10 MISTAKES TO AVOID WHEN

Developing a Mental Health Program

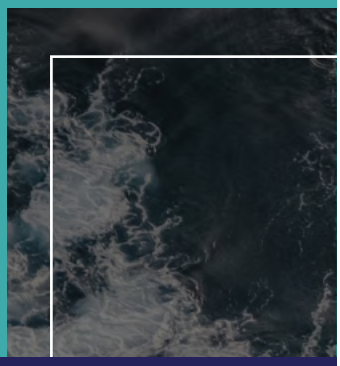
BY DR. SALLY SPENCER-THOMAS

www.SallySpencerThomas.com

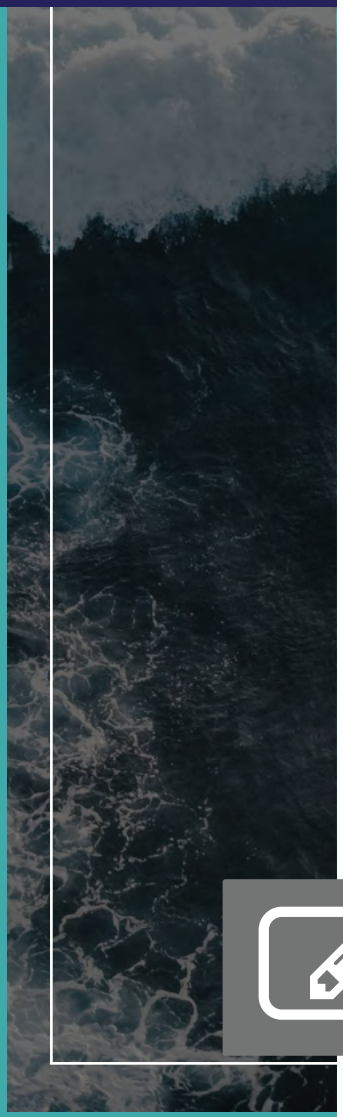
Suggested Citation:

Spencer-Thomas, S. (2022). 10 Mistakes Leaders Make When Developing a Mental Health Program. Conifer, Colorado. Sally Spencer-Thomas LLC.

© Sally Spencer-Thomas LLC



#1



Believing that simply having an EAP means they have a "mental health program."

Many organizations with over 50 workers have the benefit of an "Employee Assistance Program" (EAP) but don't really know what it does, who is using it, or if it's any good. Often, the contract goes to the lowest bidder and the value of the EAP is thin. The bare bones EAP usually amounts to a slow-responding, telehealth resource that is challenging to navigate and demoralizes the end user.

Top tier EAPs are a different story. Their services are robust, usually offering multidisciplinary mental health services, psychoeducation, assessments, and even financial counseling and legal support. Even still, organizations must be fully engaged partners with their EAPs for the programs to have an impact.

Many barriers to EAP usage exist, and when organizations access the utilization rates of this benefit, many are surprised to see how low they are. People often do not know that the EAP exists, what services are offered, or if they are eligible. They also have concerns about confidentiality and if their use of the resource will somehow be used against them. Thus, the organization must continually work collaboratively with the EAP to promote resources, normalize usage, and evaluate impact.

Furthermore, having mental health services available to people is just one component to a much larger comprehensive approach. Everyone can and should play a role in their organization's mental health and psychological safety plan. Getting people connected to mental health support services does not solve all mental health problems. Rather, organizations must also look at what drives despair and distress as well as understand the various cultural or systemic issues that contribute. Getting "troubled people" to counselors won't help if the environment in which they reside is broken.

For those organizations that don't have an EAP, they are not aware of the other mental health services and supports available to them in their community or through other online means. They do not know how to find quality resources, what questions to ask, or how to determine a resource's credibility.

For these reasons, we recommend an annual "Mental Health Services Audit." Organizations need to "kick the tires" of their resources, become better informed consumers who can advocate for the right services and metrics, and develop deeper relationships with their providers so that when the "warm handoff" is needed to support a person, everyone has confidence in the referral and it feels less like tossing a hot potato.

ALTERNATIVE ACTION STEPS: Conduct a mental health services audit and build out an "upstream, midstream, and downstream" strategy that extends beyond the EAP services.

