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THE DUTY OF CALIFORNIA COUNTIES TO PROVIDE MENTAL HEALTH CARE FOR THE INDIGENT AND HOMELESS

The increasing number of homeless and indigent mentally ill poses difficult issues for courts, legislatures, and local governments. California has failed to recognize a constitutional or statutory right to community or mental health treatment. This Comment advocates that, as a starting point, counties in California have a statutory duty under the Welfare and Institutions Code to provide aid to the homeless and indigent.

INTRODUCTION

This Comment concerns the homeless and indigent mentally ill: the street people many of us see when walking to our downtown offices. Of Los Angeles' estimated 50,000 homeless, one-third "might be termed severely and chronically mentally ill."1

Nationwide, estimates of the total homeless range from a conservative 250,000 to 300,000 estimated by the United States Department of Housing and Urban Development,2 to between two and three million estimated by the Community for Creative Non-Violence.3 Although practical problems exist in counting the homeless,4

4. The Community for Creative Non-Violence (CCNV) filed suit in 1984 challenging HUD's estimate of 250,000 to 350,000 homeless, fearing that a ⅓ths reduction in the working estimate of the number of homeless would mislead legislators and private benefactors and lead to a reduction in benefits. CCNV contacted various shelter providers in large cities to verify HUD's estimates of homeless, and found wide discrepancies. For example, 16,300 homeless were sheltered on any given night in New York (which would make this the absolute minimum number of homeless), yet HUD estimated the
there is no doubt that the number has increased dramatically since the 1970 United States Census set the number of homeless at 20,957 across the nation.\textsuperscript{5} It has been estimated that 33% to 50% of the approximate two million homeless are chronically mentally ill.\textsuperscript{6}

This Comment discusses the causes of homelessness and suggests what should be done to meet the needs of the homeless mentally ill. Further, this Comment describes efforts to establish a constitutional right to treatment in the least restrictive setting and California's rejection of a constitutional or statutory right to such treatment. Finally, this Comment concludes that California counties have a duty to provide mental health care for indigents based on state welfare laws.

\textbf{THE CAUSES OF HOMELESSNESS}

Hundreds of thousands of mentally ill people live on the streets. Most experts blame this phenomenon on three decades of massive deinstitutionalization, during which the majority of patients were discharged from mental hospitals.\textsuperscript{7}

The massive depopulation of mental hospitals\textsuperscript{8} was seen as a more humane way to deal with the mentally ill. The advent of psychoactive drugs\textsuperscript{9} and the increasing costs of institutional care\textsuperscript{10} made moving many patients into the community an attractive proposition. Ad-
ditionally, after exposés revealed that mental hospitals "were vast dehumanizing warehouses whose neglected, ill-fed, and abused inmates could, with little exaggeration, be counted among the living dead," reforms sought release of patients into the community, believing treatment in the community would be more effective.11

Another powerful motivating force behind deinstitutionalization was the belief that patients' civil rights were being violated by institutional treatment and methods of commitment.12 In the 1960s and 1970s, patient advocates began to challenge some practices of the mental health system. Lawsuits were brought to enforce patients' "right to treatment,"13 arguing that taking away a patient's liberty for the purpose of treatment without subsequently providing treatment, was a violation of a patient's right to due process.14

The first right to treatment suits were habeas corpus actions which sought alternative types of treatment or release for individual patients.15 Later suits were framed as class actions challenging the quality of care and conditions within the institutions.16

One health professional, Dr. Richard Lamb, blames patients' rights advocates for contributing to the problem of homelessness. Dr.
Lamb argues that "patients' rights to freedom are not synonymous with releasing them to the streets where they cannot take care of themselves, are too disorganized or fearful to avail themselves of what help is available, and are easy prey for every predator."18

Others question whether deinstitutionalization was successful. According to one writer:

[Deinstitutionalization] has meant a nightmare existence in the blighted centers of our cities, amidst neighborhoods crowded with prostitutes, ex-felons, addicts, alcoholics, and other human rejects now repressively tolerated by our society. Here they eke out a precarious existence, supported by welfare checks they may not even know how to cash. They spend their days locked in or out of dilapidated "community-based" boarding houses.19

