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Adding Insult to Injury: The Lack of Medically-Appropriate Housing for the Homeless HIV-III

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Adding Insult to Injury: The Lack of Medically-Appropriate Housing for the Homeless HIV-III

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Homelessness is a great tragedy. AIDS is another. No words are sufficient to describe the plight of those facing both afflictions¹

I. INTRODUCTION

Many citizens believe that every person has a right to food, clothing, shelter, and freedom from disease.² Although not widely adopted as a legal measure,³ the Universal Declaration of Human Rights,⁴ issued by the United Nations General Assembly in 1948, represents an “ideal goal” with respect to human rights.⁵ It states:

Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food,

1. *Mixon v. Grinker*, No. 14932/88, slip op. at 1 (N.Y. Sup. Ct. Jan. 11, 1989) (order granting preliminary injunction), *aff'd and modified on other grounds*, 157 A.D.2d 423, 556 N.Y.S.2d 855 (App. Div. 1990).

2. For example, the members of the Institute of Medicine's Committee on Health Care for Homeless People “support the principle that decent housing is every American's right.” Vladek, *A National Scandal*, ISSUES SCI. & TECH., Fall 1988, at 86.

3. Banks, *AIDS and the Right to Health Care*, 4 ISSUES L. & MED. 151, 159 (1988).

4. Art. 25(1), U.N. Doc. A/810, U.N. Sales No. 1952.1.15 (1948) [hereinafter Universal Declaration of Human Rights], *reprinted in* Blasi, *Litigation Strategies for Addressing Bureaucratic Disentitlement*, 16 N.Y.U. REV. L. & SOC. CHANGE 591, 591 (1988).

5. Banks, *supra* note 3, at 159.

clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.⁶

Similarly, the Housing Act of 1949⁷ expresses the goal that every family should have a "decent home and suitable living environment."⁸ Vigorous legal and social debate over the provision of basic necessities to indigents, however, tends to undermine these noble aspirations.⁹ In many jurisdictions, courts and legislatures are still wrestling over whether all people have a right to the basic necessities of life, regardless of their ability to pay.¹⁰ In jurisdictions that have recognized such a right, controversy surrounds the selection of appropriate governmental entities to provide particular services and ensure enforcement of these entitlements.¹¹ As the deinstitutionalization of the 1950's through 1980's aptly demonstrates, the federal government believes that housing and medical care are essentially a local concern, while local governments are neither adequately funded nor prepared to accomplish the task. Finally, the scope of governmental services to be provided remains an unresolved issue.¹² For example, once a governmental entity acts to provide medical services, does it also have a duty to ensure adequate shelter so that the recipient of the medical attention will have an appropriate environment in which to recover?

While governmental entities debate over whether there is a duty to provide for basic necessities, and whose responsibility it is, a new crisis is emerging stemming from a rapidly increasing number of individuals who lack both adequate medical care and shelter. Although many of the arguments incorporated in this Comment may apply to various medically needy populations, this Comment focuses on HIV-

6. Universal Declaration of Human Rights, *supra* note 4.

7. Pub. L. No. 81-171, 63 Stat. 413 (codified as amended in scattered sections of 12 and 42 U.S.C.).

8. *Id.* § 2.

9. See, e.g., Lehmann, *Access to Care*, QUALITY REV. BULL., Feb. 1988, at 55; Reidinger, *Paying for AIDS: Government's Role Grows*, A.B.A. J., Jan. 1990, at 94; Ruffenach, *Debate Grows over Rationing Medical Care*, Wall St. J., Mar. 27, 1990, at B1, col. 6.

10. E.g., *Joanne S. v. Carey*, 115 A.D.2d 4, 5, 498 N.Y.S.2d 817, 818 (App. Div. 1986) ("There has been a bitter battle . . . throughout America as to whether State or local governments, or private resources, alone, should bear the responsibility for sheltering the homeless.").

11. The issue of which governmental entities should implement and enforce established duties is beyond the scope of this Comment.

12. See *infra* notes 185-223 & 314-23 and accompanying text.

ill¹³ homeless people and their special search for housing.¹⁴

A disproportionate number of HIV-infected people suffer from a loss of housing.¹⁵ New York City, where approximately eight thousand of the estimated ninety thousand homeless people are persons with AIDS ("PWA's"),¹⁶ is an extreme example of the "emerging crisis."¹⁷ The magnitude of this unique new problem is difficult to quantify,¹⁸ but experts agree that "[h]ousing is one of the biggest

13. HIV is an acronym for Human Immunodeficiency Virus, the retrovirus responsible for causing Acquired Immune Deficiency Syndrome ("AIDS"). HIV-illness encompasses a spectrum of disease with AIDS being the most severe. For a basic understanding of HIV-illness, see *infra* notes 46-67 and accompanying text.

14. Special concerns arise because the number of homeless people with HIV-illness has grown at a tremendous rate throughout the United States since 1981. Schulman, *Thousands May Die in the Streets*, 248 THE NATION 480, 480 (1989). Moreover, the underlying issues of stigmatization, discrimination, and the unique medical characteristics associated with HIV-illness are particularly problematic.

15. Schietinger, *Housing for People with AIDS*, 12 DEATH STUDIES 481, 481-82 (1988) (suggesting that the HIV-ill are left without homes because of: (1) rejection based on fear of contagion; (2) rejection based on fear of the dying process; and (3) financial devastation associated with HIV-illness and treatment).

16. In 1990, terminology in this area is still evolving. For example, scholars and advocates have begun to use the terms HIV-illness and HIV-disease as they gain a better understanding of the spectrum of disease that often culminates in AIDS. *E.g.*, *Mixon v. Grinker*, No. 14932/88, slip op. at 2 (N.Y. Sup. Ct. Jan. 11, 1989); Speech entitled *Current Issues in AIDS Research and Testing* by Dr. Margaret Hamburg of the National Institute of Health, A.A.L.S. Joint Program: Section on Gay and Lesbian Issues, Section on Law and Medicine, Section of Real Property (Jan. 4, 1990); Speech entitled *A Constitutional Right to Appropriate Housing—The New York Litigation* by Nan Hunter of the American Civil Liberties Union, A.A.L.S. Joint Program: Section on Gay and Lesbian Issues, Section on Law and Medicine, Section of Real Property (Jan. 4, 1990); City of New York Plan entitled *Expansion of Services for the HIV-III*, submitted May 13, 1989, in connection with the *Mixon v. Grinker*, No. 14932/88 (N.Y. Sup. Ct. Jan. 11, 1989), litigation. The term "person with AIDS" ("PWA") is favored by The National Association for People with AIDS to describe the symptomatic HIV-ill. Founding Statement of People with AIDS/ARC (The Denver Principles), *reprinted in* 22 CLEARINGHOUSE REV. 743, 743 (1988). In its founding statement in 1983, this group explained its preference in the opening paragraph: "We condemn attempts to label us as 'victims,' which implies defeat, and we are only occasionally 'patients,' which implies passivity, helplessness, and dependence upon the care of others. We are 'people with AIDS.'" *Id.* Another example of the evolving terminology is the term AIDS-related Complex ("ARC"), which already has fallen into disuse. Albert, *A Right to Treatment for AIDS Patients?*, 92 DICK. L. REV. 743, 749 & n.49 (1988); see *infra* note 52 and accompanying text.

17. Schulman, *supra* note 14, at 480. Other studies claim that there is no way of knowing how many homeless people with HIV-illness exist. For example, one writer states that the dimension of the problem is unknown and that there are no estimates of the number of homeless PWA's in New York City. Chevront, *Double Jeopardy: Facing AIDS and Homelessness*, 13 CITY LIMITS, Feb. 1988, at 12, 13.

18. The quantification problem is compounded where, as here, each of the individual components of the homeless HIV-infected population is inherently difficult to quantify. See U.S. DEP'T OF HEALTH & HUMAN SERVS., SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 12 (1986) [hereinafter SURGEON GENERAL'S REPORT] (explaining that "[i]t is difficult to predict the number [of HIV-infected individuals] who will develop ARC or AIDS because symptoms sometimes take as long as nine years to show up,"

problems (facing PWA's) that isn't being addressed.'"¹⁹

Ideally, legislation should be enacted both on federal and state levels to guarantee a minimum entitlement of medically-appropriate housing for the HIV-ill. A push for legislation, however, requires a strong, unified voice. Because of the overall political impotence and powerlessness of today's homeless population,²⁰ homeless PWA's lack the requisite "constituency . . . to effect majoritarian reform."²¹ As past crises have illustrated, "individuals and politically ineffective groups have traditionally had recourse to the courts where majoritarian bodies have either violated or ignored their concerns."²²

and "[t]he majority of infected antibody positive individuals who carry the AIDS virus show no disease symptoms and may not come down with the disease for many years."); Langdon & Kass, *Homelessness in America: Looking for the Right to Shelter*, 19 COLUM. J.L. & SOC. PROBS. 305, 305 n.1 (1985) (noting that the nature of the homeless population makes it impossible to count accurately the members of the population); Note, *Establishing a Right to Shelter for the Homeless*, 50 BROOKLYN L. REV. 939, 939 n.3 (1984) (discussing the difficulty in ascertaining "the numbers of homeless in a large city with any degree of precision" and comparing recent calculations of homeless populations in specific cities).

Nevertheless, estimates are available. As of July 1989, approximately 100,000 cases of AIDS were reported in the United States. CENTERS FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORTS ON HIV/AIDS, Jan.-Dec. 1989, at 176. In 1989, 35,238 new AIDS cases were reported to the Centers for Disease Control as compared to 32,196 AIDS cases reported in 1988. Schiffman, *Total AIDS Cases Rose 9% in 1989, According to U.S.*, Wall St. J., Feb. 9, 1990, at B4, col. 1. Because AIDS cases are underdiagnosed and underreported, this represents merely the "minimum number of persons with severe human immunodeficiency virus (HIV)-related disease." CENTERS FOR DISEASE CONTROL, *supra*, at 176. The number of reported AIDS cases has helped researchers to estimate that one to one and one-half million persons in the United States are HIV-infected. Similarly, researchers use empirical data to estimate that the United States contains from 250,000 to three million homeless people. Comment, *Homeless Families: Do They Have a Right to Integrity?*, 35 UCLA L. REV. 159, 162 & n.12 (1987) (enumerating various agencies and their estimates of the nationwide homeless population).

19. Chevront, *supra* note 17, at 12 (quoting Barbara Van Buren, former director of the AIDS Services Delivery Consortium, a coalition of 29 public and private agencies that work with the HIV-ill).

20. Note, *supra* note 18, at 940 n.8; see Hayes, *Litigating on Behalf of Shelter for the Poor*, 22 HARV. C.R.-C.L. L. REV. 79, 89-90 (1987). In assessing the utility of litigation to promote rights for the homeless, Hayes observes that litigation must be real and substantive with the injunction as its main objective and that the plaintiffs must be able to withstand public scrutiny. *Id.* at 88. Moreover, Hayes argues that legislative and regulatory proposals may result in "more of the remedies sought by lawyer and client." *Id.* at 88-89; see also Note, *Hunger and Homelessness in America*, 66 DEN. U.L. REV. 277, 283 (1989) ("The greatest potential for innovation in dealing with the problem rests with state legislatures."). Finally, Hayes stresses that litigation should serve to educate the public. Hayes, *supra*, at 89.

21. Note, *Requiring Due Care in the Process of Patient Deinstitutionalization: Toward a Common Law Approach to Mental Health Care Reform*, 98 YALE L.J. 1153, 1160 (1989) (citing Chayes, *The Role of the Judge in Public Law Litigation*, 89 HARV. L. REV. 1281, 1315 (1976)); see Note, *supra* note 18, at 940 n.8 (noting that the homeless poor, as a rule, have been characterized by almost complete political impotence as a political force).

22. Note, *supra* note 21, at 1171 (citing Chayes, *The Role of the Judge in Public Law Litigation*, 89 HARV. L. REV. 1281, 1308 & 1315 (1976)).

Even though litigators for the homeless HIV-ill are faced with rather unusual challenges because they represent a group suffering from multiple stigmatization,²³ advocacy may be the most effective way²⁴ at this time to improve conditions for the homeless HIV-ill.

This Comment explores potential legal avenues to provide medically-appropriate housing for the homeless HIV-ill. Section II provides background information regarding the distinct conditions of homelessness and HIV-illness. This background enables the reader to understand fully the unique characteristics of the homeless population with HIV-illness. Section III describes and emphasizes the similarities between the two major arguments employed in this Comment: the right to shelter²⁵ and the right to health care.²⁶ Section IV examines existing law and concludes that the most promising judicial approach for medically-appropriate housing is to establish a right to shelter for all people within a jurisdiction. A line of cases known as the "right to shelter" cases provides the legal foundation that home-

23. Stigmatization may be triple or quadruple as in the case of a drug-abusing, mentally ill, homeless HIV-ill person. See, e.g., Breo, *Treating the American Tragedy—MDs Try to Heal the Sick Homeless*, 263 J. A.M.A. 3201, 3201 (1990). For a brief discussion of stigmatization of the homeless HIV-ill, see *infra* note 73.