© Sally Spencer-Thomas LLC

#2

Having a "Check the Box" mentality.

We would never think a one-time training in CPR would keep our skills sharp over the long haul, and yet one-and-done training for mental health remains the norm. It seems sometimes that these efforts are more window dressing— "See, we *are* doing something!"

While the symbolic impact of these efforts and the annual awareness days do matter, they often fall prey to what we call the State Trooper Effect. When we are driving along at, say, 10 miles or so over the speed limit and we see a police car with a trooper pointing their radar gun, we immediately slow down. Then, some of us even wave and smile: "Look at me! I'm a law-abiding citizen!" As soon as the state trooper is in our rearview mirror, however, our lead foot kicks in and we go right back to speeding.

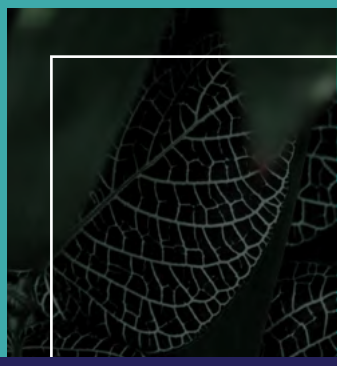
The same is true for "Check the Box" approaches. When the training or awareness campaign is in front of us, we may pay attention and even change our behavior for the short term; however, without additional reinforcements, we are likely to just fall back into old patterns.

The antidote to the "Check the Box" mentality is the "Slow Drip Over Time" approach. Many small messages, policy changes, trainings, and resources can be baked into everyday culture and processes. Their presence becomes such a daily part of the routine we begin to think, "This is just how we do it around here." It becomes a mindset rather than a compliance (i.e., State Trooper Effect) behavior change.

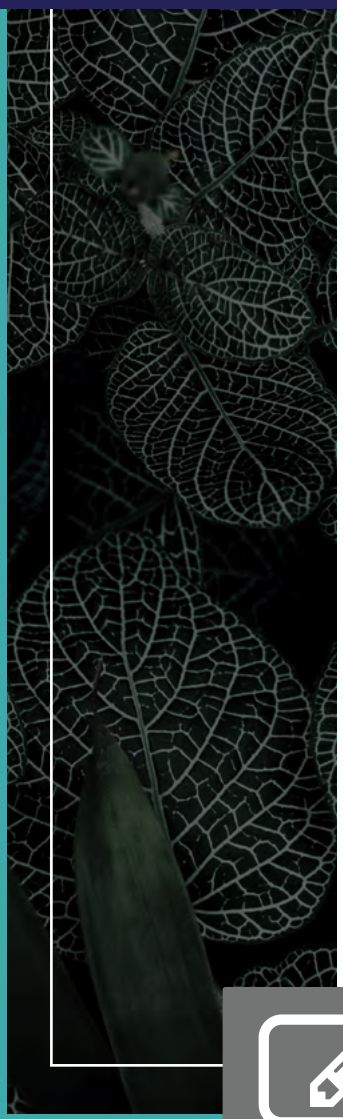
The other problem with the "Check the Box" approach is that these efforts are often not evaluated, so we never really know: Did our efforts make a difference? Is our approach a good match for the end user? Did its impact last into the long term? These quality assurance questions are essential for building a comprehensive and sustained approach to mental health promotion and suicide prevention.

ALTERNATIVE ACTION STEPS: Build a long-term, multifaceted approach that is integrated into health and safety priorities.

© Sally Spencer-Thomas LLC



#3



Relying on raising awareness only.

Raising awareness is a necessary but insufficient condition for change. We need to have a problem on the radar to know that there is something to address. Nevertheless, awareness does not on its own lead to impact. How long did we know that smoking was bad for us, and yet for many the behavior continued?

