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September 21st, 2020

Steering Committee (Zoom) Meeting minutes

Objectives:

* Discuss some of the cultural models for mental health covered in the Frameworks presentation at the last meeting, noting the prevalence of each model in our community
* Identify as a group where/when these models may occur, and how they can be tweaked to better represent how mental health and mental illness are framed for individuals in our community
* After reaching an understanding of these models/frames, discuss the implications for our work and possible next steps for the committee

Note: Please consult the handout Bridget emailed out on 9/21 explaining the models. For clarity, I will refer to the models as:

* Model 1 – Health Individualism
* Model 2 – Mentalism
* Model 3 – Spectrum of Normality
* Model 4 – Chemistry is Genetic

First “Break-Out” discussion: Do you recognize these models from your community?

* Guiding questions:
	+ Where or when do you encounter them?
	+ How widespread are they? Are they used by certain people or are they generalized models?
	+ Are there other models that you think better describe your community?
* Breakout Room #1 report
	+ Individualism (Model 1 and 2) seems to translate to “if its not my problem then I don’t need to deal with it”
	+ Anxiety and depression not seen as genetic the way more severe mental illnesses are (Model 4)
* Breakout Room #2 report
	+ Healthy individualism and mentalism (model 1 and 2) are similar in that either way it’s your own fault that you struggle with mental illness because you could be doing something
	+ Model 1 seems to be diminishing in terms of assigning “blame”
	+ Model 2 is still prevalent, but has diminished somewhat
		- 2 decreasing in favor of 4
	+ Model 3 (normal vs abnormal) is still very prevalent
* Group discussion
	+ Health Individualism as “mental wellness”
		- Among younger people this model is more predominant in a positive way
		- Jennifer Kass pointed out how doctors encourage patients to practice mental wellness
		- (Roger) Wellness is not the whole picture- it can be part of the treatment and management though
		- Both a positive and negative interpretation of this model- good to encourage healthy behaviors, bad to blame someone for not doing these things
	+ Are we hearing these conversations even happening that frequently? (Roger)
		- Model 3 is heard a lot in the media and seen in media representation/depiction of mental illness
		- Media is a huge source of information and where we get a lot of our attitudes from
		- Younger generation seems more accepting, older generations will shut down conversation if it comes up
	+ Models 1 and 2 seem more prevalent in rural areas
		- People who haven’t experienced it themselves or know someone intimately who has are most entrenched in the “get over it” models
	+ Additional models that might better fit our communities?
		- “Stoicism”- difficulties should be suffered through in silence
		- aspects of this model popped up in the discussion of the other models

Second Breakout Discussion: What are the consequences of using these models?

* Guiding Questions:
	+ Consequences for the general public’s understanding of mental health? For individuals we are in conversation with around mental health challenges or crises?
	+ Are there things missing from the models that you think would be important for people to understand?
* Breakout Room #2 report
	+ Consequences- stigma persisting
	+ If it’s the individual’s responsibility, then why provide social services? Why have a separate legal system?
	+ If these models go unadressed, things will persist in a negative way
* Breakout Room #1 report
	+ We want to be able to fix things
	+ Danger of the platitudes, or giving advice
		- Makes people not want to talk about it in the first place
	+ Internalization of stigma as a consequence
	+ You don’t need to provide social supports
	+ If you’re experiencing something severe, it MUST be genetic (and therefore not determined by other factors like life events)
		- Impact on trauma-informed care, does not account for some important factors
* Group Discussion
	+ Mental illnesses themselves can create chemical changes in your brain, not just result from them- problems with Model 4
		- If you don’t believe this, you will be less likely to be open to medication
		- There’s no family history, so I must not be experiencing a mental illness
		- Discussion of brain chemistry speaks to the limitations of our vocabulary- for example, how would we discuss environmental determinants?
	+ Stoicism model- if pain is irrelevant, how do we get people to take pain seriously and treat what they’re experiencing?
		- Take aspects of stoicism and leverage them to encourage treatment
			* If you don’t want to be a burden (aspect of stoicism model) then managing your depression will lessen that burden
			* Issue of using the term “burden”- necessity of carefully navigating problematic vocabulary so that we are truly achieving the end that we want rather than causing further issues

Meeting Overview

* Breakout groups allowed for more in depth discussion and understanding of cultural models and identifying ways that people frame mental health
* Models themselves aren’t necessarily negative, it’s how they shape people’s thinking and actions that can have negative results, which is why it’s important for us to gain a greater understanding of these frames
* Ran out of time for the discussion of next steps