24. While noting that advocacy groups have used litigation to improve conditions for members of the homeless population in the past, Hayes opines that litigation is an ineffective tool for these purposes. Hayes, *Homelessness & the Legal Profession*, 35 LOY. L. REV. 1, 1 (1989).

A common litigation problem which arises both at the relief stage and at the liability stage is that the courts utilize the doctrines of justiciability, separation of powers, sovereign immunity, and political question to declare a lack of subject matter jurisdiction (or standing). Chackes, *Sheltering the Homeless: Judicial Enforcement of Governmental Duties to the Poor*, 31 WASH. U.J. URB. & CONTEMP. L. 93, 99 (1987). A classic example of overcoming the barrier of the justiciability doctrine is found in the case of *Klostermann v. Cuomo*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 247 (1984), *rev'g* 91 A.D.2d 593, 458 N.Y.S.2d 190 (App. Div. 1982). In *Klostermann*, the plaintiffs challenged the city and state governments' failure to create and enforce special discharge plans under the New York Mental Hygiene law, N.Y. MENTAL HYG. LAW § 29.15(f)-(h) (McKinney 1988), for released mentally disabled patients. *Klostermann*, 61 N.Y.2d at 532-33, 463 N.E.2d at 591-92, 475 N.Y.S.2d at 250-51. The New York Court of Appeals reversed the trial court's holding that the claim was nonjusticiable by recognizing the distinction "between a court's imposition of its own policy determination upon its governmental partners[, which is nonjusticiable,] and its mere declaration and enforcement of the individual's rights that have already been conferred by the other branches of government[, which is justiciable]." *Id.* at 535, 463 N.E.2d at 593, 475 N.Y.S.2d at 252. For further discussion of *Klostermann*, see *infra* note 295.

25. One commentator defines the right to shelter as a governmental entity's duty "to ensure that every person within the state who is homeless and requests shelter receives it," at least on a temporary basis. Note, *A Right to Shelter for the Homeless in New York State*, 61 N.Y.U. L. REV. 272, 272 n.7 (1986).

26. Almost all jurisdictions have constitutional or statutory provisions that authorize or mandate governmental entities to furnish some medical care for indigents. NATIONAL HEALTH LAW PROGRAM, MANUAL ON STATE AND LOCAL GOVERNMENT RESPONSIBILITIES TO PROVIDE MEDICAL CARE FOR INDIGENTS 5 (1985).

lessness advocates need to secure emergency and permanent shelter for the homeless. In support of the argument that medically-appropriate housing is a natural outgrowth of the right to shelter, Section IV explores the exemplary New York case of *Mixon v. Grinker*²⁷ in detail. Section V recognizes an alternative and innovative analysis. This analysis concludes that where a jurisdiction does not recognize a right to shelter, advocates can argue that the judiciary should recognize a right to shelter for the homeless as part of a duty to care for the indigent sick. Admittedly, this approach is nontraditional and calls for radical extensions of existing law. However, the argument is intended to stimulate creativity. Moreover, Section VI furnishes a nonlegal rationale for legislators and politicians who must appeal to taxpayers. This rationale economically compares the cost-effectiveness of home and community care to the expenses of hospitalization. Finally, Section VII concludes that federal and state legislative reform is necessary to obtain uniform and equitable results.

II. BACKGROUND: HOMELESSNESS AND AIDS

This Section demonstrates that the conditions of homelessness and symptomatic HIV-infection are distinct, but lethal, concurrent conditions. A disproportionate number of HIV-ill people suffer from a loss of housing.²⁸ An understanding of the common characteristics of the homeless and HIV-infected populations is essential to a recognition of a right to medically-appropriate housing.

The homeless population is heterogeneous, consisting of several subgroups that mirror the United States's indigent population.²⁹ The evolving diversification is demonstrated by single men and women, families with children, adolescents, minorities, and the elderly, who have replaced the stereotypical white male alcoholics or drug addicts on the streets and in shelters.³⁰ Although various definitions of homelessness have been posed,³¹ this Comment adopts the Stewart B.

27. No. 14932/88 (N.Y. Sup. Ct. Jan. 11, 1989) (order granting preliminary injunction), *aff'd and modified on other grounds*, 157 A.D.2d 423, 556 N.Y.S.2d 855 (App. Div. 1990) (This decision marks the first time a court enjoined governmental officials from refusing to provide medically-appropriate housing to the HIV-ill.).

28. Schietinger, *supra* note 15, at 481.

29. Stern, *Serious Neglect: Housing for Homeless People with AIDS*, CITY LIMITS, Apr. 1989, at 13.

30. INSTITUTE OF MEDICINE, HOMELESSNESS, HEALTH AND HUMAN NEEDS 18 (1988); Comment, *supra* note 18, at 163; Note, *supra* note 20, at 279.

31. See Langdon & Kass, *supra* note 18, at 308 (defining the homeless as "those who have no stable access to housing and who usually reside either in emergency temporary shelters provided by local governments or private charities, or in various public places, including streets, doorways, parks, public transportation terminals, and abandoned buildings");

McKinney Homelessness Assistance Act's comprehensive definition.³² The McKinney Act defines a homeless person as:

- (1) an individual who lacks a fixed, regular, and adequate nighttime residence; [or]
- (2) an individual who has a primary nighttime residence that is—
 - (A) a supervised or publicly operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
 - (B) an institution that provides a temporary residence for individuals intended to be institutionalized; or
 - (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.³³

Many homeless individuals seek refuge in public shelters, if available.³⁴ For example, in New York City, as many as one thousand people are lodged in a single large space that one observer described as "noisy, dirty, smelly, and . . . often either brutally hot or underheated."³⁵ Public shelters are usually closed during the day, and adequate rest and nutrition are impossible for shelter residents.³⁶ Long waits for food, showers, and clean clothes are common.³⁷ Moreover, sexual assaults against homeless women are highly prevalent.³⁸

As one study³⁹ reports, homelessness and health care specifically interact in three ways: (1) health problems cause homelessness;⁴⁰ (2)

McKittrick, *The Homeless: Judicial Intervention on Behalf of a Politically Powerless Group*, 16 FORDHAM URB. L.J. 389, 389 n.1 (1988) (quoting H.R. Rep. No. 47, 99th Cong., 1st Sess. 2 (1985)) (discussing broad definitions of homelessness and adopting the definition of "those individuals and families who lack sufficient resources to provide for their own shelter"); Comment, *An Overview of Homelessness in America*, 35 LOY. L. REV. 216, 217 (1989) (discussing the difficulties in capturing the diversity of the homeless population in a single definition).

32. 42 U.S.C. § 11302 (1988).

33. *Id.* § 11302(a).

34. Langdon & Kass, *supra* note 18, at 316-17.

35. Schulman, *supra* note 14, at 481.

36. *Id.*

37. *Id.* at 480. The waits usually entail standing for long periods of time, and they are physically taxing. *Id.*

38. INSTITUTE OF MEDICINE, *supra* note 30, at 41.

39. Sutherland, *Health Care for the Homeless*, ISSUES SCI. & TECH., Fall 1988, at 79.

40. *Id.* Although the most common medical antecedents to homelessness are the major mental illnesses, physical problems also have substantial impact. INSTITUTE OF MEDICINE, *supra* note 30, at 39-40. For example, AIDS is likely to become another important cause of homelessness, especially as its prevalence among intravenous drug abusers increases. *Id.* at 40; see Complaint at para. 11, *Mixon v. Grinker*, No. 14932/88 (N.Y. Sup. Ct. Jan. 11, 1989) (order granting preliminary injunction) (alleging that the "occurrence of persistent and

homelessness causes health problems;⁴¹ and (3) homelessness makes health problems harder to treat.⁴² A wide range of health care problems afflicts members of the homeless population with greater frequency than the general population.⁴³ These problems include a disproportionate prevalence of HIV-illness among the homeless and inadequate treatment facilities designed for the HIV-ill.⁴⁴

Because AIDS has been identified as a cause of homelessness,⁴⁵ a basic understanding of HIV-illness is essential to address properly this

recurring illness as one progresses along the HIV continuum is a main cause of homelessness among the HIV-infected"), reprinted in PRACTISING LAW INST., THE RIGHTS OF THE HOMELESS 389, 393 (1988); Chackes, *supra* note 24, at 94 (discussing possible causes of homelessness); see also INSTITUTE OF MEDICINE, *supra* note 30, at 41 (explaining that as HIV-infection progresses and leads to repeated and more serious bouts with opportunistic infections, an individual typically becomes unable to work and to pay rent; and that in extreme cases, homelessness results); Turkel, *Representing People with AIDS*, in AIDS LEGAL GUIDE 1-1 (A. Rubinfeld 2d ed. 1987) (explaining that by the time an attorney meets a client with AIDS, the client has lost most "personal assets, due in part to enormity of . . . medical expenses"); cf. Hayes, *supra* note 24, at 5 (arguing that governmental decisions during the 1980's inevitably resulted in increased homelessness). Other health problems that contribute to homelessness include alcoholism and drug dependence, disabling conditions, major illnesses, and employment-related injuries. INSTITUTE OF MEDICINE, *supra* note 30, at 40.

41. Lave, *Band-Aid Solutions*, 26 SOC'Y, May-June 1989, at 11 (Because "the health problems of the homeless are both caused by and exacerbated by their homeless state," remedying the health care problems is only a Band-aid solution.); Sutherland, *supra* note 39, at 80 (Street people "rarely have the opportunity to lie down, and hence suffer from a disproportionate number of problems" unique to their situations.).

42. Sutherland, *supra* note 39, at 80. Most routine medical treatments are often impossible for the homeless. *Id.* Because most homeless individuals do not eat properly, careful dietary control is out of the question. *Id.*

43. See INSTITUTE OF MEDICINE, *supra* note 30, at 41.

44. Thousands of individuals with HIV-infection live in shelters or on the streets and do not receive any medical care at all. Schulman, *supra* note 14, at 481. Ten percent of New York City's shelter residents is estimated to have AIDS. Drapkin, *Medical Problems of the Homeless*, in HOMELESSNESS IN AMERICA 92 (C. Caton ed. 1990). The AIDS unit of the New York City Commission on Human Rights has received numerous reports about hospitalized HIV-ill people being evicted by their former landlords upon release from the hospital because they were unable to pay rent. Chevront, *supra* note 17, at 12. The commission ranks such cases as among its most devastating because "not only [does] the person with AIDS have to cope with a swift decline in health but also [has] to face the possibility of having nowhere to live during the crisis period." *Id.* (quoting a report of the New York City Commission on Human Rights AIDS Unit).

45. INSTITUTE OF MEDICINE, *supra* note 30, at 40. According to the recommendations of the Committee on Health Care for Homeless People, all homeless people should have stable residences. Lave, *supra* note 41, at 11. AIDS is just another "health care problem" which need not be singled out for special attention. *Id.* Nonetheless, there are valid reasons why the homeless HIV-ill need special consideration even beyond that of a healthy homeless person. See *infra* notes 68-73 and accompanying text. Indeed, the health care financing system's tendency to categorize and to function by classifying separate groups supports the proposition that advocates should pursue housing and special treatment for the homeless HIV-ill. See Benjamin, *Long-Term Care and AIDS: Perspectives from Experience with the Elderly*, 66 MILBANK Q. 415, 417 (1988).

aspect of the homelessness problem.⁴⁶ HIV attacks the body's immune defense system.⁴⁷ When HIV enters the blood stream, the infected person's body enters a seropositive state,⁴⁸ producing antibodies which can be detected in that person's blood usually two weeks to three months after infection.⁴⁹ Once infected with HIV, a person may remain in a seropositive state,⁵⁰ or may develop AIDS.⁵¹ AIDS is simply the final stage of a series of health problems along the spectrum of disease caused by HIV.⁵² "Full-blown AIDS"⁵³ is the most serious condition caused by HIV whereby the immune system collapses, and infectious "opportunistic diseases,"⁵⁴ such as Kaposi's sarcoma, invade the body.⁵⁵

46. As stated previously, HIV is an acronym for Human Immunodeficiency Virus, the retrovirus that causes AIDS. See *supra* note 13. Scientists have also called this virus HTLV-III, or Human T-Lymphotropic Virus Type III, and LAV, or Lymphadenopathy Associated Virus. SURGEON GENERAL'S REPORT, *supra* note 18, at 9. Surgeon General Koop refers to HIV as the "AIDS virus." *Id.*

47. Green, *The Transmission of AIDS*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 28 (H. Dalton & S. Burris eds. 1987). For a capsulized explanation of the medical facts of AIDS and a description of HIV's invasion of the T-Lymphocytes or T-helper cells, see *id.* at 29-31.