The problem with "Raising Awareness" tactics for mental health promotion and suicide prevention is that they usually take pathways that can result in unintended consequences. With suicide prevention awareness campaigns, for instance, we often pound the drum of death data— "THEY ARE DYING! THEY ARE DYING! THEY ARE DYING!" While I understand the rationale behind this approach and have certainly done it myself to foster urgency and spur action, the unintended consequence is running the risk of developing a self-fulfilling prophecy—a cultural script, if you will. We reinforce a narrative of how things play out: who dies, when they die, how they die, and why they die. Instead of only presenting the dire statistics of suicide deaths and attempts, we need to, in equal measure, talk about the positive statistics—how many people live and grow through their periods of suicidal intensity? How many people reach out and are successfully helped? How many people have been saved by services like crisis lines and peer support?

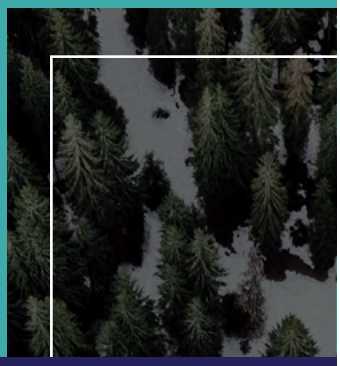
Another common tactic is to list the criteria for mental health diagnoses. Again, improving mental health literacy often means understanding what qualifies for a mental health condition and what does not. The trouble with this tactic is that we sometimes inadvertently create armchair psychologists who start diagnosing themselves, family members, friends, and even strangers. Many of these methods rely extensively on increasing the public's biogenetic and neurological explanations of mental health conditions while downplaying the social determinants and underlying social justice inequities that drive despair. For instance, learning a list of symptoms does not give any information about the impact at work for the individual employee. The problem-solving component of many of these trainings and campaigns is based solely on steering the person to treatment so they can cope, not on resolving root causes so they can heal.

A recovery and healing approach instead focuses on what the person needs right now. Education about diagnostic categories can happen in a recovery-oriented teaching program, but in a way that informs learners that they are learning medical information, that the medical information is not the basis for engaging with a person who is in distress, and that it does not inform us about the person in a meaningful way.

Together, these foreboding messages of death and illness can elicit fear rather than hope. While fear can be motivating, it often drives self-protective instincts to withdraw and separate ourselves from "the Other" rather than to connect through compassionate action.

ALTERNATIVE ACTION STEP: Move beyond awareness and into action—build skills, improve policy, and change behavior.

© Sally Spencer-Thomas LLC



Developing stigma reduction campaigns.

#4

Our brains are hardwired to remember the negative things. You are driving down the highway and your brain becomes so complacent you might notice yourself drifting off or not remembering anything you saw for the last 15 minutes. Then, all of a sudden, a deer jumps in front of you, or the car next to you unexpectedly veers into your lane—now you are awake!

In other words, our brains are more likely to remember problems, crises, and things out of the norm so we can protect ourselves and learn. So, when we constantly talk about the stigma of mental illness, we aren't weakening prejudice toward mental health conditions. Rather, we reinforce the connection through repeated association.

Similarly, many anti-stigma campaigns compare myths and facts. Do you know what the post-test results show? *People remember the myths more than the facts*[1].

What is "stigma" really? Many researchers define stigma as a multi-dimensional concept based in social separation, prejudice, and discrimination[2]. When we understand it as a form of bias, we realize that we are all susceptible. Humans are built for bias, created via the shortcuts our brains take so we can process lots of information at once.

What is the best way to dismantle this bias? Developing relationships with people who live with marginalized conditions. When we understand people as whole human beings, our differences tend to fall away[3]. Thus, storytelling— and what some have called the "Contact" approach—are more "sticky," effective ways of mitigating prejudice around mental health conditions and suicide.

ALTERNATIVE ACTION: Develop messages that change the narrative to hope and recovery. Share positive actions people can take to help themselves and others through inspiring stories of healing and support.

1 Dobson, K. S., & Wolf, S. (2021, May 20). "Myths and Facts" Campaigns are at Best Ineffective and May Increase Mental Illness Stigma. Stigma and Health. Advance online publication. http://dx.doi.org/10.1037/sah0000323

2 Stuber, J., Meyer, I. & Link, B. (2008). Stigma, prejudice, discrimination and health. Soc Sci Med; 67(3): 351–357. doi:10.1016/j.socscimed.2008.03.023.