For some of the deinstitutionalized mentally ill it is even worse. After they are released, many of the mentally ill find themselves stripped of virtually all resources. Often they are left without the most basic requirements, such as food, housing, income, or social or family support. Although many are eligible for benefits, they cannot apply because they are incompetent. At times, their perceptions of reality are so distorted that they will refuse food or shelter.20

The results are often tragic, because the homeless mentally ill are vulnerable targets for crime who die in disproportionately high numbers.21 Painful examples occur, such as a "mentally ill Vassar graduate who lived at Union Station in Washington [who] was not committed because she was not dangerous, and was soon found brutally stabbed near her 'home.'"22

Deinstitutionalization failed because adequate community facilities were not, and still have not, been created.23 The American Psychiatric Association's (APA) Task Force on the Homeless Mentally Ill blames the method of deinstitutionalization for the high numbers of homeless mentally ill. The Task Force found that deinstitutionalization had emptied mental hospitals of three fourths of their inpatient population and had left approximately one million people "cast adrift under circumstances that most persons think no longer exist in this country."24

APA Task Force Chairman Dr. Richard Lamb blames the failure of deinstitutionalization on a lack of planning for such fundamental

18. Lamb, supra note 9, at 902.
20. Hearings, supra note 6, at 553-54. See also Rhoden, supra note 7, at 391-92.
21. See Rhoden, supra note 7, at 391-92; Collin, supra note 7, at 321-22; see also Appellant's Opening Brief at 6, Mental Health Ass'n of Cal. v. Deukmejian, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (citing trial testimony) [hereinafter Opening Brief].
22. Rhoden, supra note 7, at 392.
23. See Lamb, supra note 9, at 890.
24. Id.
resources as structured living arrangements and adequate treatment and rehabilitative facilities in the community. Resistance of community mental health centers to provide the mentally ill with services was not anticipated, nor was the reluctance of many states to allocate funds for community-based services.25

A United States General Accounting Office Report (GAO Report) found that instead of successful deinstitutionalization with well-funded community programs, we are left with “seriously flawed institutional and community programs competing for dwindling resources, while the demand for those resources steadily increases as more people seek care.”26

Other experts argue that deinstitutionalization was not an articulated goal in the beginning; therefore, there was no need to plan in advance for adequate facilities upon release.27 Further, “[e]ven after it became a policy of the government, health planners and politicians frequently assumed that when patients were released from state hospitals, communities would develop alternatives. However, local officials simultaneously assumed that federal social welfare programs would provide sufficient care for the former patients.”28

Another reason named for the failure of deinstitutionalization is the lack of a central “delivery system” of services for the mentally ill. Services are rarely provided in any organized, systematic manner. Patients are often lost in the bureaucratic shuffle, because they are unable to negotiate the necessary steps to apply for and receive aid and services which they need.29 The GAO Report recognized the lack of organized support services available to the mentally ill, calling the existing services, at best, a group functionally related by loosely linked subsystems.30

ADDRESSING THE NEEDS OF THE HOMELESS MENTALLY ILL

Some experts argue that reinstitutionalizing the mentally ill will solve the problems of homelessness and lack of care.31 Many profes-

25. Id. at 890-91.
27. See Rhoden, supra note 7, at 392.
28. Id. at 392-93.
29. Id. at 393; Lamb, supra note 9, at 900.
30. See GAO REPORT, supra note 26, at 8.
31. See Borus, Deinstitutionalization of the Chronically Mentally Ill, 305 NEW ENG. J. OF MED. 339 (1981); Feldman, Out of the Hospital, Onto the Streets: The Over-
sionals reject this argument believing that those who support reinstitutionalization exaggerate the care patients are said to have received while institutionalized. Opponents of reinstitutionalization cite the reasons which prompted deinstitutionalization in the first place: loss of freedom, inadequate and restrictive care, and abuse and neglect by staff.  

The APA Task Force on the Homeless Mentally Ill suggests that the ultimate goal is to have a case manager responsible for each chronically mentally ill person in the county. This manager would guide the mentally ill individual through the maze of mental health services, including financial aid and rehabilitative and residential care.  