48. In the seropositive state, blood tests indicate infection with HIV by revealing the presence of HIV antibodies. *Id.* at 29.

49. SURGEON GENERAL'S REPORT, *supra* note 18, at 10. A simple test is used to detect the antibodies. *Id.*

50. Albert, *supra* note 16, at 748-49. At this stage, the individual's immune system is under attack, but continues to function. Despite a lack of symptoms, the individual is capable of transmitting the virus. *Id.* "A critical but unresolved question is whether an individual can remain in this first stage indefinitely or if the disease always progresses to the point when disease symptoms appear." *Id.* at 749 (discussing scientific studies and their respective conclusions).

51. SURGEON GENERAL'S REPORT, *supra* note 18, at 10-11; Green, *supra* note 47, at 30.

52. SURGEON GENERAL'S REPORT, *supra* note 18, at 9. However, it is too soon in the history of this syndrome to determine whether all or most people infected with HIV will develop AIDS. See S. SONTAG, AIDS AND ITS METAPHORS 29 (1989). Seropositive individuals with clinical symptoms less severe than those associated with AIDS originally were said to suffer from AIDS-related complex ("ARC"), which "causes moderate damage to the immune system." Green, *supra* note 47, at 30. This term's use has declined, and the condition it describes is now generally considered to be AIDS, albeit a milder form. Albert, *supra* note 16, at 749 & n.49. Some people have died from ARC without ever having contracted AIDS. Stern, *supra* note 29, at 13. The federal Centers for Disease Control (the "CDC") regards the distinction between AIDS and ARC as artificial. *Id.*

53. S. SONTAG, *supra* note 52, at 28-29 (defining "full-blown" as the "form in which the disease is inevitably fatal").

54. SURGEON GENERAL'S REPORT, *supra* note 18, at 10. Germs that would ordinarily be fought off by a healthily functioning immune system "us[e] the opportunity of [the body's] lowered resistance to infect and destroy." *Id.* These germs include bacteria, protozoa, fungi, and other viruses and cancers. *Id.* Pneumocystis carinii pneumonia, tuberculosis, and Kaposi's sarcoma are some of the most common diseases caused by HIV and germ infection. *Id.*

55. See Green, *supra* note 47, at 30.

Because of the wide range of physical responses to HIV infection, it is impossible to characterize the symptoms of AIDS in an all-encompassing phrase or sentence.⁵⁶ HIV-disease, an episodic illness, is characterized by periods of both acuteness and relative health.⁵⁷ Symptoms may take years to develop and could appear as "memory loss, indifference, loss of coordination, partial paralysis or mental disorders."⁵⁸ Furthermore, symptoms "may include a persistent cough and fever associated with shortness of breath or difficult breathing."⁵⁹ Chronic diarrhea and other intestinal disorders are common.⁶⁰ Kaposi's sarcoma, which causes visible purplish skin lesions to appear on the body, is also a common ailment.⁶¹

Finally, although AIDS per se is not transmissible, infection with HIV can be transmitted.⁶² HIV is transmitted under very limited circumstances,⁶³ including sexual contact,⁶⁴ exchange of blood,⁶⁵ and perinatal events.⁶⁶ There is absolutely no risk, however, from casual

56. Indeed, individuals may react differently to HIV-infection. SURGEON GENERAL'S REPORT, *supra* note 18, at 11.

57. Lambert, *Places for AIDS Patients Are Still Scarce*, N.Y. Times, Dec. 17, 1989, at E6, col. 1.

58. SURGEON GENERAL'S REPORT, *supra* note 18, at 12. Long-term manifestations of AIDS might include delayed brain damage resulting from an attack on the nervous system. *Id.*

59. *Id.* at 11-12. Symptoms of what used to be known as ARC, *see supra* note 52, often include loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, fatigue, lack of resistance to infection, or swollen lymph nodes. *Id.* at 11; *see also* Green, *supra* note 47, at 30.

60. Schulman, *supra* note 14, at 481.

61. Persons afflicted with Kaposi's sarcoma need privacy in bathing to maintain dignity and confidentiality. *See* Memorandum of Law in Support of Plaintiff's Motion for a Preliminary Injunction and Class Certification at 11, *Mixon v. Grinker*, No. 14932/88 (N.Y. Sup. Ct. Jan. 11, 1989) [hereinafter Memorandum of Law]. Discrimination among shelter residents is rampant. For example, one of the *Mixon* plaintiffs could stay only one night at a shelter because other residents, who observed his skin lesions in the group showers, threatened him. This is psychologically, as well as physically, damaging. *Id.* at 8; *see also* Schulman, *supra* note 14, at 480.

62. Krim, *Preface* to AIDS LEGAL GUIDE at P-1 (A. Rubinfeld 2d ed. 1987).

63. Green, *supra* note 47, at 31.

64. Albert, *supra* note 16, at 748; Green, *supra* note 47, at 31-32.

65. Green, *supra* note 47, at 32-33. Intravenous drug abusers, for example, commonly transmit HIV through the sharing of infected needles. *Id.* at 32. Among the homeless, drug use often is open and widespread in shelters. Kolata, *Twins of the Streets: Homelessness and Addiction*, N.Y. Times, May 22, 1989, at A1, col. 2, A13, col. 1. Shelters apparently worsen the drug problem. *Id.* Many homeless advocates do not publicly discuss the problem of addiction because they fear that the public would lose its sympathy for the homeless. *Id.* at A1, col. 3.

66. *See* SURGEON GENERAL'S REPORT, *supra* note 18, at 20. Prenatal infection is demonstrated by HIV-infected children born to HIV-infected mothers. Lifson, *Do Alternate Modes for Transmission of Human Immunodeficiency Virus Exist?*, 259 J. A.M.A. 1353, 1355 (1988). The possibility of postnatal infection from breast-feeding "continues to be evaluated." *Id.* at 1353.

contact.⁶⁷

The realities associated with a homeless person's daily existence starkly contrast with the daily needs of a symptomatic HIV-infected person. Once a homeless person becomes HIV-infected, the development of AIDS is likely to be accelerated by malnutrition and repeated infections.⁶⁸ Homeless people commonly suffer from "inadequate food and nutrition, a clothing shortage, physical violence and sexual victimization, poor physical and mental health, alcoholism or alcohol abuse, and inadequate job and life skills."⁶⁹ At the very least, an HIV-infected person needs adequate food and nutrition,⁷⁰ a psychologically safe environment,⁷¹ and plenty of rest to combat fatigue.⁷² The tendency for the general public to attach a stigma to those with HIV-illness also adds to the misfortunes of the homeless HIV-ill.⁷³

The estimated survival time of a PWA has become longer

67. SURGEON GENERAL'S REPORT, *supra* note 18, at 13. Even where family members of an HIV-ill person shared food, towels, cups, razors, and toothbrushes, and kissed each other, there was no evidence of HIV transmission. *Id.*; see Green, *supra* note 47, at 33-36.

68. Repeated infections, in turn, lead to activation of the T4 lymphocyte, resulting in replication of the HIV virus, death of the cell, compromise of the immune system, and subsequent development of AIDS. Drapkin, *supra* note 44, at 31.

69. Chackes, *supra* note 24, at 94.

70. A high-protein diet is frequently recommended. Rovner, *Nutrition: Key in AIDS Care*, Wash. Post (Health), Sept. 26, 1989, at 8.

71. Dealing with the knowledge of a terminal illness is aggravated by having to deal with a crisis situation everyday, such as trying to find a place to sleep, food to eat, and clean clothes to wear. Rosenthal, *Health Care for the Homeless: Treating the Byproducts of Life on the Streets*, N.Y. Times, Feb. 22, 1990, at B9, col. 1. "The homeless are struggling for survival so much of the day" *Id.* (quoting Dr. Mark Dollar, who specializes in treating the homeless); see also *supra* note 61.

72. Schulman, *supra* note 14, at 480 (quoting a homeless PWA who could not obtain proper rest or nutrition in a shelter, and, thus, returned to the streets where his AIDS-related skin lesions worsened to the point that he could not stand in food lines).

73. For example, despite medical data describing the limited transmissibility of HIV infection, "the public treats AIDS as though it were a highly contagious disease spread by a wide range of [everyday] activities." Green, *supra* note 47, at 28-29 (relating several incidents illustrating the public's panic surrounding AIDS). Many shelters for the homeless around the country categorically exclude HIV-ill persons. NATIONAL COALITION FOR THE HOMELESS, FIGHTING TO LIVE: HOMELESS PEOPLE WITH AIDS v (1990).

Stigmatization is perpetuated by the fact that "AIDS has hit hardest persons of color, members of the gay community, IV [intravenous] drug users and homeless youth." *Id.* at iv. For example, in New York City, the homeless HIV-ill are presently being placed in special medical sections of large public shelters where the HIV-ill residents are referred to by the other residents with "anti-homosexual epithets." Lambert, *Amid Protests, Dinkins Plans AIDS Shelters*, N.Y. Times, Feb. 21, 1990, at A15, col. 6. Advocates strongly urge providers to develop HIV-dedicated facilities which arguably would be more efficient and offer better services than integrated facilities. Speech entitled *A Constitutional Right to Appropriate Housing—The New York Litigation* by Nan Hunter of the American Civil Liberties Union, A.A.L.S. Joint Program: Section on Gay and Lesbian Issues, Section on Law & Medicine, Section on Real Property (Jan. 4, 1990). However, HIV-dedicated facilities tend to reinforce the stigma associated with HIV-disease. *Id.*

because scientists "can respond with more appropriate symptomatic treatment"⁷⁴ as they continue to learn more about the disease.⁷⁵ Treatment, however, is still in the experimental stages.⁷⁶ Drug therapy, such as zidovudine ("AZT"), has serious side effects.⁷⁷ Although development of a vaccine against AIDS is theoretically possible, society should respond to the AIDS epidemic with the assumption that a vaccine may not be available in the foreseeable future.⁷⁸

Aggravation of HIV-illness takes different forms depending upon the infected individual's living situation. Public shelters are not safe for HIV-ill individuals.⁷⁹ The greatest danger to a person whose immune system is suppressed by HIV-infection is proximity to diseases that can be easily transferred among people through casual contact.⁸⁰ Non-HIV-infected homeless persons commonly complain about infectious diseases,⁸¹ which worsen because of the homelessness condition.⁸² The incidence of tuberculosis, for example, is disproportionately high among shelter residents and people living on the streets.⁸³ The HIV-ill are in great danger of developing full-blown AIDS when placed in shelters where the incidence of infectious diseases is very high. Alternatively, the HIV-ill who stay away from shelters because of violence or poor conditions live in alleys, under bridges, in subways, and on benches. They encounter formidable obstacles in obtaining showers, adequate rest, and nutritional meals, which also puts them in great danger of developing full-blown AIDS.⁸⁴ Because life on the streets offers harsh exposure to natural

74. Albert, *supra* note 16, at 749-50 (noting that scientists can better diagnose AIDS because they understand it more fully).

75. See Krim, *supra* note 62, at P-1 to P-3 (discussing the success of AIDS educational programs).

76. Albert, *supra* note 16, at 751.

77. *Id.*

78. *Id.*

79. See *supra* notes 34-38 and accompanying text.

80. Memorandum of Law, *supra* note 61, at 14-15.

81. Collins, *Health for the Homeless: Miami Physician Takes Care to the Streets*, AM. MED. NEWS, Feb. 3, 1989, at 19.

82. Rosenthal, *supra* note 71, at B9, col. 1.

83. Collins, *supra* note 81, at 19.

84. *Id.* These obstacles result in "poor hygiene, no showers, no change of clothes, and, thus,] what [the homeless] get they can't get rid of." *Id.* (quoting Dr. Pedro Jose Greer, a physician who regularly treats the homeless at Miami's Camillus Health Concern).

elements,⁸⁵ lack of personal security,⁸⁶ and susceptibility to disease,⁸⁷ it is easy to understand why the emerging new crisis is a growing number of homeless HIV-ill. The most effective way to quell the crisis is to provide adequate shelter and appropriate health care concurrently.

