Argument to Retain the IMD Rule: **footnotes to the text:**

The full-text document, including the footnotes below, is posted on the Web site of the Thomas Scattergood Behavioral Health Foundation (*Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate,* http://www.scattergoodfoundation.org/sites/default/files/IMD_Exclusion_Rule_Debate_053118.pdf)

Lawmakers did not want federal payments to replace state financial commitments.[1]

[1]"The committee believes that responsibility for the treatment of persons in mental hospitals—whether or not they be assistance recipients—is that of the mental health agency of the State" (1). When Congress adopted the IMD rule, state psychiatric hospitals predominated and states generally did not pay for care in private psychiatric hospitals. Nevertheless, Congress also made the rule applicable to freestanding private psychiatric hospitals, likely reflecting the concerns about long-term institutional care described below and to encourage the use of community services and acute-care general hospitals instead.

In contrast to 1963, when state systems provided state hospital services and little else,[2] the vast majority of public service system dollars now support individuals in community settings (2).[3]

[2] "Until the passage of the Community Mental Health Act in 1963, community mental health programs had been initiated in a few states, but in most states, 'SMHA' meant 'state hospital.' The vast majority of state expenditures and services for individuals with mental illness was devoted to state psychiatric hospitals" (2).

[3] Between FY 1981 and FY 2015, state hospital expenditures increased 159% while community expenditures increased 1,528% (2).

Not only is the expansion of community services frequently overlooked as a solution, so too is the fact that the number of *private* psychiatric hospital beds has actually *increased* in recent decades (2),[4] and it is these beds, not state hospital beds, that are especially suited for crisis care.

[4]Between 1982 and 2010, while state and county psychiatric hospital beds decreased by 69%, all other mental health inpatient and residential beds increased by 14%. Between 1983 and 2014, state and county psychiatric hospital beds decreased 66%, from 117,084 to 39,907, while private psychiatric hospital beds increased 77%, from 16,079 to 28,461. Notably, much of the decrease in state hospital capacity was occasioned not only by the increased reliance on community services but also by a significant decrease in their use to serve individuals with "organic brain syndrome" or intellectual and developmental disabilities, who occupied nearly 40% of state hospital beds in 1970 but now are largely served in other settings (2).

Although the worst abuses of psychiatric institutions may be in the past,[5] institutionalization of individuals who could be served in community settings is *itself* harmful, regardless of whether abuse occurs.

[5]Although the types of abuses that occurred in the Willowbrook State School on Staten Island or Byberry (Philadelphia State Hospital) are not common today, abuse, neglect, and poor conditions in psychiatric hospitals are hardly a relic of the past, as evidenced by numerous Justice Department findings and enforcement actions and other examples (http://www.scotusblog.com/wp-content/uploads/2016/03/15-7bsacJudgeDavidL.BazelonCenterForMentalHealthLaw.pdf).

Enforcement by the U.S. Department of Justice and private plaintiffs has resulted in *Olmstead* settlement agreements across the country that require states to offer sufficient assertive community treatment, supported housing, mobile crisis services, supported

employment, and peer support services to avoid needless institutionalization in state psychiatric hospitals, psychiatric nursing facilities, adult homes, and other institutional settings.[6]

[6]See, for example, *United States v. Georgia* (state psychiatric hospitals; settlement approved 2010); *United States v. Delaware* (state psychiatric hospital and private IMDs; settlement approved 2011); *United States v. North Carolina* (privately operated adult care homes for individuals with mental illness; settlement approved 2012); *United States v. New Hampshire* (state psychiatric hospital and state nursing home for individuals with serious mental illness; settlement approved 2014); *United States v. New York* (adult homes for individuals with mental illness; settlement approved 2014); *Disability Rights New Jersey v. Velez* (state psychiatric hospitals; settlement approved 2009); *Williams v. Quinn* (privately operated IMD nursing homes in Illinois; settlement approved 2010); *T.W. v. Carroll* (state psychiatric hospitals; settlement approved 2015); *Office of Protection and Advocacy v. Connecticut* (privately operated nursing homes; settlement approved 2014); *Napper v. County of Sacramento* (individuals at risk of placement in psychiatric hospitals, emergency rooms, or psychiatric nursing homes due to community service cuts; settlement approved 2012); *Katie A. v. Bonta* (California foster care children with mental health needs in or at risk of placement in institutions; settlement approved 2011); and *T.R. v. Quigley* (Washington State children with mental health needs in or at risk of placement in institutions; settlement approved 2013).