The APA Task Force Report cites the need for an adequate number of graded, supervised community housing settings. Most chronically mentally ill persons cannot manage to live by themselves, and therefore need various levels of supervision in a housing setting. The APA Task Force suggests settings offering different levels of supervision, including quarterway and halfway houses, board-and-care homes, foster care and crisis or temporary hostels.

Another important need is for "[a]dequate, comprehensive, and accessible psychiatric and rehabilitative services . . . [which] must be assertively provided through outreach services when necessary." The APA Task Force advocates direct psychiatric services in the shelters and on the streets to provide outreach contact with the mentally ill in the community. Services available should include: psychiatric assessment and evaluation, crisis intervention, individualized treatment plans, and psychotropic medication.

Further, the APA Task Force advocates treatment and rehabilitative services "provided assertively" by seeking out the person who might need help, if the person cannot come to the facility. The need for rehabilitative services, such as training in skills needed for everyday living, is emphasized in order to make the mentally disabled person as self-sufficient as possible. Finally, the APA Task Force calls for "[n]ew laws and procedures . . . to ensure provision of psychiatric care in the community . . . to guarantee a right to treatment in

32. See Lamb, supra note 9, at 904. See generally supra notes 7-17 and accompanying text.
34. Recommendations of APA, supra note 33, at 908. See also Rhoden, supra note 7, at 420.
35. Id.
36. Id.
37. Id.
the community.  

THE CONSTITUTIONAL RIGHT TO TREATMENT

Advocates of mental health care treatment first argued for a right to treatment, and later, for a right to treatment in the least restrictive setting or in the community. The first decision clearly recognizing a constitutionally based right to treatment for involuntarily committed patients was Wyatt v. Stickney, a 1971 decision of the federal district court in Alabama.

Wyatt was a class action suit challenging conditions within Alabama’s mental institutions. The court held that when a patient is committed for the purpose of treatment, the patient has a “constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition . . . .” The court pointed out that the purpose of civil commitment was treatment, not punishment, and that treatment was the only justification, from a constitutional standpoint, that allowed civil commitment. Wyatt did not, however, articulate a specific constitutional theory upon which this right was based.

In 1974, the Fifth Circuit Court of Appeals specifically set forth a constitutional basis for a right to treatment. The court in Donaldson v. O’Connor set forth a two-part theory upon which this right was based, premised upon the notion that involuntary commitment without treatment violates substantive due process.

The first part of the theory applies to those patients committed under a state’s parens patriae authority. Parens patriae gives a state

38. Id. at 909 (emphasis added).
41. Id. at 785.
42. Id. at 784.
43. 493 F.2d 507 (5th Cir. 1974), vacated, 422 U.S. 563 (1975).
44. Id.
the right to commit an individual who, although not dangerous to others, is in need of care or treatment.¹⁴ The court held that non-treatment of an involuntarily committed, non-dangerous individual violated substantive due process.¹⁴

The second part of the theory is called the *quid pro quo* theory. It is based upon the premise that any involuntary commitment is a curtailment of liberty similar to criminal incarceration, and therefore a state must justify depriving a person of his liberty by giving him something in return — treatment for his mental illness.¹⁵ Similarly, the Third Circuit held in *Clark v. Cohen*¹⁶ that individuals who are involuntarily committed “must be provided with the means to end their commitment, otherwise civil commitment would be equivalent to placement in ‘a penitentiary.'”¹⁷ In 1975 the Supreme Court heard *Donaldson* and backed away from the Fifth Circuit’s finding of a constitutional right to treatment.⁶⁰ While the Court unanimously agreed that Donaldson should have been released,⁵¹ it pointed out in a footnote that the issue before it was not the right to treatment or the adequacy of treatment, but rather the propriety of treatment.⁵²

Further, Chief Justice Burger devoted ten pages of his twelve-page concurrence to the proposition that the Fifth Circuit’s analysis supporting a constitutional right to treatment had “no basis in the decision of this Court.”⁶³ Consequently, the constitutional right to treatment set forth by the court of appeals appeared to suffer an early death.⁵⁴