III. OVERVIEW: PARALLELS IN THE ANALYSIS OF THE RIGHT TO SHELTER AND THE RIGHT TO HEALTH CARE

Lacking both a home and easy access to appropriate medical services places the homeless HIV-ill in a unique situation worthy of special consideration. Existing law does not address effectively this particular mixture of misery, which afflicts thousands of Americans. Very few plaintiffs have attempted to enforce both a right to shelter and a right to health care.⁸⁸ To a limited extent, each of these rights has been separately established under state constitutions and state statutes.⁸⁹ Under the proper circumstances—that is, under a combination of constitutional provisions, statutes, and regulations, along with a judiciary willing to liberally construe them—governmental duties to the poor can be found under existing law to include medically-appropriate housing⁹⁰ and other “life-sustaining services.”⁹¹

There is no federal constitutional right to shelter.⁹² Similarly, neither the United States Supreme Court nor any federal court of appeals has recognized a federal constitutional right to health or health care.⁹³ Although the federal government has not acted on

85. Callahan v. Carey, N.Y.L.J., Dec. 11, 1979, at 10, col. 4 (N.Y. Sup. Ct. Dec. 5, 1979), *aff'd mem.*, 118 A.D.2d 1054, 499 N.Y.S.2d 567 (App. Div. 1986).

86. See Memorandum of Law, *supra* note 61, at 10, 12; see, e.g., NATIONAL COALITION FOR THE HOMELESS, ENDING THE SILENCE: VOICES OF HOMELESS PEOPLE LIVING WITH AIDS 20 (June 1990) (transcript of testimony by Ervin Marrero to the United States House of Representatives, Banking, Finance and Urban Affairs Committee, Subcommittee on Housing and Community Development Hearings on Homelessness and AIDS).

87. Collins, *supra* note 81, at 19.

88. See *infra* notes 126-84 & 224-35 and accompanying text.

89. See *infra* note 95.

90. See *infra* notes 200-23 and accompanying text.

91. Chackes, *supra* note 24, at 94.

92. Lindsey v. Normet, 405 U.S. 56, 74 (1972) (stating that “[w]e do not denigrate the importance of decent, safe, and sanitary housing. But the Constitution does not provide judicial remedies for every social and economic ill Absent constitutional mandate, the assurance of adequate housing . . . [is a] legislative, not judicial, function[.]”); see Note, *supra* note 18, at 943 & n.23.

93. E.g., Harris v. McRae, 448 U.S. 297 (1980); Banks, *supra* note 3, at 160 n.53 (citing Kinney, *Making Hard Choices Under Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1157 (1986)); Metcalfe, *Indigent Health Care in Saint Louis*, 32 ST. LOUIS U.L.J. 1075, 1084 & n.70 (1988).

these matters,⁹⁴ state courts have relied on state constitutions and state statutes to impose duties on governmental entities.⁹⁵ Moreover, state legislatures have the power to establish such duties. In the establishment of these duties, some of the paramount issues to be considered by legislators and, eventually, the courts are the scope of the government's obligation, and the ability and willingness of courts to dictate the means of implementation to the appropriate governmental entities.⁹⁶

Some commentators argue that once these duties have been statutorily established, courts should construe the statutes liberally.⁹⁷

94. For example, Senator Edward Kennedy introduced the Health Security Act in 1970, but Congress never enacted it into law. Banks, *supra* note 3, at 161 (citing 116 CONG. REC. 30142 (1970)).

95. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 5; e.g., Callahan v. Carey, N.Y.L.J., Dec. 11, 1979, at 10, col. 4 (N.Y. Sup. Ct. Dec. 5, 1979) (holding that all homeless men have a right to emergency housing under the laws and constitution of New York), *aff'd mem.*, 118 A.D.2d 1054, 499 N.Y.S.2d 567 (App. Div. 1986); Metcalfe, *supra* note 93, at 1085-86 (discussing the statutory duties to provide health care to indigents of Missouri local governments).

Courts have relied on state statutes to impose a "duty to relieve the poor," Chackes, *supra* note 24, at 105, for both general and discrete groups. Comment, *supra* note 31, at 239 (discussing Turner v. City of New Orleans, No. 87-8281 (Civ. Dist. Ct. Orleans Parish, La., May 12, 1987), where plaintiffs challenged state statutory provisions).

96. Courts first look to the express language of the statutory or constitutional provisions to determine the scope of the duty. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 6-7; Metcalfe, *supra* note 93, at 1085. Courts also examine legislative intent and judicial interpretations of the provisions. *Id.* Moreover, courts should interpret a statute "in the light of some assumed purpose." Llewellyn, *Remarks on the Theory of Appellate Decision and the Rules or Canons About How Statutes are to be Construed*, 3 VAND. L. REV. 395, 400 (1950). Courts often examine a statute's policy, which includes the drafter's conscious ideas as well as circumstances "utterly un contemplated at the time of its passage." *Id.* As time passes between a statute's enactment and its subsequent interpretation, courts tend to examine the statute's broader purposes in light of the new situation. *Id.* Thus, courts have good cause to reevaluate state statutes in light of new circumstances: the increase in the homeless HIV-ill population and the move away from former stereotypes.

An important interpretive issue regarding the scope of rights and duties is whether relevant statutory provisions impose mandatory or discretionary duties. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 5-6. Legislatures "frequently use the word 'shall' to specify the 'mandatory' nature of the duty." Chackes, *supra* note 24, at 106 (footnote omitted); see, e.g., CAL. WELF. & INST. CODE § 17000 (West 1980). Some discretionary statutes merely authorize or enable governmental entities to provide care for the poor. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 6; see, e.g., TENN. CODE ANN. § 71-5-2308 (1987). For example, where a governmental entity violates a clear statutory mandate as to welfare benefits, courts usually order modification of the benefits. Chackes, *supra* note 24, at 112. Where a governmental entity's conduct is clearly discretionary, courts ordinarily uphold the conduct, unless the conduct "conflict[s] with the statute, or . . . is unreasonable or arbitrary and capricious." *Id.* at 113 (footnote omitted).

97. Chackes, *supra* note 24, at 113; see SUTHERLAND & SAND'S STATUTORY CONSTRUCTION § 71.08 (4th ed. 1972). The California Supreme Court has cited with approval legislation mandating that indigents' rights and duties should be liberally construed. Mooney v. Pickett, 4 Cal. 3d 669, 676 n.8, 483 P.2d 1231, 1236 n.8, 94 Cal. Rptr. 279, 284 n.8

They believe that the remedial purposes of state poor laws can best be achieved by broadening both the class of indigent beneficiaries and the scope of rights to which indigents are entitled. Some judges who believe the problem of homelessness requires a judicial solution already have been broadly interpreting these statutes.⁹⁸ Certain judges have had to be more creative than others, however, because the statutory and constitutional provisions on which courts have relied to establish indigents' rights to emergency health care and temporary shelter vary in terms of their specificity. In the area of health care, some state courts have interpreted broadly statutes of general authorization to impose mandatory duties on governmental entities to provide indigents with health care.⁹⁹ Other health care provisions are explicitly aimed at a particular segment of the population so that broad judicial construction is unnecessary.¹⁰⁰ Similarly, in finding a right to shelter, some courts have imposed a duty to provide shelter based upon statutes that did not even expressly refer to shelter rights,¹⁰¹ or which had merely an incidental reference to shelter.¹⁰² In other cases, broad construction was, again, unnecessary because the statutes specifically required shelter to be provided.¹⁰³

The question of relief often is litigated subsequent to the judicial or legislative establishment of a right to health care or shelter.¹⁰⁴

(1971) (citing CAL. WELF. & INST. CODE § 11000 (West 1965), *amended by* CAL. WELF. & INST. CODE § 11000 (West Supp. 1991) (changing the standard from "liberally" to "fairly and equitably" construed)). Courts have utilized liberal construction to broaden the classes of beneficiaries under applicable statutes. See *Graham v. Schoemehl*, No. 854-00035 (Mo. Cir. Ct. 1985); *Hodge v. Ginsberg*, 303 S.E.2d 245 (W. Va. 1983).

98. See *McKittrick*, *supra* note 31, at 407-08.

99. *E.g.*, *Industrial Comm'n v. Navajo County*, 67 Ariz. 172, 167 P.2d 113 (1946). At least 14 states have statutes that do not explicitly mention medical care. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 6 n.18. However, courts have interpreted provisions "for 'relief,' 'support,' or 'maintenance' of the poor to include medical care." *Id.* at 6.

100. *E.g.*, CAL. WELF. & INST. CODE § 17000 (West 1980). This statutory provision explicitly creates a duty for every California city and county to provide health care to indigent California residents.

101. *E.g.*, *McCain v. Koch*, 127 Misc. 2d 20, 484 N.Y.S.2d 985 (Sup. Ct. 1984), *modified*, 117 A.D.2d 198, 502 N.Y.S.2d 720 (App. Div.), *appeal granted*, 121 A.D.2d 997, 503 N.Y.S.2d 997 (App. Div. 1986), *later proceeding*, 68 N.Y.2d 713, 497 N.E.2d 679, 506 N.Y.S.2d 312, *rev'd*, 70 N.Y.2d 109, 511 N.E.2d 62, 517 N.Y.S.2d 918 (1987); *Callahan v. Carey*, N.Y.L.J., Dec. 11, 1979, at 10, col. 4 (N.Y. Sup. Ct. Dec. 5, 1979), *aff'd mem.*, 118 A.D.2d 1054, 499 N.Y.S.2d 567 (App. Div. 1986); see, e.g., N.Y. CONST. art. XVII, § 1 ("The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine.").

102. *E.g.*, *Maticka v. Atlantic City*, 216 N.J. Super. 434, 524 A.2d 416 (Super. Ct. App. Div. 1987); *Hodge v. Ginsberg*, 303 S.E.2d 245 (W. Va. 1983).

103. *E.g.*, *Dukes v. Durante*, 192 Conn. 207, 471 A.2d 1368 (1984); *Klostermann v. Cuomo*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 247 (1984).

104. In litigation involving the homeless, extraordinary writs like injunction and mandamus

Claims that arise under state poor laws can be categorized either as level-of-benefits or denial-of-benefits cases.¹⁰⁵ A level-of-benefits case involves a judicial interpretation as to whether the nature and amount of benefits provided by the governmental entity meets the statutory mandate.¹⁰⁶ A denial-of-benefits case involves a challenge to the allegedly improper refusal to provide benefits to individuals based on the discretionary eligibility limitations imposed by the governmental entity.¹⁰⁷ Courts are less likely to intervene in a level-of-benefits case because certain discretionary decisions by governmental entities are nonjusticiable.¹⁰⁸ Even where the justiciability doctrine is inapplicable, courts are reluctant to fashion remedies which might encroach upon the province of other governmental branches.¹⁰⁹ However, as noted by the New York Court of Appeals, the judiciary must be able to distinguish "between a court's imposition of its own policy determination upon its governmental partners[, which is nonjusticiable,] and its mere declaration and enforcement of the individual's rights that have already been conferred by the other branches of government[, which is justiciable]."¹¹⁰ Of course, it is easier to argue a denial-of-benefits case. If the court finds that a governmental entity improperly denied relief, it can more easily fashion an appropriate remedy.¹¹¹ An example of the judicial interpretation of a state law may prove illustrative for advocates in other states. In California, for example, indigent plaintiffs in a level-of-benefits case prevailed where a county government arbitrarily and capriciously reduced the county's general assistance levels for indigent county residents.¹¹² A California court

are typically utilized. Chackes, *supra* note 24, at 96 (citing D. MANDELKER, D. NETSCH & P. SALSICH, STATE AND LOCAL GOVERNMENT IN A FEDERAL SYSTEM 767 (2d ed. 1983)). In both types of actions, plaintiffs must prove, inter alia, the existence of a legal right on the part of the plaintiff. *Id.* at 96, 98.

105. *Id.* at 107.

106. *Id.* at 112.

107. *Id.* at 107.

108. *Id.* at 110-11. The responsible officials may argue that the separation of powers or political question doctrine bars judicial review. *Id.* at 111.

109. *Id.* at 113. Courts refuse to "issue[] specific directions to . . . responsible government officials telling them how to restructure programs or at what level to set future benefits." *Id.* Where appropriate, however, courts have declared that existing levels of benefits conflict with statutory mandates, *id.*, and some courts "have gone a . . . step farther and explicitly ordered government officials to set new levels of benefits in accordance with . . . statutory requirements." *Id.*

110. *Klostermann v. Cuomo*, 61 N.Y.2d 525, 535, 463 N.E.2d 588, 593, 475 N.Y.S.2d 247, 252 (1984); see Chackes, *supra* note 24, at 118-19. For a discussion of *Klostermann* and the justiciability issue, see *infra* note 295.

111. Chackes, *supra* note 24, at 107 ("[T]he grant or denial of benefits is a two-dimensional choice.").

112. *Boehm v. County of Merced*, 163 Cal. App. 3d 447, 453, 209 Cal. Rptr. 530, 533 (Ct.

of appeal held that "minimum subsistence" included allocations for housing and medical care,¹¹³ and that "aid" included necessities of life such as food, housing, utilities, clothing, transportation, and medical care.¹¹⁴ This decision supports the proposition that judicial interpretations of existing statutes may establish a sufficiently broad governmental duty to provide both housing and medical services for the homeless.