3 Igartua, J. and Frutos, F (2017). Enhancing Attitudes Toward Stigmatized Groups With Movies: Mediating and Moderating Processes of Narrative Persuasion. International Journal of Communication 11, 158–177. Retrieved on January 28, 2022 from https://ijoc.org/index.php/ijoc/article/view/5779/1891

© Sally Spencer-Thomas LLC

Not “baked into” health and safety priorities.

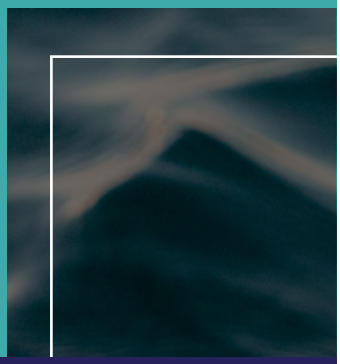
#5

When mental health initiatives are stand-alone programs, they are less effective and more likely to be chopped from the budget when times get tight. An integrated strategy helps people to connect the dots between overall health and safety and psychological health and safety. With a siloed approach, however, we have less of an opportunity to understand how mental health and safety impacts things like productivity, innovation, and engagement.

Rather than getting delegated to a “wellness” person, mental well-being is understood as everyone’s job when we strategically and intentionally prioritize it. We do this by having the topics show up in matter-of-fact ways multiple times during a person’s tenure—from recruitment to selection, orientation to promotions, and through to retirement. People are empowered to think about how their gifts, skills, and passions can help the cause rather than leave the work to the mental health experts alone.

ALTERNATIVE ACTION: Strategically integrate mental health promotion and suicide prevention efforts into other health and safety priorities and cultivate a psychologically safe climate.

© Sally Spencer-Thomas LLC



Do not seek first to understand.

#6

Leaders often think they know what the issues are. They make assumptions and want to jump right into the so-called solutions. Here is what they are missing: listening deeply to people is a solution.

We gain so much when we take the time to create a safe space for people to share their perspectives about distress, mental health barriers and buffers, and their attitudes about culture and resources.

Listening to diverse community stakeholders **before** any change (training, education, skill development, etc.) is essential for a number of reasons:

- To gain buy-in and hear the naysayers' concerns
- To better understand the resources that already exist to support people
- To determine how well mental health services are known and trusted
- To identify champions and storytellers who can share stories of living through tough times
- To gather baseline data for benchmarking future change
- To prioritize needs for urgency and resources in strategy development

Listening sessions can combine focus groups, interviews, and surveys. A best practice is to have these data collected and synthesized by a neutral third party without an agenda or preconceived ideas—someone who has not become desensitized to the culture. Eventually, from this process, mental health champions, ambassadors, and advisors will emerge to ensure the mental health program is "by, about, and for" the people.

ALTERNATIVE ACTION: Conduct a gap analysis through a complete needs and strengths assessment involving surveys, focus groups, interviews, and other listening tactics.

© Sally Spencer-Thomas LLC

Relying only on outside experts rather than building internal capacity.

#7

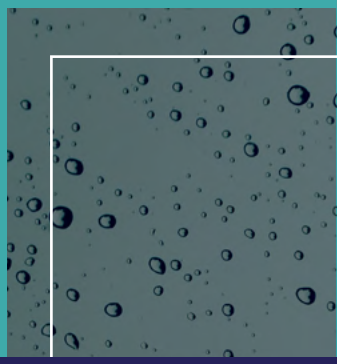
The mental health community often inadvertently compromises the confidence of everyday people as powerful allies in peers' mental health journeys. We have repeatedly made mental health conditions appear overly complicated with academic jargon and medicalized treatment. This overcomplication tells the general population that they should not get involved because everyday people are not qualified to help.

Yes, qualified mental health providers have a unique and life-saving role in the chain of recovery. However, if we only rely on mental health professionals to address these concerns, we are never going to get in front of mental health emergencies. There are many people who do not understand how psychotherapy works, don't see it as relevant, or have a strong mistrust of the healthcare system and are reluctant to reach out to professionals because of it.

ALTERNATIVE ACTION: Develop internal capacity for mental health knowledge, skills, and advocacy. What does this look like?