The Supreme Court, since deciding *Donaldson*, has recognized a

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45. Id. at 521.
46. Id.
47. Id. at 521-23.
48. 794 F.2d 79 (3d Cir. 1986).
49. Id. at 94.
50. See 422 U.S. 563, 573 (1975).
51. Id. at 576.
52. Id. at 574 n.10. In reversing the Fifth Circuit, the Court found the lower court’s decision needlessly broad and remanded for a finding of defendant Florida State Hospital Director’s liability in light of the qualified immunity of state officials under 28 U.S.C. § 1983. See id. at 573, 577.
53. Id. at 580 (Burger, C.J., concurring).
limited right to habilitation for the mentally retarded. In *Youngberg v. Romeo* the Supreme Court based the right to habilitation on the liberty component of the fourteenth amendment's due process right, which requires the "[s]tate to provide minimally adequate or reasonable training to ensure safety and freedom from undue restraint." The Court explained that due process is satisfied if restraints on freedom are based on the judgment of qualified professionals. Some federal courts have mandated patient placement in a less restrictive environment when the professionals treating the patient have recommended such action. However, in instances where maintaining patients in an institution is not a substantial departure from the usual judgment of professionals in similar situations, courts have not recognized a constitutional right to treatment in the least restrictive setting.

Post-*Youngberg* decisions have expanded its scope, which recognized restraints based on the judgment of qualified professionals. In 1984, the Second Circuit Court of Appeals held that there was no right to community placement for mentally retarded individuals. The court of appeals reversed the lower court's order to move 400 mentally retarded residents into community placement facilities because their placement in institutions was depriving them of their basic liberties. The appellate court focused on the *Youngberg* decision and reasoned that the question before it was "not what treatment was actually provided, but whether the treatment decision was professionally made and [fell] within the scope of professional

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55. Generally, the law speaks of the "right to treatment" for the mentally ill, while the common phrase for the retarded is the "right to habilitation."
57. Id at 319. See generally Brakel, supra note 26, at 337-40.
58. Youngberg, 457 U.S. at 321-323 (citations omitted).
59. See, e.g., Thomas v. Murrow, 781 F.2d 367 (4th Cir. 1986) (approving the district court's order to place the patient in the community when the professional in charge of his care recommended such action).
60. See Society for Good Will to Retarded Children v. Cuomo, 737 F.2d 1239, 1247-48 (2d Cir. 1984). The court explained that the focus should be on whether a patient's "basic" liberty interests are being safeguarded, not whether the optimal course of treatment, as decided by experts in the field, is followed. Id. at 1248. In this case, the appeals court held that there was no constitutional entitlement to community placement or placement in the least restrictive environment, overruling the district court's decision that mentally retarded persons have a constitutional right to treatment in an environment which would assist them in preserving basic self-care skills. See also infra notes 63-67 and accompanying text.
61. See Soc'y for Good Will, 737 F.2d 1239 (2d Cir. 1984).
62. See generally id.
acceptability.’

In California, the appellate court in *Mental Health Association v. Deukmejian* held that there is no state constitutional right to community health treatment or mental health treatment in a least restrictive environment. The law in this area is still uncertain because the California Supreme Court subsequently decertified the opinion for official publication. In *Mental Health Association*, the plaintiffs sought the creation of a state and county fund for the implementation of a community-based, mental health residential and rehabilitative program for gravely mentally disabled persons within Los Angeles County. Plaintiffs sought to aid the “revolving door” population defined as “those who are released to the community without adequate support but are ‘disabled enough’ to suffer frequent and repeated loss of liberty by hospitalization, but ‘not disabled enough’ to be given continuing and appropriate follow-up care once they are released to the community.”

**No Right To Community Health Treatment Based Upon State Mental Health Statutes**

In *Mental Health Association v. Deukmejian*, the plaintiffs also argued that the statutory scheme comprised of the Lanterman-Petris-Short Act (LPS), Community Residential Treatment Act

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63. Id. at 1249 (emphasis added). See also Phillips v. Thompson, 715 F.2d 365, 368 (7th Cir. 1983) (holding no constitutional right to community placement, or more generally, no constitutional right to treatment in the least restrictive environment).


65. Id.

66. 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130.

67. The series of events making up the “revolving door” phenomenon is described as follows:

(Ch)ronically mentally ill persons (a) are confined at the state hospitals longer than necessary because of a lack of appropriate placements in the community, (b) when experiencing an acute episode are referred to a state hospital instead of given appropriate crisis intervention and support services in the community, (c) are eventually discharged without appropriate aftercare and support programs to help them maintain themselves in the community, and (d) predictably, return to the hospital unnecessarily when they “decompensate.”