Arguably, the provision of medically-appropriate housing for the HIV-ill falls into the denial-of-benefits category. Some courts have defined shelter to require protection from health-threatening situations.¹¹⁵ Under this definition, the housing that governmental entities typically provide for homeless people does not constitute shelter for the HIV-ill.¹¹⁶ This is because the HIV-ill are constantly placed in jeopardy of contracting infectious diseases that speed the final collapse of their immune systems by simply being in casual contact with persons suffering from or carrying infectious diseases. Governmental entities, then, regularly deny the rights of the HIV-ill.

Reliance on existing state constitutions and statutes to provide a legal right to shelter is likely to result in the "haphazard, uneven provision of shelter."¹¹⁷ The outcome of such litigation depends on the precision of applicable laws, the local political climate, and the conservatism or liberality of the judiciary at a given time.¹¹⁸ Similarly, the extent of a local government's legal responsibility to provide shelter and medical services to indigents remains uncertain.¹¹⁹ For this reason, legislative reform is heralded as a necessary step in the clarification of governmental duties.¹²⁰ Major federal legislation holds the most potential for success because the resulting uniformity would

App. 1985), later approved *sub nom.* *Boehm v. Superior Court*, 178 Cal. App. 3d 494, 223 Cal. Rptr. 716 (Ct. App. 1986).

113. *Boehm*, 178 Cal. App. 3d at 501, 223 Cal. Rptr. at 720. "Medical care . . . include[s] care 'for the prevention or alleviation of a physical or mental defect or illness.'" Comment, *The Duty of California Counties to Provide Mental Health Care for the Indigent and Homeless*, 25 SAN DIEGO L. REV. 197, 211 (1988) (quoting BLACK'S LAW DICTIONARY 885 (5th ed. 1979)).

114. *Boehm*, 178 Cal. App. 3d at 501, 223 Cal. Rptr. at 720.

115. See, e.g., *Barnes v. Koch*, 136 Misc. 2d 96, 101, 518 N.Y.S.2d 539, 543 (Sup. Ct. 1987).

116. *Mixon v. Grinker*, No. 14932/88 (N.Y. Sup. Ct. Jan. 11, 1989), *aff'd and modified on other grounds*, 157 A.D.2d 423, 556 N.Y.S.2d 855 (App. Div. 1990); cf. *McCain v. Koch*, 70 N.Y.2d 109, 120, 511 N.E.2d 62, 66, 517 N.Y.S.2d 918, 923 (1987) (citing *McCain v. Koch*, 127 Misc. 2d 20, 24, 484 N.Y.S.2d 985, 987 (Sup. Ct. 1984)). See generally Chackes, *supra* note 24, at 120-21 (discussing the *McCain* decision).

117. Langdon & Kass, *supra* note 18, at 348.

118. *Id.*

119. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 37.

120. *Id.*

help to achieve consistent and long-lasting results.¹²¹

Under existing laws, the right to medically-appropriate housing may be established more successfully with a right to shelter argument than with a right to health care argument. Indeed, *Mixon v. Grinker*,¹²² the only successful right to medically-appropriate housing case for HIV-ill individuals, relied upon the right to shelter cases in New York.¹²³ At this time, an attempt to extend existing law has more potential for success than an attempt to create a new legal right.¹²⁴

In other jurisdictions that may not recognize a right to shelter, many have established methods for indigents to obtain health care.¹²⁵ Because the right to health care argument to establish the right to medically-appropriate housing is a more targeted approach that emphasizes only the HIV-ill and not other homeless individuals, courts may more readily accept the need for a limited right to housing. In these jurisdictions, the argument that certain types of housing with minimal support services are more cost-effective and humane than hospitalization may prove useful.

IV. THE RIGHT TO SHELTER ARGUMENT

A. *Establishing the Right*

Commentators differ when estimating the potential for success in establishing a legal right to shelter using existing state statutes and constitutions.¹²⁶ While some of the state statutes specifically provide

121. McKittrick, *supra* note 31, at 423.

122. No. 14932/88 (N.Y. Sup. Ct. Jan. 11, 1989), *aff'd and modified on other grounds*, 157 A.D.2d 423, 556 N.Y.S.2d 855 (App. Div. 1990).

123. *Id.* For an analysis of *Mixon*, see *infra* notes 200-23 and accompanying text.

124. In *Mixon*, plaintiffs' counsel emphasized that they were "not inviting the Court to create a new right or to engage in the type of discretionary resource allocation and priority setting which the justiciability doctrine reserves to the executive branch." Memorandum of Law in Opposition to Defendants' Motion to Dismiss and in Further Support of Plaintiffs' Motion for a Preliminary Injunction and Class Certification at 2-3, *Mixon v. Grinker*, No. 14932/88 (N.Y. Sup. Ct. Jan. 11, 1989).

125. See *infra* notes 225-313 and accompanying text.

126. Some commentators are skeptical about the use of state statutes to establish a legal right to shelter. See Note, *supra* note 18, at 946. "[J]udges in jurisdictions less liberal than New York may be reluctant to interpret general statutory language to imply an enforceable right to shelter." *Id.* (citing K. Hopper & L. Cox, *Litigation in Advocacy for the Homeless: The Case of New York City* 3-4 (May 1982) (unpublished report)). One commentator concluded that the successful establishment of a right to shelter for the homeless in *Callahan v. Carey*, N.Y.L.J., Dec. 11, 1979, at 10, col. 4 (N.Y. Sup. Ct. Dec. 5, 1979), *aff'd mem.*, 118 A.D.2d 1054, 499 N.Y.S.2d 567 (App. Div. 1986), was a fluke. *Id.* at 947. Furthermore, in 1986, a New York federal district court noted that "whether the homeless have a right to shelter [under the New York Constitution] is extremely unclear." *Weiser v. Koch*, 632 F. Supp. 1369, 1379 (S.D.N.Y. 1986) (citing *Canaday v. Koch*, 608 F. Supp. 1460, 1466-67

for housing or shelter,¹²⁷ none of the state constitutions explicitly do so.¹²⁸ The constitutions of New York¹²⁹ and Montana,¹³⁰ however, come the closest by setting forth an affirmative governmental obligation to provide for indigents.¹³¹ The following summary of the differ-

(S.D.N.Y. 1985), *aff'd*, 768 F.2d 501 (2d Cir. 1985)). Other commentators are more certain that the right to shelter is established after *Callahan* and its progeny. For example, one commentator has argued that article XVII, section 1 of the New York Constitution guarantees a right to shelter for the homeless. Note, *supra* note 25, at 272-73.

Langdon and Kass identify two categories of statutes under which they surmise that an obligation to provide shelter for homeless persons exists: general assistance ("GA") and adult protective services. Langdon & Kass, *supra* note 18, at 324. They concede, however, that most city and state governments have admitted to no more than a moral duty. *Id.* at 323. They refer to one state (West Virginia), four counties (Los Angeles in California, and Orange, Westchester, and Dutchess in New York), and two cities (New York City and Atlantic City) that have accepted legal responsibility for sheltering the homeless. *Id.* at 323 n.93. State GA programs differ as to recipients' eligibility requirements and benefit levels, but they usually provide for minimal aid to those persons considered to be truly needy. *Id.* at 325. The statutory language regarding eligibility determines the scope of a state's duty—that is, whether the state must include shelter in its provisions for the homeless. *Id.* at 326. Most GA statutes "do not expressly identify shelter as one of the forms of assistance that state or local governments have the power to provide to the poor," *id.* at 327, because these statutes only impose general obligations "to provide [the] poor with whatever support is necessary and appropriate." *Id.* In states in which a court may broadly construe the state GA law or county "poor law," it may impose a governmental obligation "to provide either shelter or the funds necessary to procure shelter." *Id.*

127. *E.g.*, *Dukes v. Durante*, 192 Conn. 207, 471 A.2d 1368 (1984); *Klostermann v. Cuomo*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 247 (1984).

128. See Langdon & Kass, *supra* note 18, at 332-33.

129. N.Y. CONST. art. XVII, § 1 ("The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine.").

130. MONT. CONST. art. XII, § 3(3) (providing that "[t]he legislature may provide such economic assistance and social and rehabilitative services for those who, by reason of age, infirmities, or misfortune are determined by the legislature to be in need"); see *id.* art. II, § 3 (stating that a person's inalienable rights include "the right to a clean and healthful environment and the rights of pursuing life's basic necessities, enjoying and defending their lives and liberties, . . . and seeking their safety, health and happiness in all lawful ways").

131. *Cf.* *Hayes*, *supra* note 20, at 80 (New York and Montana are the only two states "whose constitutions provide a basis for an affirmative obligation to do something for citizens who are in need."). Other state constitutions also arguably "contain language which unambiguously obligates the government to provide for the needs of the poor." Langdon & Kass, *supra* note 18, at 333; see, e.g., ALA. CONST. art IV, § 88 ("It shall be the duty of the legislature to require the several counties of this state to make adequate provision for the maintenance of the poor."); KAN. CONST. art. 7, § 4 ("The respective counties of the state shall provide, as may be prescribed by law, for those inhabitants who, by reason of age, infirmity or other misfortune, may have claims upon the aid of society."); OKLA. CONST. art. 17, § 3 ("The several counties of the State shall provide, as may be prescribed by law, for those inhabitants who, by reason of age, infirmity, or misfortune, may have claims upon the sympathy and aid of the county."). Moreover, at least "seventeen state constitutions contain[] some provision concerning a right to aid for the poor." Comment, *supra* note 31, at 238 (citing Langdon & Kass, *supra* note 18, at 232).

New Jersey has addressed extensively the issue of a constitutional right to shelter. Comment, *supra* note 31, at 238. In *Railroad v. New Brunswick Mun. Welfare Dep't*, Nos. A-

ent types of claims that have been successful provides the legal foundation for the recognition of a right to medically-appropriate housing based on an established right to shelter.

New York's litigation and interpretive case law is among the nation's most well-developed in the area of homelessness.¹³² In the 1979 decision of *Callahan v. Carey*,¹³³ a New York trial court first recognized a right to emergency housing.¹³⁴ The plaintiffs, homeless men,¹³⁵ claimed that existing federal, state, and city laws created a mandatory duty for governmental officials to provide adequate emergency housing for all homeless men "seeking lodging and shelter and meals."¹³⁶ Initially, the court granted a preliminary injunction, ordering the public officials to submit a plan for the provision of shelter, including bed and board, for all homeless men who applied for it.¹³⁷ In so holding, the court cited four types of express legal authorities: (1) a provision of the New York State Constitution acknowledging that "[t]he aid, care and support of the needy are public concerns . . . [that] shall be provided by the state";¹³⁸ (2) sections of the New York Social Services Law providing that each public welfare district is responsible for the assistance and care of needy persons within its territory,¹³⁹ and that social services officials have the duty to care for those "unable to maintain themselves"¹⁴⁰ and to utilize community

4439-85T5, A-4733-85T4 (N.J. Super. App. Div. Dec. 8, 1986) (consolidated), *petition for certification denied*, 111 N.J. 638, 546 A.2d 550 (1988), a New Jersey appellate court concluded that no state constitutional right to shelter exists. *Id.*; see Comment, *supra* note 31, at 238 (citing Connell, *A Right to Emergency Shelter for the Homeless Under the New Jersey Constitution*, 18 RUTGERS L.J. 765, 800 (1987)). This was "the first appellate level decision to reach this conclusion." *Id.*

132. Hayes, *supra* note 24, at 2 (discussing pending litigation in Louisiana and the similarities between the New York and Louisiana statutes).

133. N.Y.L.J., Dec. 11, 1979, at 10, col. 4 (N.Y. Sup. Ct. Dec. 5, 1979), *aff'd mem.*, 118 A.D.2d 1054, 499 N.Y.S.2d 567 (App. Div. 1986).

134. Hayes, *supra* note 20, at 81; Hayes, *supra* note 24, at 5 (noting that the *Callahan* case was the first time that a court held that a right to subsistence exists); see Comment, *supra* note 31, at 234.

135. Class action certification was denied on the grounds that it was unnecessary. The defendants were governmental officials, "and any resolution of the case adverse to the government would, by stare decisis, bind the government in its dealings with the prospective class members." McKittrick, *supra* note 31, at 404 n.96 (citing *Callahan*, N.Y.L.J., July 18, 1980, at 6, col. 3 (N.Y. Sup. Ct. 1980)).

136. *Callahan*, N.Y.L.J., Dec. 11, 1979, at 10, col. 4.

137. *Id.*

138. *Id.* at 11, col. 5 (citing N.Y. CONST. art. XVII, § 1).