- Training-the-trainer models (often in partnership with a mental health professional)
- Mental health champions who educate and advocate
- Leadership skill development in psychological safety and emotional intelligence
- A peer support program (see Mistake #8)

© Sally Spencer-Thomas LLC



Underestimating the power of peer support.

#8

The truth is that peers help one another every day in very meaningful ways. Peers are much more accessible than professional mental health services and often have shared experiences that let others know they are not alone.

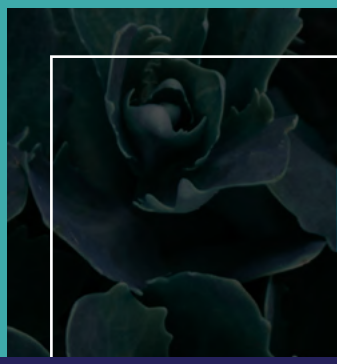
Peers are often highly trusted and the first to know when someone is going through a personal challenge. Because of this high trust and common lived experience, they are often effective bridges to resources. They can normalize the process of reaching out when they say, "I've been in a dark place, too. Here is what helped me…." They are also in a position to follow up and ensure the resources are working out well after help-seeking has started.

With some training and supervision, a small cohort of dedicated peers can make a huge impact. Many times, emerging mental health crises can be resolved at the peer level. Having someone there standing shoulder-to-shoulder gives people strength because they feel seen and known.

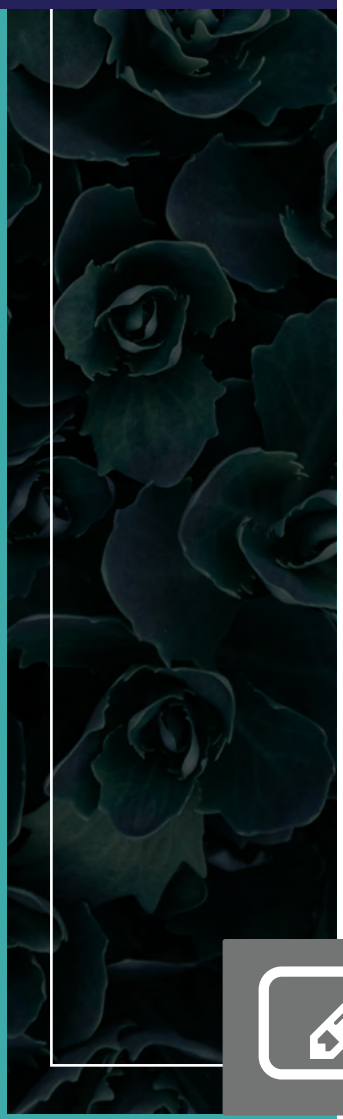
Peers also benefit from being peers; their mental health is bolstered during the service. "Doing good feels good," and being a role model for others keeps people accountable to their own wellness practices. Thus, cultivating peer allyship in many organizations is an important consideration in any mental health program.

ALTERNATIVE ACTION: Build an internal formal or informal peer support program where a cohort of carefully selected peers learn how to connect through shared meaningful experiences, offer compassion, empower others, and become bridges to resources.

© Sally Spencer-Thomas LLC



#9



Leadership doesn't lead.

If mental health seems far from an organization's mission, many leaders may think, "This is not my job." They couldn't be further from the truth.

Leadership is essential in any organization to drive a culture of trust, validate people's experiences, and model emotional well-being, compassion, and self-care.

A leader cannot just delegate the mental health program to a person whose title may seem more connected. A leader needs to get in the arena and be "vocal, visible, and visionary." When they model their own vulnerability and demonstrate the benefits of help-seeking, they do more to shift culture than just about anything else.

Leaders can link the importance of mental health to the priorities of the organization by saying, "This is why mental health and suicide prevention matter to us." They can then make it personal by saying, "This is why it matters to me." When they say, "I get it, me too," and give a specific example of a challenge they have faced, leaders show they understand that they are human. This expression of vulnerability earns them credibility as courageous and trustworthy people and helps them be even more impactful leaders.

Leaders can also acknowledge when community members are facing challenges right now by listing specific examples which emerge through listening sessions. They can offer forums for connecting and informal check-ins that let people know they matter and that leadership wants to hear about their challenges.