Opening Brief, supra note 21, at 5 (Finding 29).

68. *Mental Health Ass'n*, 186 Cal. App. 3d at 1536 n.3, 233 Cal. Rptr. at 132 n.3.

69. CAL. WELF. & INST. CODE §§ 5000-5579 (West 1984 & Supp. 1987) [hereinafter LPS]. The Welfare and Institutions Code is comprised of separate divisions dealing with mental health and welfare assistance for the needy. Division Five is entitled “Community Mental Health Services,” and includes the Lanterman-Petris-Short Act, the Community Residential Treatment Act, and the Short-Doyle Act. Division Nine, entitled “Public Social Services,” includes a section entitled “County Aid and Relief to Indigents” which contains what is commonly referred to as “welfare laws” for the indigent.

The LPS was enacted to end inappropriate involuntary commitment of the mentally disabled and to protect the safety of both the public and the mentally disabled.
(CRT), and Short-Doyle Act (Short-Doyle) mandated a full continuum of services including least restrictive treatment in a community-based setting.

The trial court found that "[a]s a result of the lack of a full continuum of programs and services, . . . gravely disabled persons . . . in Los Angeles County are frequently subjected to the 'revolving door' process." It held, however, that the state had no duty to provide community-based mental health services.

The appellate court affirmed, holding that no statutory right to community-based treatment exists under the LPS, CRT or Short-Doyle. Instead, as the trial court had found, the statutory scheme created a "preference for mental health treatment in the least restrictive environment but did not create an absolute right to it." The lack of legislative funding for a mandatory community program was considered proof that the legislature did not intend to mandate community treatment.

Both the trial court and appellate court classified the statutory language as permissive, rather than mandatory. The appellate

70. CAL. WELF. & INST. CODE §§ 5450-66 (West 1984 & Supp. 1987) [hereinafter CRT]. The CRT was enacted to establish residential treatment programs in each county to provide alternatives to institutionalized care and was designed to provide community-based residential treatment.

71. CAL. WELF. & INST. CODE §§ 5600-5778 (West 1984 & Supp. 1987) [hereinafter Short-Doyle]. Short-Doyle is the funding mechanism for community mental health services as provided by the LPS as amended by the CRT.

72. Mental Health Ass'n, 186 Cal. App. 3d at 1540, 233 Cal. Rptr. at 134-35.

Expert testimony at trial defined a full continuum of services including: "[A]ppropriate long-term hospitalization, 24-hour acute intensive care, short-term crisis residential care, out of home placement, emergency service and evaluation, acute day treatment, outpatient services, case management, community support services, community outreach services, mental health advocacy and foster family care." Id. at 1540 n.4, 233 Cal. Rptr. at 134 n.4.

73. Opening Brief, supra note 21, at 4.

74. Mental Health Ass'n, 186 Cal. App. 3d at 1531, 233 Cal. Rptr. at 130.

75. Id. at 1540, 233 Cal. Rptr. at 135.

76. Id. at 1540, 233 Cal. Rptr. at 135 (emphasis added).

77. Id. at 1540, 1542, 233 Cal. Rptr. at 135-36 (citing CAL. WELF. & INST. CODE § 5450.1 (West 1984 & Supp. 1987), which states in part: "To this end, counties may implement the community residential treatment system described in this chapter either with available county allocations or, as new moneys become available, by applying for funds to the State Department of Mental Health.")(emphasis original).

78. 186 Cal. App. 3d at 541, 233 Cal. Rptr. at 135 (citing CAL. WELF. & INST. CODE § 5325 (West 1984 & Supp. 1987), which provides in part: "It is the intent of the Legislature that persons with mental illness shall have rights including, but not limited to, the following: (a) A right to treatment services which promote the potential of the person to function independently. Treatment should be provided in ways that are least restrictive of the personal liberty of the individual.") (emphasis original).
court pointed out language which evidenced the legislature's intent to promote, rather than mandate, a community-based mental health system. 79 Lastly, the appellate court stated that its holding encompassed the committed mentally ill population as well as the "revolving door" population either in or out of the hospital at the time of trial. 80

Since Mental Health Association v. Deukmejian, California has not recognized a state constitutional right to community-based mental health treatment. 81 Nor does such a right exist based upon state mental health statutes. 82

RIGHT TO COMMUNITY MENTAL HEALTH TREATMENT BASED UPON STATE WELFARE STATUTES

Since establishing a state or county duty to provide mental health treatment in the community based on California mental health laws has failed, a duty must be established based on California welfare laws.