139. *Id.* (citing N.Y. SOC. SERV. LAW § 62(1) (McKinney 1983) ("[E]ach public welfare district shall be responsible for the assistance and care of any person who resides or is found in its territory and who is in need of public assistance and care which he is unable to provide for himself.")).

140. *Id.* (citing N.Y. SOC. SERV. LAW § 131(1) (McKinney 1983) ("It shall be the duty of social service officials . . . to provide adequately for those unable to maintain themselves"))

resources to keep families together;¹⁴¹ (3) a section of the New York City Administrative Code requiring the city to provide shelter to every needy applicant;¹⁴² and (4) a New York Court of Appeals decision¹⁴³ that stated that the New York counties have a duty to aid destitute people even when the higher levels of government refuse to share the cost.¹⁴⁴ The *Callahan* court, however, ultimately based its recognition of the right to emergency shelter primarily on public policy concerns over the health risks that living on the streets posed to homeless people.¹⁴⁵ In reaching its decision, the court heard and extensively cited witnesses¹⁴⁶ who testified that homeless men suffered frostbite and death from exposure to the elements in previous winters.¹⁴⁷

"After six months of protracted fighting and bickering"¹⁴⁸ between the Coalition for the Homeless and the City of New York, the parties settled, and the court issued a final judgment in the form of a consent decree.¹⁴⁹ The consent decree mandated shelter and board

Furthermore, the goal of the officials, "whenever possible, [is to] administer such care, treatment and service as may restore such persons to a condition of self-support or self-care, and [to] further give such service to those liable to become destitute as may prevent the necessity of their becoming public charges.")).

141. *Id.* (citing N.Y. SOCIAL SERV. LAW § 131(3) (McKinney 1983) (stating that in providing services to "maintain and strengthen family life[,] . . . the public welfare official may utilize appropriate community resources" and that "[w]henver practicable, assistance and service shall be given a needy person in his own home"))).

142. *Id.* (citing N.Y. CITY ADMIN. CODE § 604.1.0(b) (n.d.), reprinted in 3 N.Y. CITY CHARTER AND CODE 455 (1978)). The New York City Administrative Code states:

It shall be the duty of the commissioner or of the superintendent of any municipal lodging house acting under him, to provide for any applicants for shelter who, in his judgment, may properly be received, plain and wholesome food and lodging for a night, free of charge, and also to cause such applicants to be bathed on admission and their clothing to be steamed and disinfected.

Id.

143. *Id.* (citing *Jones v. Berman*, 37 N.Y.2d 42, 332 N.E.2d 303, 371 N.Y.S.2d 422 (1975)).

144. *Jones v. Berman*, 37 N.Y.2d 42, 54-55, 332 N.E.2d 303, 309-10, 371 N.Y.S.2d 422, 430-31 (1975).

145. *Callahan*, N.Y.L.J., Dec. 11, 1979, at 11, col. 5; see Hayes, *supra* note 20, at 81 (gratefully acknowledging that commentators tend to ignore the fact that the "entire legal analysis buttressing the [*Callahan*] decision is contained in a single sentence in the footnotes").

146. These witnesses were employees at homeless shelters in New York City. *Callahan*, N.Y.L.J., Dec. 11, 1979, at 11, col. 5.

147. *Id.* New York City had theretofore created shelters that were tantamount to no shelter at all because they were "less inviting than the subway system." Hayes, *supra* note 24, at 6. In these shelters, homeless people suffered injuries to their health, safety, and dignity each day. *Id.* (discussing the testimony of a witness from the Catholic Worker, a private charitable organization).

148. Hayes, *supra* note 24, at 6.

149. Final Judgment by Consent, *Callahan v. Carey*, N.Y.L.J., Dec. 11, 1979, at 10, col. 4 (N.Y. Sup. Ct. Dec. 5, 1979) (No. 42582/79), reprinted in PRACTISING LAW INST., THE RIGHTS OF THE HOMELESS 223 (1988) [hereinafter *Callahan Consent Judgment*].

for each homeless man who applied for it as long as he met the eligibility standards of the New York State home relief programs or was in need of temporary shelter because of "physical, mental or social dysfunction."¹⁵⁰ The consent decree also mandated that some minimum standards of decency be maintained.¹⁵¹

In 1983, New York courts extended the right to emergency shelter to homeless women in *Eldredge v. Koch*,¹⁵² and in 1984, to homeless families with children in *McCain v. Koch*.¹⁵³ In granting summary judgment in favor of the homeless women plaintiffs, the *Eldredge* trial court stated that the "contention [that women were constitutionally entitled to treatment equal to that accorded to men] is so obviously meritorious that it scarcely warrant[ed] discussion."¹⁵⁴ The *McCain* trial court, applying a different line of reasoning with respect to homeless families with children, granted a preliminary injunction barring the denial of emergency shelter to eligible homeless families and requiring the city to meet minimal standards of health and safety.¹⁵⁵ The *McCain* trial court's reasoning was based on the assumption that the local government undertook the duty to provide emergency shelter.¹⁵⁶ Thus, the issue became "whether the shelter provided should meet reasonable minimum standards."¹⁵⁷ The New York Court of Appeals affirmed the preliminary injunction as to the provision of shelter, and held that the courts have the power, "once [local governments] under[take] to provide housing, to make that shelter minimally habitable."¹⁵⁸

150. *Id.* at 224-25.

151. *Id.* at 225-27; see Hayes, *supra* note 24, at 6. For example, the decree declared that each bed in the shelter had to be at least 30 inches wide with a well-constructed mattress, a clean pillow and pillow case, clean sheets, and a clean blanket. Callahan Consent Judgment, *supra* note 149, at 225-26. The decree also provided for mail and laundry services, group recreation, and storage facilities. *Id.* at 226-27.

152. 118 Misc. 2d 163, 459 N.Y.S.2d 960 (Sup. Ct.), *rev'd on other grounds*, 98 A.D.2d 675, 469 N.Y.S.2d 744 (App. Div. 1983); see Hayes, *supra* note 24, at 7 n.5.

153. 127 Misc. 2d 20, 484 N.Y.S.2d 985 (Sup. Ct. 1984), *modified*, 117 A.D.2d 198, 502 N.Y.S.2d 720 (App. Div.), *appeal granted*, 503 N.Y.S.2d 997 (App. Div. 1986), *later proceeding*, 68 N.Y.2d 713, 497 N.E.2d 679, 506 N.Y.S.2d 312, *rev'd*, 70 N.Y.2d 109, 511 N.E.2d 62, 517 N.Y.S.2d 918 (1987).

154. *Eldredge*, 118 Misc. 2d at 163, 459 N.Y.S.2d at 961. The reversal of the summary judgment was based on the necessity for further evidence on the issue of specific breaches; it did not affect the trial court's legal reasoning. 98 A.D.2d at 675-76, 469 N.Y.S.2d at 745.

155. *McCain*, 127 Misc. 2d at 25, 484 N.Y.S.2d at 988. The *McCain* intermediate appellate court expressly applied the same line of analysis as in *Eldredge* to find a right to shelter for homeless families with children. *McCain*, 117 A.D.2d at 214, 502 N.Y.S.2d at 729.

156. *McCain*, 127 Misc. 2d at 24, 484 N.Y.S.2d at 987.

157. *Id.* For a discussion on the proper scope of services, see *infra* notes 185-99 and accompanying text.

158. *McCain v. Koch*, 70 N.Y.2d 109, 118, 511 N.E.2d 62, 66, 517 N.Y.S.2d 918, 922 (1987).

Arguably, because the *Callahan* court did not specify the extent to which it relied on the New York Constitution, and because the final judgment was in the form of a consent decree without final adjudication of any factual or legal issue, the New York Constitution alone may not provide a right to shelter.¹⁵⁹ Interestingly, in *McCain*, the intermediate appellate court found a probability of success on the merits on the issue of a state constitutional right to shelter.¹⁶⁰ The Court of Appeals, however, never directly addressed the issue of whether "plaintiffs are . . . likely to 'prove that . . . article XVII [of the New York Constitution] substantively guarantees minimal physical standards of cleanliness, warmth, space and rudimentary convenience in emergency shelter.'" ¹⁶¹ Nevertheless, in 1987, a supreme court of New York County continued to recognize an "affirmative governmental obligation to provide aid to the needy,"¹⁶² including a governmental duty to provide emergency shelter to homeless families.¹⁶³ Although an argument based on a constitutional mandate might prevail, the New York Constitution has been instrumental thus far only when invoked in conjunction with state statutes or other constitutional provisions.

Litigants also have been successful in a number of states other than New York in establishing a right to shelter.¹⁶⁴ For example, advocates have pressed statutory claims in West Virginia,¹⁶⁵ New

159. In fact, one commentator argues that the *Callahan* approach is limited to situations of an emergency nature. Note, *supra* note 18, at 947. Thus, other jurisdictions may not similarly interpret "general statutory language to imply an enforceable right to shelter." *Id.* at 946.

160. *McCain v. Koch*, 117 A.D.2d 198, 214-15, 502 N.Y.S.2d 720, 730 (App. Div. 1986).

161. *McCain*, 70 N.Y.2d at 118, 511 N.E.2d at 65, 517 N.Y.S.2d at 922 (quoting *McCain*, 117 A.D.2d at 217, 502 N.Y.S.2d at 731).

162. *Barnes v. Koch*, 136 Misc. 2d 96, 100, 518 N.Y.S.2d 539, 542 (Sup. Ct. 1987).

163. *Id.* (citing N.Y. CONST. art. XVII, § 1; and *Palmer v. Cuomo*, 121 A.D.2d 194, 503 N.Y.S.2d 20 (App. Div. 1986)). Aid to the needy in New York is "not a matter of legislative grace; rather, it is specifically mandated by our constitution." *Tucker v. Toia*, 43 N.Y.2d 1, 7, 371 N.E.2d 449, 451, 400 N.Y.S.2d 728, 730 (1977). *But see Weiser v. Koch*, 632 F. Supp. 1369 (S.D.N.Y. 1986); *see supra* note 126.

164. Comment, *supra* note 31, at 239. For example, a consent decree was entered in *Graham v. Schoemehl*, No. 854-00035 (Mo. Cir. Ct. Nov. 11, 1985). The stated intent of the decree was to provide necessary shelter and services for those "who are or will become homeless." Consent Decree at 7, *Graham v. Schoemehl*, No. 854-00035 (Mo. Cir. Ct. Nov. 11, 1985). The decree defines homeless persons as "those without shelter, . . . or with inadequate shelter such that a person cannot live in it without substantial risk to life, health and safety." *Id.*; *see also Massachusetts Coalition for the Homeless v. Secretary of Human Resources*, 400 Mass. 806, 511 N.E.2d 603 (1987).

165. *Hodge v. Ginsberg*, 303 S.E.2d 245 (W. Va. 1983).

Jersey,¹⁶⁶ and California.¹⁶⁷ Moreover, at least fourteen states have enacted legislation that arguably can support a right to emergency shelter.¹⁶⁸

In *Hodge v. Ginsberg*,¹⁶⁹ West Virginia's highest state court held that pursuant to the state's adult protective services statutes,¹⁷⁰ West Virginia was required to provide food, shelter, and medical care to indigent persons unable to carry on the daily activities needed to sustain life and reasonable health.¹⁷¹ "If [this] . . . precedent is followed, similar laws existing in several other states would support a right to shelter for all homeless persons in those states,"¹⁷² or at least for segments of the homeless population.¹⁷³ In those states having mandatory protective services laws, "eligible segments of the homeless population—generally, the aged and mentally incapacitated—have a statutory right to shelter."¹⁷⁴ Moreover, in those few states where legislatures broadly defined eligibility to include those persons who are not necessarily incapacitated, but merely unable to provide shelter for themselves, a broad right to shelter for all homeless persons may exist.¹⁷⁵

New Jersey courts also have recognized a right to shelter under the state's protective services laws¹⁷⁶ even though the New Jersey

166. *Maticka v. Atlantic City*, 216 N.J. Super. 434, 523 A.2d 416 (Super. Ct. App. Div. 1987). For a commentator's perspective on New York, West Virginia, and New Jersey claims, see Note, *supra* note 20, at 283-84.

167. *Hansen v. Department of Social Servs.*, 193 Cal. App. 3d 283, 238 Cal. Rptr. 232 (Ct. App. 1987).

168. Note, *supra* note 20, at 284 & n.59. The use of state statutes, especially public health laws, has the greatest potential for success in current litigation for the homeless HIV-ill. Telephone interview with Virginia Shubert of the Coalition for the Homeless (Oct. 13, 1989).

169. 303 S.E.2d 245 (W. Va. 1983). In a class action on behalf of homeless persons, "the Supreme Court of Appeals of West Virginia declared that under the Social Services for Adults Act of 1981, the state was obligated to provide shelter, food, and medical care for its homeless population." Langdon & Kass, *supra* note 18, at 328-29 (discussing the *Hodge* decision).

