now to make a difference.

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