In California, it is the duty of each county to provide aid to its indigents. Section 17000 of the Welfare and Institutions Code states:

Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions. 83

This aid is called General Assistance or General Relief in most counties. The California appellate court has described it as a "program of last resort" for indigents unable to meet standards of other relief programs. 84

General Assistance has existed in California since 1855. 85 Section 17000 is virtually identical to the 1931 amendment to the Pauper

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79. Id. at 1541-42, 233 Cal. Rptr. at 135-36 (citing Cal. Welf. & Inst. Code § 5450 (West 1984 & Supp. 1987), which states in part: "It is the intent of the Legislature to establish a system of residential treatment programs in every county which provide, in each county, a range of available services which will be alternatives to institutional care and are based on principles of residential, community-based treatment.").
80. Id. at 1548, 233 Cal. Rptr. at 141.
81. The present state of the law in this area is now unclear because the California Supreme Court has ordered the Mental Health Ass'n opinion decertified for official publication. See supra notes 64-65 and accompanying text.
82. See Mental Health Ass'n, 186 Cal. App. 3d at 1540, 233 Cal. Rptr. at 134.
85. See Mooney, 4 Cal. 3d at 677, 483 P.2d at 1236, 94 Cal. Rptr. at 284 (citing Senate Comm. on Governmental Efficiency, Welfare in California 98-99 (1970)).

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Act of 1901. The major difference is the use of the word "pauper" in the 1931 amendment as compared to the use of the word "indigent" in section 17000.

In Mooney v. Pickett, the California Supreme Court held that the Pauper Act imposed a mandatory duty on counties to provide aid to all indigent persons. The court upheld an action by the city and county of San Francisco to sell municipal bonds to raise money to support indigents. In its opinion, the court stated: "[t]he statutes are neither in terms nor spirit limited to the relief of chronic or permanent paupers, or any other class of poor persons, but extend to every person coming within the terms of the statute dependent upon public assistance for the necessities of life." The legislature repealed the Pauper Act in 1933 and enacted a law mandating county aid to "all able-bodied indigent persons and those indigents incapacitated by age, disease or accident." In 1937 the legislature enacted the Welfare and Institution Codes, including section 17000.

The Board of Supervisors ("Board") in each county is responsible, in the exercise of its discretion, for setting the standards of aid and care to be provided to indigents. However, a court must override that discretion if the county arbitrarily or capriciously sets the level of aid. In Mooney, the court limited the county's discretion, stating that it could "be exercised only within fixed boundaries," and its regulations must be adequate to provide "the means of life;" therefore, the court upheld the city of San Francisco's sale of municipal bonds to raise money for indigent support.

In Boehm v. Merced County, the appellate court held that the

86. 4 Cal. 3d at 677, 483 P.2d at 1236, 94 Cal. Rptr. at 284. The Pauper Act of 1901 provided:

Every county and every city and county shall relieve and support all pauper, incompetent, poor, indigent persons and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, or by their own means, or by state hospitals or other state or private institutions.

See 2 CAL. GEN. LAWS ANN. act 5814 (Deering 1931).

87. 4 Cal. 3d 669, 483 P.2d 1231, 94 Cal. Rptr. 279.
89. 1932 Cal. Stat. 761.
90. Mooney, 4 Cal. 3d at 678, 483 P.2d at 1236, 94 Cal. Rptr. at 284.
91. See CAL. WELF. & INST. CODE § 17001 (West 1984).
93. See Mooney, 4 Cal. 3d at 679, 681, 483 P.2d at 1237, 1239, 94 Cal. Rptr. at 285, 287.
Merced County Board of Supervisors acted arbitrarily and capriciously in reducing General Assistance levels without first determining the actual cost of obtaining the basic necessities of life. The Board reduced grant levels from $198 per month for an individual to $175 per month.