170. *Hodge*, 303 S.E.2d at 247 (citing W. VA. CODE §§ 9-6-1 to 9-6-8 (Cum. Supp. 1982)).

171. *Id.* at 251.

172. Langdon & Kass, *supra* note 18, at 328 (footnote omitted).

173. *Id.*

174. *Id.* at 329. In light of the changing homeless population, the HIV-ill may be deemed to be an eligible segment of the homeless population.

175. *Id.* at 329-30. Those opposed to judicial intervention advocate narrower interpretations of statutory language. McKittrick, *supra* note 31, at 409-10. The West Virginia Legislature subsequently solidified the *Hodge* decision by amending the statute to provide that the department "shall," rather than "may," develop an assistance plan. *Id.* at 409 (citing W. VA. CODE § 9-6-7 (1990)).

176. See, e.g., *Maticka v. Atlantic City*, 216 N.J. Super. 434, 524 A.2d 416 (Super. Ct. App. Div. 1987)). In *Maticka*, the court emphasized the stated purposes of N.J. STAT. ANN. §§ 44:10-1 to 44:10-18 (West 1982), which are:

(1) To provide for the care of eligible dependent children in their own homes or

Constitution does not guarantee a right to emergency shelter.¹⁷⁷ These laws are designed to provide emergency care and services to incapacitated adults deemed unable to protect themselves from abuse or neglect.¹⁷⁸ Protective services statutes generally include shelter and other basic necessities.¹⁷⁹

Finally, in *Hansen v. Department of Social Services*,¹⁸⁰ taxpayers on behalf of homeless families challenged the compliance of the California Department of Social Services ("DSS") with state statutes.¹⁸¹ The plaintiffs in this consolidated action sought to compel DSS to provide families who are homeless, or who are imminently threatened with homelessness, with emergency shelter, child welfare services, or other assistance.¹⁸² In support of its existing policy, under which DSS did not assist homeless families to obtain housing, DSS argued that "it is the intent of the Legislature that 'emergency shelter care,' as mentioned in section 16504.1, be solely provided to a neglected or abused child during the period that the child is initially removed from his or her home for the purpose of evaluating the need for state intervention and protection."¹⁸³ The court, however, *inter alia*, enjoined DSS from defining emergency shelter care so restrictively as to "exclude homeless children, regardless of whether homeless children remain with their parent(s), guardian(s), or caretaker(s)" to further

in the homes of relatives, under standards and conditions compatible with decency and health,

(2) To help maintain and strengthen family life,

(3) To help such parents or relatives to attain the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection, and

(4) To provide for the care of a dependent child whose parents have been denied assistance under the provisions of section 2.

Id. § 44:10-1(a) (footnote omitted).

177. *Maticka*, 216 N.J. Super. at 442, 524 A.2d at 420; see Langdon & Kass, *supra* note 18, at 306.

178. Langdon & Kass, *supra* note 18, at 327.

179. *Id.* at 328.

180. 193 Cal. App. 3d 283, 238 Cal. Rptr. 232 (Ct. App. 1987).

181. *Id.* at 286-87, 238 Cal. Rptr. at 234. The state statute primarily at issue, known as the Child Welfare Act, requires "emergency shelter care" to be provided for children who are: (1) still with their families and can remain safely with them, CAL. WELF. & INST. § 16501.1 (West 1982); (2) in need of temporary foster care, *id.* § 16501.2; and (3) in need of "an alternative permanent family structure . . . because of abuse, neglect, or exploitation [and] cannot safely remain at home and who are unlikely ever to return home," *id.* § 16501.3.

182. *Hansen*, 193 Cal. App. 3d at 286-87, 238 Cal. Rptr. at 234.

183. *Id.* at 290, 238 Cal. Rptr. at 236. Thus, "homeless children [were] eligible to receive emergency shelter care, provided that such children have been, or are in the process of being, removed from their homes." *Id.* Plaintiffs, however, contended that emergency shelter care shall be accorded a broad meaning and shall be provided to all homeless children, whether or not separated from their families. *Id.* at 290-91, 238 Cal. Rptr. at 237.

the California legislature's policy to meet the housing needs of low-income families.¹⁸⁴ Thus, this was a victory in the establishment of a right to emergency shelter for all people within the state of California.

B. *The Scope of the Right and the Corresponding Duty*

Whether the right to shelter is premised on state constitutions or statutes, the shelter provided must meet certain minimum standards of habitability. As provided in *McCain v. Koch*,¹⁸⁵ under the well-established duty of undertaking, once a city undertakes to provide emergency housing, it is obligated to preserve certain minimum standards of sanitation, safety, and decency.¹⁸⁶ "In a civilized society a 'shelter' which does not meet minimal standards of cleanliness, warmth, space and rudimentary conveniences is no shelter at all."¹⁸⁷ Providing uninhabitable shelter, then, is tantamount to improperly denying relief to the homeless.¹⁸⁸

In addition to *McCain*, two other New York cases provide a basis for arguing that once a city undertakes to provide shelter, it must evaluate the needs or health risks of the homeless individuals when determining the type of shelter to provide. For example, in *Barnes v. Koch*,¹⁸⁹ the plaintiffs sought to relocate homeless families residing in a public shelter and to restrain further placement in the shelter.¹⁹⁰ "High concentrations of lead in chipping and falling lead paint"¹⁹¹ presented immediate health threats to the residents, especially those with young children.¹⁹² A New York trial court acknowledged its lack of power to *determine* minimum standards of comfort, but utilized its equitable power to *enforce* minimum standards of hab-

184. *Id.* at 298, 238 Cal. Rptr. at 242. The court reviewed related state and federal statutes and interpretive caselaw regarding the provision of emergency shelter to children to demonstrate the well-established legislative interest in providing such shelter to homeless families. *Id.* at 295-96, 238 Cal. Rptr. at 240.

185. 70 N.Y.2d 109, 119, 511 N.E.2d 62, 66, 517 N.Y.S.2d 918, 923 (1987).

186. *Id.* The New York Court of Appeals cited the list of minimum standard provisions provided in the trial court's order granting a preliminary injunction to homeless families with children and compelling defendants to provide adequate emergency housing. *Id.* at 115, 511 N.E.2d at 63-64, 517 N.Y.S.2d at 920. The Court of Appeals emphasized that "the substance of the minimum standards in the injunction was [subsequently] included in more rigorous departmental regulations for hotels and motels used for emergency housing promulgated by the Commissioner of Social Services." *Id.* Hence, this is an illustration of litigation positively affecting legislation.

187. *McCain*, 127 Misc. 2d at 24, 484 N.Y.S.2d at 987.

188. *McCain*, 70 N.Y.2d at 120, 511 N.E.2d at 66, 517 N.Y.S.2d at 923 (citing *Tucker v. Toia*, 43 N.Y.2d 1, 9, 371 N.E.2d 449, 452, 400 N.Y.S.2d 728, 731 (1977)).

189. 136 Misc. 2d 96, 518 N.Y.S.2d 539 (Sup. Ct. 1987).

190. *Id.* at 97, 518 N.Y.S.2d at 540.

191. *Id.*

192. *Id.*

itability recognized by the Court of Appeals in *McCain*.¹⁹³ It surmised that the right to shelter was an entitlement that included "the right to be sheltered free of potentially significant health threats"¹⁹⁴ because "implicit in the term shelter is a requirement that the individuals involved not be placed in a situation directly threatening to their health."¹⁹⁵ Thus, this decision supports the proposition that when a governmental entity undertakes to provide shelter, it must evaluate the needs of the individual inhabitants.

Similarly, in *Slade v. Koch*,¹⁹⁶ the plaintiffs were homeless families with special medical needs, including "pregnant women, families with children under six months of age, and families whose members ha[d] physical, psychological or medical conditions."¹⁹⁷ At issue was the governmental entity's compliance with provisions of New York's Family Shelter regulations.¹⁹⁸ The court granted preliminary relief, noting that the "placement of tiny babies and pregnant mothers in mass shelters w[ould] cause irreparable harm."¹⁹⁹ Consequently, the outcome of this case implies that courts must take into consideration

193. *Id.* at 100, 518 N.Y.S.2d at 542 (citing *McCain v. Koch*, 70 N.Y.2d 109, 511 N.E.2d 62, 517 N.Y.S.2d 918 (1987), *rev'g*, 117 A.D.2d 198, 502 N.Y.S.2d 720 (App. Div. 1986)).

194. *Id.* at 101, 518 N.Y.S.2d at 543.

195. *Id.* at 100, 518 N.Y.S.2d at 542.

196. 135 Misc. 2d 283, 514 N.Y.S.2d 847 (Sup. Ct.), *modified*, 136 Misc. 2d 119, 517 N.Y.S.2d 389 (Sup. Ct. 1987) (The trial court originally issued an injunction against New York City, and subsequently modified it to include the state.).

197. *Id.* at 284, 514 N.Y.S.2d at 848.

198. *Id.* at 284 & n.2, 514 N.Y.S.2d at 848 & n.2. Section 900.6(d) of the New York Code states: "The only shelter for families to which a family including a pregnant woman or an infant under six months old may be referred by a local social services district is a Tier II facility" 18 N.Y. COMP. CODES R. & REGS. § 900.6(d) (1988). A Tier II facility, pursuant to section 900.2(b), is a congregate shelter that provides private sleeping accommodations for individual families, meals, and additional services. *Id.* § 900.2(b). A Tier I facility is a barracks-style shelter with open sleeping areas, meals, and some services. *Id.* Section 900.6(e) states: "The only shelter for families to which a family including a member having a medical, physical or other special need which cannot be adequately served in a Tier I facility may be referred is a Tier II facility" *Id.* § 900.6(e). Section 900.6(f) states:

A district shall not refer to a Tier I or II facility a family containing a member who: (1) has a mental or physical condition that makes such placement inappropriate or otherwise may cause danger to him/herself or others; (2) is likely to substantially interfere with the health, safety, welfare or care of other residents; (3) is in need of a level of medical, mental health, nursing care or other assistance that cannot be rendered safely and effectively by the facility, or that cannot be reasonably provided by the facility through the assistance of other community resources; or (4) has a generalized systemic communicable disease or a readily communicable local infection which cannot be properly isolated and quarantined in the facility.

Id. § 900.6(f).

199. *Slade*, 135 Misc. 2d at 290, 514 N.Y.S.2d at 852. In the instant case, after having been placed in Tier I shelters, two infants contracted severe diarrhea, one child was unable to receive her regular physical therapy and suffered asthma attacks and an ear infection, and one

the special medical needs of homeless families when placing them in shelters.

It is possible that every jurisdiction currently contains an appropriate statute on which to base a right to shelter. Creative advocates seeking to discover a path to shelter must diligently examine their state statutes and administrative regulations when representing a homeless client in need of extensive services. Once the right to shelter is established, the duty of undertaking analysis can be employed to require the governmental entity to evaluate the special medical needs of the homeless individuals so that medically-appropriate housing can be provided to the homeless HIV-ill.

C. *Mixon v. Grinker: When HIV and Homelessness Come Together*

Case law and common sense demonstrate that housing endangering the life of a resident is tantamount to a complete denial of shelter.²⁰⁰ A claim based on such an argument would be a denial-of-benefits claim.²⁰¹ The threshold goal of the advocate for the homeless HIV-ill should be the provision of medically-appropriate housing that, at the very least, does not provide a vehicle for further threatening the lives or health of its inhabitants.²⁰²

In *Mixon v. Grinker*,²⁰³ the plaintiffs were three homeless individuals who displayed symptoms of HIV-infection.²⁰⁴ They sought a judgment determining that the City of New York was required to provide them and all others similarly situated "with medically appropriate housing which include[d], at a minimum, a private sleeping area and sanitary facilities."²⁰⁵ They also sought a declaratory judgment that the existing barracks-style shelters were medically inappropriate and unlawful.²⁰⁶ The plaintiffs argued that the city had a duty to provide all homeless persons with housing placements which were appropriate to their needs and medical conditions, and that the city had violated this duty by relegating the plaintiffs to the municipal shelter

pregnant woman "suffered a miscarriage, unattended, on the floor of the communal bathroom." *Id.* at 286-87, 514 N.Y.S.2d at 849.

200. *See supra* note 116 and accompanying text.

201. *See supra* notes 107-11 and accompanying text. This characterization will help to overcome justiciability obstacles and gain access to judicial review.

202. *E.g.*, *Barnes v. Koch*, 136 Misc. 2d 96, 100, 518 N.Y.S.2d 539, 542 (Sup. Ct. 1987).

203. No. 14932/88 (N.Y. Sup. Ct. Jan. 11, 1989), *aff'd and modified on other grounds*, 157 A.D.2d 423, 556 N.Y.S.2d 855 (App. Div. 1990).