During rough patches, leaders can declare, "While we had no choice but to rise to these challenges, we have choices about how we take care of each other. Your work matters because you matter to us. Your families matter to us. We don't want you to just survive the coming weeks and months, we want you to thrive because we need you. You are part of our community and part of our family. Today, I want to talk about how we are going to take care of you and each other over the next few weeks."

When leaders allocate the resources of money, time, and human capital to the effort of promoting mental health and preventing suicide, people see that they are walking their talk. They see leadership has a plan to help them. When leaders have firsthand knowledge of the mental health resources they are promoting, those resources gain credibility.

Leaders can also offer gratitude for the community's service and dedication to a culture of care. They can connect how the efforts are contributing to the overarching importance of the communal mission and vision. They can recognize and reward key people or groups for doing specific actions that demonstrate resilience and care for one another.

ALTERNATIVE ACTION: Engage leaders in high-level briefings and strategy sessions to understand root causes, champion solutions, and inspire hope.

© Sally Spencer-Thomas LLC

#10

Ignoring the psychosocial hazards.

The increased attention to "mental health literacy" and the urgency to get distressed people to counselors may be a deflection away from the importance of psychosocial hazards in the environment. If organizations believe that mental health symptoms and suicide crises are only due to untreated or mistreated mental illnesses, they may be engaging in a state of denial about their own systemic contribution to the problems. One tactic used to minimize an organization's role is medicalizing suicide as being the sole result of individual psychopathology and as wholly separate from their work life.

Environmental toxicity, or "psychosocial hazards," have historically been underappreciated in the discourse about mental health promotion and suicide prevention. However, research[4] connects a number of organizational stress-related factors to risk of suicide death and attempts, even when controlling for mental health problems. Such hazards include:

Organizational Design Challenges

- Low control, lack of decision-making power, and limited ability to try new things
- Excessive demands and constant pressure
- Effort-reward imbalance
- Insecurity about the future
- Lack of autonomy or variety

Toxic Interpersonal Relationships

- Bullying, harassment, and hazing
- Prejudice and discrimination
- Lack of support

Lack of Purpose or Connection to Mission

- Heightened dissatisfaction and the feeling of being "trapped"
- Effort is not meaningful or rewarding

Improvements in organizations' psychosocial conditions may improve well-being and prevent suicide beyond what any mental health resource can do.

ALTERNATIVE ACTION: Understand the root cause of which psychosocial hazards are impacting employee well-being. Then, seek to mitigate or eliminate those hazards at the environmental level rather than only the individual level.

4 Milner, A., Currier, D., LaMontagne, A., Spittal, M., & Pirkis, J. (2017) Psychosocial job stressors and thoughts about suicide among males: a cross-sectional study from the first wave of the Ten to Men cohort. Public Health. 147:72-76. doi: 10.1016/j.puhe.2017.02.003. Epub 2017 Mar 28. PMID: 28404500.

© Sally Spencer-Thomas LLC

We Can Help

Contact us for customized support in correcting these mistakes and building a robust and comprehensive mental health promotion and suicide prevention strategy for your community.

LEADERSHIP BRIEFING AND STRATEGIC SUPPORT: Empower leaders to integrate suicide prevention and mental health promotion into a long-term strategy that is "baked into" other health and safety priorities.

NEEDS AND STRENGTHS ASSESSMENT: Conduct surveys, focus groups, interviews, and other forms of data collection to ascertain environmental aspects of job strain, stress, trauma, and life disruption that negatively impact the community's vibrancy, perceptions of mental health and suicide, and access to resources.

COMMUNICATION STRATEGY: Develop a long-term messaging plan around suicide prevention, mental health promotion, and resilience wherever health and safety messaging are happening. Cultivate stories of recovery, resilience, making meaning, and support to create a more powerful, humanized tale of the issues.

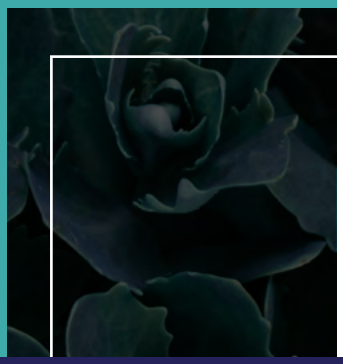
TRAININGS AND WORKSHOPS: Increase knowledge, decrease bias, and develop skills in resilience, mental health literacy, and suicide prevention, including basic skills and advanced training for managers and supervisors.