After remand, the appellate court stated: "[t]he County must set GA [General Assistance] standards of aid and care that provide benefits necessary for basic survival." The court defined minimum subsistence, explaining that it "must include allocations for housing, food, utilities, clothing, transportation and medical care." Further, the court stated that it defied "all notions of human dignity not to include allowances for clothing, transportation and medical care, and transportation in minimum subsistence figures, adding that "such allowances are essential and necessary to 'encourage [self-respect and] self-reliance, . . . in a "humane" manner consistent with modern standards.'"

If a county does not wish to provide an allowance for any of the basic necessities of food, clothing, housing, utilities, transportation or medical care, it must perform a study which demonstrates the need omitted will be provided by some other program which is available to the General Assistance recipients.

The *Boehm* court based its decision on the legislative intent and statutory purpose of the General Assistance program, as prescribed in section 10000 of the Welfare and Institutions Code, which provides in part:

> The purpose of this division is to provide for protection, care, and assistance to the people of the state in need thereof, and to promote the welfare and happiness of all of the people of the state by providing appropriate aid and services to all of its needy and distressed. It is the legislative intent that aid shall be administered and services provided promptly and humanely, with due regard for the preservation of family life, and without discrimination . . . as to encourage self-respect, self-reliance, and the desire to be a good citizen, useful to society.

Similarly, in *County of San Diego v. Muniz*, the California Supreme Court found that promoting self-sufficiency was one purpose of General Assistance legislation. The *Muniz* court reached the conclusion that the county could not try to recoup past General Assistance benefits from wages *per se*, but only from money left over after

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95. *Id.* at 453, 209 Cal. Rptr. at 533.
97. *Id.* (emphasis added).
100. CAL. WELF. & INST. CODE § 10000 (West 1984).
the recipient met the basic needs of himself and his family. The
court based its decision on the legislative purpose in providing relief
for the needy as found in section 10000.102 Further, the Muniz
court pointed to section 10650, which indicates legislative intent to prevent
persons who could otherwise be self-supporting, productive members
of society from becoming or remaining public assistance recipients.108 Additionally, section 17111 indicates legislative intent that
General Assistance foster self-sufficiency among General Assistance
recipients by allowing them to retain the tools of their trades and a

car of reasonable value.104

The Boehm court also noted section 11000, which stated at the
time of trial: "[t]he provisions of law relating to a public assistance
program shall be fairly and equitably construed to effect the stated
objects and purposes of the program."108 Further, the Boehm court
recognized budgetary constraints imposed upon counties, but stated
those constraints could not justify excluding the basic necessities of
life from General Assistance aid provided for indigents.108 Lack of
funds has long been recognized as an invalid excuse for not meeting
a statutory mandate.107

"Aid," as defined by the Boehm court, includes the necessities of
life: food, housing, utilities, clothing, transportation, and medical
care.108 Therefore, according to section 17000, counties have a duty
to meet those needs, unless they are met by some other program.
Counties, in meeting their mandatory duty to provide the necessities
of life, must provide medical care.

Medical care has been defined to include care "for the prevention
or alleviation of a physical or mental defect or illness."108 The Welfare and Institutions Code defines the scope of health and medical
care as including:

102. Id.
104. Id. § 17111 (West 1984).
105. Id. § 11000 (West 1984). Section 11000 was amended in 1982 to read: "The
provisions of law relating to a public assistance program shall be fairly and equitably
construed to effect the stated objects and purposes of the program." (italics indicate
amendment).
106. See Boehm, 178 Cal. App. 3d at 503, 223 Cal. Rptr. at 722; see also Robbins,
38 Cal. 3d at 217, 695 P.2d at 707, 211 Cal. Rptr. at 410; Mooney, 4 Cal. 3d at
675, 483 P.2d at 1235, 94 Cal. Rptr. at 283.
107. See Collins, 216 Cal. at 190, 13 P.2d at 913; Los Angeles v. Payne, 8 Cal. 2d
563, 573, 575 (1937); Mooney, 4 Cal. 3d at 676, 695 P.2d at 1235, 94 Cal. Rptr. at 283;
City and County of San Francisco, 57 Cal. App. 3d at 44, 128 Cal. Rptr. at 714.
108. See Boehm, 178 Cal. App. 3d at 501, 223 Cal. Rptr. at 720.
Care and treatment for the mentally ill falls within the scope of "medical care," defined above as services for conditions which "cause suffering, endanger life . . . and interfere with [the] capacity for normal activity." Often the mentally ill go hungry and go without adequate shelter and clothing because their debilitated mental condition prevents them from seeking help or causes them to refuse help when it is offered. The APA Task Force on the Homeless recommended many levels of structured living arrangements for the mentally ill, because some need daily assistance with ordinary "life" tasks such as shopping, food preparation, medication, hygiene and socialization skills. Further, the APA Task Force suggested that psychiatric and rehabilitative services be aggressively offered with professionals seeking out the needy mentally ill, because many are unable to seek or find help.

