# THE MADISON MODEL

## Remarks by Madison Mayor Dave Cieslewicz
## Obihiro, Japan
## January 2008

- Thank you Mr. Mayor and distinguished guests for this opportunity to speak with you today.

- The Madison Model is the name given to the Adult Mental Health community system of care, which is located in Madison, Wisconsin.

- It is a system that is known throughout the world for being a progressive system of care and a pioneer in community based treatment that we have been evolving over the past quarter of a century.

- Today I am going to discuss many of the salient features of our system and how we keep the focus of treatment in the community. Maybe some aspects of this presentation will be relevant and applicable to your treatment networks.

**Historic Background**

- From a historical perspective, deinstitutionalization has been occurring in the United States since the 1950s with the advent of psychotropic medications.

- In the 1950s there were over 1,400 people in the state hospital located in Madison, Wisconsin. While this hospital served over half of the state, many of these people were from the Madison community.

- Thanks in part to the advent of psychotropic medications, people's legal protections, political considerations about saving money, and the emphasis on community based treatment, there are now approximately 300 people in this institution and only a few people are from the Madison community.

- From 1950-1975, the first 25 years of deinstitutionalization, people were placed in the community without supports, in settings such as cheap hotels.

- In these settings, people had to fend for themselves with minimal supports and frequently ended up back in inpatient settings -- this has been referred to as the "revolving door."

**The Madison Response**

- Our state responded to this dilemma in 1974 by designating the counties as being responsible for the community-based treatment, as well as the payment for inpatient

care. We have been working at developing a comprehensive community based continuum of care over the past 25 years

- We started with a lot of people in inpatient settings, and we gradually established many responsible community based alternatives.

- Deinstitutionalization has been accomplished for many years, and now almost all of the people live in the community, which is our primary emphasis.

- For those people living in the community:

    - 88% reside in their own apartments with external supports and
    - 12% reside in staff supervised living arrangements.

- The involuntary inpatient days at our state hospital have decreased from a high of 5,602 in 1977 to a low of 1,050 days in 1998.

- 85% of our funding is for community-based services versus 15% for inpatient.

**Why Community-Based Treatment?**

- The community affords each individual the best opportunities to reach their fullest potential within the most normalizing environment. This is where most of us would like to live, work, and recreate.

- The need to belong and to be a part of society is a universal desire across all societies and cultures.

- Community treatment allows people to be the most productive

- Community treatment is also the most cost effective.

- It costs $211,000 for one person annually in the state hospital compared with $7,800 for one person to be treated in the community with only acute inpatient treatment as needed. Twenty-seven people can be treated in a community-oriented system compared to the cost of one person in the hospital (data from the year 2000).

- Approximately 67% of requests for inpatient treatment receive community-based alternatives.

**Community Service Overview**

- Our entire service delivery system has 40 contracted programs operating through 18 private non-profit organizations.

- It is a public-private partnership that works well for us and for the consumers receiving the services.

- We have a single fixed point of responsibility for all services, which greatly enhances service coordination. Most systems are bifurcated, having one entity responsible for inpatient and another for services to be provided in the community.

- The Emergency Services Unit provides the 24-hour crisis response, as well as acting as the inpatient gatekeeper.

- Our Centralized Referral Exchange program provides access for supervised living arrangements, community support programs, and case management services.

- All other programs, such as the day program and work programs, do their own intakes and determine who they will accept based on the criteria specified within their contracts.

- Case managers are designated within each program. If a person is involved with multiple programs, the case manager who is spending the most time with the consumer is also designated as the system case manager, meaning they are responsible for coordinating all aspects of the treatment plan and making sure that everybody is working together in the best interest of the consumer.

**City of Madison Role**

- Dane County is the primary provider of mental health services, but the City of Madison plays a role as well, especially in creating an infrastructure of support for those services.

- We provide affordable and safe housing through our Section 8 and Community Development Authority programs, which provide an alternative to the old system of placing individuals in cheap hotels.

- We provide public transportation to provide mobility to these individuals, which is very important to reduce their issues of isolation.

- Our emergency response providers – police and Emergency Medical Services (EMS) – work closely with health care providers and the County to identify mental health issues that they come into contact with and help those individuals connect with health professionals for medical care.

**System Performance Indicators - Target Population**

- In conclusion, I am going to present some of our system performance indicators or measurements of our accomplishments.

- We prioritize providing comprehensive services to the people with the most serious and persistent mental illnesses within a community-based model of care.

- One of the most significant ways to assess what is valued is how the money is spent. Eighty-five percent of our funding is used for community-based care, only 15% for institutionalized care.

- We should have a goal that 95% of our target population is able to live in the community.

- Set goals for average lengths of stay:

    - 5 days for voluntary community hospitals
    - 15 days for involuntary state hospital
    - One year for our long-term health care center

- Supervised living arrangements should not be used as permanent settings; rather, the goal is to teach the necessary skills for people to live more independently.

- 50% of our targeted population should be involved in paid work in natural community work settings. The work should be in keeping with their interests and abilities.

## Conclusion

- I am pleased to have this chance to share with you Madison's model for mental health treatment. I am also pleased to have the opportunity to learn more about the innovations taking place in Obihiro, and find ways to make our system even better.

- I would like to thank Dr. David LeCount for helping me prepare this information. I know that many of you have met Dr. LeCount during his many visits to Obihiro and other parts of Japan. We are fortunate to have him as a part of our community.

- Thank you all.

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