TRAIN-THE-TRAINER CERTIFICATION COURSE: Build internal capacity by developing a cohort of trainers certified to deliver suicide prevention training.

PEER SUPPORT PROGRAM DEVELOPMENT: Enroll peers, ombudsmen, and ambassadors to increase awareness of and comfort with mental health and suicide prevention resources, improve positive co-worker assistance, and normalize help-seeking and help-giving behavior. Emphasize the least restrictive peer support, collaboration, and empowerment.

MENTAL HEALTH AND CRISIS RESOURCES AUDIT: Evaluate and promote culturally relevant mental health, addiction, and crisis services that are well-versed in state-of-the-art, best suicide prevention practices.

© Sally Spencer-Thomas LLC



About The Author

SALLY SPENCER-THOMAS, PSY.D.

Sally Spencer-Thomas is a clinical psychologist, inspirational international keynote speaker, podcaster, and impact entrepreneur. Dr. Spencer-Thomas was moved to work in suicide prevention after her younger brother, a Denver entrepreneur, died of suicide after a difficult battle with a bipolar condition. Known nationally and internationally as an innovator in social change, Spencer-Thomas has helped start up multiple large-scale, gap-filling efforts in mental health. She initiated the award-winning campaign Man Therapy (www.ManTherapy.org), acted as the lead author on the National Guidelines for Workplace Suicide Prevention (www.WorkplaceSuicidePrevention.com), and founded "Construction Working Minds" (www.ConstructionWorkingMinds.com).

Dr. Spencer-Thomas has held leadership positions at the International Association for Suicide Prevention, the American Association for Suicidology, and the National Suicide Prevention Lifeline. She has won multiple awards for her advocacy, including the 2021 ENR Newsmaker, the 2014 Survivor of the Year from the American Association of Suicidology, the 2014 Invisible Disabilities Association Impact Honors Award, the 2012 Alumni Master Scholar from the University of Denver, the 2015 Farbarow Award from the International Association for Suicide Prevention, and the 2016 Career Achievement Alumni Award from the University of Denver's Graduate School of Professional Psychology.

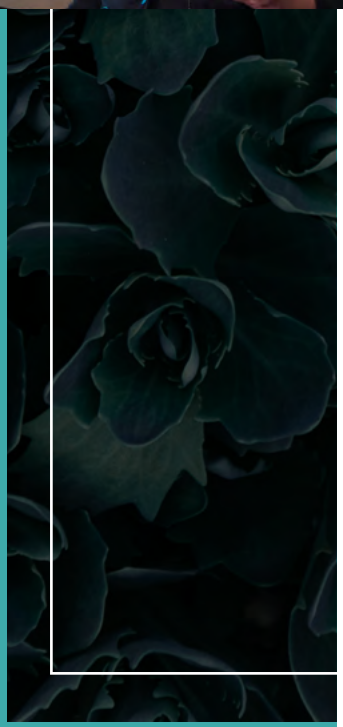
In 2016 she was an invited speaker at the White House, where she presented on men's mental health. In her recent TEDx Talk, she shared her goal to elevate the conversation to make mental health promotion and suicide prevention a health and safety priority in our schools, workplaces, and communities.

She has a Doctorate in Clinical Psychology from the University of Denver, a Master's in Nonprofit Management from Regis University, a Bachelor's in Psychology and Studio Art, and a Minor in Economics from Bowdoin College. She has written four books on mental health, such as Guts, Grit & The Grind (https://www.gutsgritgrind.com), and violence prevention. She lives with her partner and three sons in Conifer, Colorado.

Connect with Sally at www.SallySpencerThomas.com, on Facebook (@DrSallySpeaks), Instagram/Twitter (@sspencerthomas and #ElevateTheConvo), LinkedIn, and on her "Hope Illuminated" podcast wherever you tune in.

Contact Information

www.SallySpencerThomas.com
720-244-6535
SallySpencerThomas@gmail.com



© Sally Spencer-Thomas LLC