MEANS BY WHICH COUNTIES CAN DELIVER MENTAL HEALTH SERVICES

Having established the duty of California counties to provide mental health care to indigents under section 17000, counties are faced with choosing how to deliver mental health services. There are essentially three options: first, services may be delivered on an inpatient basis in existing facilities; second, services may be delivered in the community; and third, services may not be delivered to indigents at all.

When deciding how to provide mental health services to those in need, each county should consider the following:

1) treatment in the community is the goal of California’s mental health care system; and
2) treatment in the community is the most effective method for the majority of the mentally ill.

Treatment in the community is the goal of California’s mental health care system, as recognized in Mental Health Association. Although treatment in the community is not mandated by California

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111. Id.
112. See supra notes 18-20 and accompanying text.
113. See Lamb, supra note 9, at 899.
114. Id.
115. 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130. See supra notes 74-79 and accompanying text.
mental health laws, it is the preferred method of treating the mentally ill, and it is the goal of the system to eventually provide community treatment, when appropriate, to all mentally ill persons.\textsuperscript{116}

Treatment in the community is the best method of treatment for the majority of mentally ill because it allows them to maintain as much of their liberty as possible.\textsuperscript{117} Additionally, it allows the mentally ill to avoid the loss of skills necessary to function in society which occurs to many institutionalized patients.\textsuperscript{118} It has been proved that community treatment and support reduce the frequency and severity of acute episodes requiring hospitalization — in even the most seriously disturbed.\textsuperscript{119}

If a county chooses to exercise the third option, and not provide mental health care for indigents, the courts may step in and force compliance with the section 17000 requirement to provide all of the necessities of life to indigents. The court has stated: “[w]hen statutes affecting the well-being — perhaps the very survival — of citizens of this state are being violated with impunity by the [county], an agent of the state, the courts, as final interpreters of the law, must intervene to enforce compliance.”\textsuperscript{120}

CONCLUSION

Counties have the duty to provide aid to indigents pursuant to section 17000 of the Welfare and Institutions Code. Aid, as defined by Boehm, includes the necessities of life: housing, food, utilities, clothing, transportation and medical care.\textsuperscript{121}

For the homeless or indigent mentally ill, mental health care is a necessity of life because without such care they will continue to be homeless, hungry and disoriented — deprived of the necessities of life because they are mentally incapable of obtaining or receiving

\textsuperscript{116} Id.

\textsuperscript{117} Lamb, supra note 9, at 900; see also supra notes 33-37 and accompanying text.

\textsuperscript{118} See supra notes 19-29 and accompanying text; see generally M. Test, Community Support Programs in Schizophrenia 347 (A. Bellach ed. 1984); Keisler, Mental Hospitals & Alternative Care, 37 AM. PSYCHOLOGIST 349 (1982).

\textsuperscript{119} See M. Test, supra note 118; Keisler, supra note 114.


\textsuperscript{121} See supra text accompanying notes 93-96.
The purpose of California’s welfare laws is to make recipients more self-sufficient. Without mental health care being provided by an aggressive program in all counties, mentally disabled indigents will not become self-sufficient. Their basic life needs will not be met, because they are unable to seek or keep receiving assistance without treatment for their mental illness.

A county-provided community-based health care system for indigents supports the state goal of treatment in the community and provides the most effective method of treatment while allowing the mentally ill to maintain more of their freedom.

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