204. *Mixon*, slip op. at 1-2.

205. *Id.* at 2.

206. Complaint, *supra* note 40, at para. 5.

system and the streets.²⁰⁷

The court granted a preliminary injunction,²⁰⁸ accepting the incremental argument that once the city became a provider of emergency shelter,²⁰⁹ it was required to make the shelter minimally habitable.²¹⁰ Because habitability requires the substantial freedom from potentially significant health threats,²¹¹ an HIV-ill person's suppressed immune system makes the exposure to people with infectious diseases life-threatening, and, hence, such a living environment is uninhabitable.²¹² Thus, in light of an HIV-ill person's specific health needs, life in ordinary shelters does not satisfy the test of minimum habitability.

The court extended protection to HIV-infected individuals in part because the stated policies of New York City already provided for assistance to individuals with CDC-defined AIDS²¹³ by providing housing units or granting rent subsidies, as opposed to placing them in shelters.²¹⁴ With regard to medically-appropriate housing, there was "no reason for a distinction between CDC defined AIDS and other HIV related illnesses."²¹⁵

207. Memorandum of Law, *supra* note 61, at 2.

208. *Mixon*, slip op. at 7 (pending trial). For a preliminary injunction, three requirements must be met: "(1) the likelihood of success on the merits; 2) irreparable injury absent granting the preliminary injunction; and 3) a balancing of the equities." *Id.* at 6 (quoting *W.T. Grant Co. v. Srogi*, 52 N.Y.2d 496, 517, 420 N.E.2d 953, 963, 438 N.Y.S.2d 761, 771 (1981)). Thus, the plaintiffs must demonstrate that they are suffering continuing and irreparable injury by being forced to live under conditions which pose a threat to their health and safety. An HIV-infected individual placed in a barracks-style shelter satisfied this requirement. *Id.* at 7.

209. In granting the preliminary injunction, the court stated:

The obligation of the City to provide shelter to the homeless emanates from the consent decree dated August 26, 1981 in the case of *Callahan v. Carey* (N.Y. Co. Index No. 42582/79), in which the City agreed to provide emergency shelter to homeless men. In *Eldredge v. Koch*, 98 A.D.2d 675 (1st Dep't 1983), the obligation was extended to women, . . . and finally in *McCain v. Koch*, *supra*, the right to emergency housing for families was recognized.

Mixon, slip op. at 6; see *supra* notes 133-58 and accompanying text.

210. *Mixon*, slip op. at 6.

211. *Id.* at 7.

212. See *supra* notes 68-73 and accompanying text.

213. The CDC sets criteria for diagnosing AIDS. In 1987, for example, the diagnostic criteria were:

(1) a positive blood test for serum antibody to the virus that causes AIDS or a positive cell culture for the virus; (2) a low number of T-helper white blood cells and a low ratio of T-helper white blood cells to T-suppressor white blood cells; and (3) the presence of one or more opportunistic infections that are indicative of underlying cellular immunodeficiency.

Green, *supra* note 47, at 30.

214. *Mixon*, slip op. at 3.

215. *Id.* at 5. Note that this concept is consistent with the use of the term "PWA" to incorporate all symptomatic HIV-ill people. See *supra* note 16.

Mixon resulted in further disputes among the City of New York, state officials, and attorneys for the plaintiffs regarding compliance with the court's order.²¹⁶ The city continued to propose shelters as the best available housing, while the state criticized the proposals, arguing that if the city developed special sections in existing shelters, a permanent lack of good institutional care would result.²¹⁷ State officials, like the plaintiffs' attorneys, advocate housing for the homeless HIV-ill in private or double rooms in specially-designed residences.²¹⁸ Specifically, the plaintiffs' attorneys argued that the city's plan failed to meet the demands of the preliminary ruling in the *Mixon* case by, inter alia, making available "private, non-congregate housing . . . only to symptomatic HIV-infected persons who are so severely ill as to require assistance with bathing or toileting,"²¹⁹ by segregating PWA's from other residents in existing shelters, which constitutes a "setting obviously lacking in the privacy needed to ward off infection,"²²⁰ and by relegating all other HIV-ill individuals to "the City's barrack shelters."²²¹

Mixon illustrates that although a policy change might establish a legal right to safe housing, it does not necessarily ensure the provision and availability of safe housing. In sum, *Mixon* was a result of a unique combination of factors. Unlike many other jurisdictions, New York already had policies and administrative directives to provide for housing for PWA's, although even that housing was not always adequate or available.²²² Critics may argue that judicial extensions of the policies, as in *Mixon*, will act as a disincentive to governments in establishing similar threshold policies for fear of having to comply with more than they initially contemplated. HIV-illness, however, is

216. See, e.g., Rimer, *Koch's Plan to House AIDS Patients Stalls*, N.Y. Times, June 15, 1989, at B13, col. 3; Letter from Virginia Shubert, of Coalition for the Homeless, Attorney for Plaintiffs, and Nan Hunter, of American Civil Liberties Union, Attorneys for Plaintiff-Intervenor, to Rosemary Myers, Assistant Corporation Counsel for New York City (Mar. 17, 1989) (complaining that the city's interim plan to house PWA's is "unacceptably vague and standardless").

217. Rimer, *supra* note 216, at B13, col. 3 (discussing statements by a New York State Department of Social Services official).

218. *Id.* In fact, the representatives of the state agencies were "very surprised and concerned to discover" that the city's plan was presented to the *Mixon* court and was publicly announced despite the ongoing discussions that had been pending between the State Department of Social Services, the State Department of Health and the New York City Human Resources Administration to develop a joint city and state plan. Letter from Lisa Kill, Assistant Attorney General of the State of New York, to Justice Lehner, who presided over the *Mixon* case (May 17, 1989).

219. Letter from Virginia Shubert to Justice Lehner (May 25, 1989).

220. *Id.*

221. *Id.*

222. See generally Chevront, *supra* note 17.

so prevalent that very soon every jurisdiction will likely have special provisions for HIV-related circumstances.²²³ As these special provisions are enacted, advocates should use the developments in New York as guiding tools in an attempt to respond to the crisis of the homeless HIV-ill.

V. THE RIGHT TO HEALTH CARE ARGUMENT

A. *Establishing the Right*

Section IV examined the "right to shelter" cases to explore the probability of a jurisdiction's recognition of a right to emergency or permanent shelter. Once established, the right to shelter could legally and logically be defined to include housing that is medically-appropriate to an individual's needs.²²⁴ Nonetheless, many jurisdictions have not established a right to shelter for all homeless people. In jurisdictions where there is little likelihood of successfully using state laws to establish a right to shelter, an alternative route to the provision of housing for indigent HIV-ill people must be created. A parallel, yet unorthodox argument, is that where a right to health care exists,²²⁵ housing is necessary to give substance to the right. Indeed, many recipients do not benefit from the health care to which they are entitled because they cannot even follow the most basic medical remedies of bed rest and regular periodic consumption of medicine.²²⁶ In sum, as part of the proper provision of health care, some type of housing is needed.²²⁷

Ideally, indigent Americans should be able to obtain necessary medical treatment without suffering from discrimination based on an inability to pay for services.²²⁸ Historically, state governments have borne the responsibility for furnishing necessary medical care to their

223. See Chackes, *supra* note 24, at 112 n.105.

224. See, e.g., *Mixon v. Grinker*, No. 14932/88 (N.Y. Sup. Ct. Jan. 11, 1989), *aff'd and modified on other grounds*, 157 A.D.2d 423, 556 N.Y.S.2d 855 (App. Div. 1990).

225. Almost all states have constitutional or statutory provisions that authorize or mandate governmental entities to furnish some medical care for indigents. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 5.

226. Members of the HIV-ill population often have to take zidovudine ("AZT") six times a day. Rosenthal, *supra* note 71, at B9, col. 4 (noting Dr. O'Connell's belief that taking AZT as prescribed is almost impossible for the homeless). A typical homeless person does not have a place to store AZT and does not have a timepiece to measure intervals between consumption.

227. An alternative, cost-reducing form of medical care, requiring stability in housing, is suggested at *infra* notes 326-39 and accompanying text.

228. Public opinion supports this notion. *Poll Finds Reagan Support Down but Democrats Still Lacking Fire*, N.Y. Times, Dec. 1, 1987, at A1, col. 5, B24, cols. 2-3 ("Americans say that the Government should guarantee medical care to everyone.").

indigent residents.²²⁹ In recent years, the federal government has assumed much of this responsibility through the Medicaid²³⁰ and Medicare²³¹ programs.²³² However, these federal programs do not address many health care needs; thus, state and local governments remain instrumental in providing medical care to the poor.²³³ In fact, almost all states have constitutional or statutory provisions that authorize or mandate governmental entities to furnish medical care for indigents.²³⁴ The classification scheme of medical assistance varies by jurisdiction.²³⁵

229. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 3.

230. 42 U.S.C. § 1396 (1988). Eligibility requirements for participation in Medicaid programs are based on categorical, income, and asset requirements which vary from state to state. Makadon, Seage, Thorpe & Fineberg, *Paying the Medical Cost of the HIV Epidemic: A Review of Policy Options*, 3 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 123, 125 (1990) [hereinafter Makadon]. The general categories include "families with dependent children, the aged, the blind, the disabled, and in some states the 'medically needy.'" *Id.*

231. Health Insurance for the Aged Act, Pub. L. No. 89-97, 79 Stat. 290 (1965) (codified as amended in scattered sections of 26, 42 & 45 U.S.C.). For Medicare eligibility, there are no income or asset requirements; however, previous contribution to the Social Security system is necessary. Makadon, *supra* note 230, at 126. The categories include "the elderly, the disabled, and those with end-stage renal disease." *Id.* Furthermore, the Medicare program "requires that individuals be disabled for 24 months after a 5-month waiting period before being able to receive benefits." *Id.* (citing R. FEIN, MEDICAL CARE, MEDICAL COSTS 72 (1986)).

232. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 3.

233. *Id.* at 3-4. Many health care providers have refused to participate in Medicaid because of "low payment levels and limitations in the extent of services covered." Makadon, *supra* note 230, at 126. The HIV-ill, in particular, suffer from lack of coverage in states in which Medicaid still does not pay for AZT, one of the few effective antiviral drugs available in the United States for the HIV-infected. *Id.* Moreover, although people with CDC-defined AIDS are considered presumptively disabled for purposes of Medicaid eligibility, *id.* at 125, the HIV-infected who do not meet that definition are not eligible for Medicaid based on their seropositive state. *Id.* The Medicare program utilizes the same definition for disability. However, its two-year waiting period has kept all but two per cent of the PWA's out of the program. *Id.* at 126. To date, the life expectancy of an individual with an AIDS diagnosis has been less than two years. *Id.*

234. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 5. All states, except Kentucky and Tennessee, have health care programs for indigents. NATIONAL CLEARINGHOUSE FOR LEGAL SERVICES, INC., *Health Benefits: How the System Is Responding to AIDS*, 22 CLEARINGHOUSE REV. 724, 734 (1988) [hereinafter NATIONAL CLEARINGHOUSE].

235. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 8. Generally, state and local medical assistance programs can be separated into six categories for classification: (1) general assistance/general relief ("GA" or "GR") programs; (2) state and/or county medical assistance programs; (3) specialized disease treatment programs; (4) public hospitals; (5) catastrophic illness programs; and (6) public health departments. *Id.* at 8-10.

In GA programs, "medical assistance is provided as an adjunct to cash assistance payments." *Id.* at 8. Recipients must meet eligibility requirements. *Id.* At least 39 states employ such a system. *Id.* "The scope of services provided varies widely, and . . . is [often] limited to emergency medical care or public hospitals." *Id.* Courts have interpreted GA provisions to require a "minimum threshold of medical care." *Id.*

Medical assistance programs at the state and/or county level are similar to GA or GR programs. *Id.* However, they are not administered as an adjunct to cash assistance programs.

The unique characteristics of HIV-illness make it difficult to accept approaches taken by governmental entities to combat other communicable diseases.²³⁶ Although humanity has dealt with various "plagues,"²³⁷ never has humanity dealt with a fatal, selectively transmissible disease. In the past, governmental entities have utilized public health laws to protect society by quarantining contagious individuals; moreover, mental health laws have also caused many individuals to be involuntarily confined.²³⁸ Thus, although both public and mental health laws may provide a form of housing for the affected individuals, neither approach adequately serves the needs of the homeless HIV-ill.²³⁹

1. PUBLIC HEALTH LAWS: CONTROLLING COMMUNICABLE DISEASES

Legislatures traditionally have enacted public health laws to pro-

Id. The scope of medical assistance programs varies widely, but these programs are usually more inclusive than GA or GR programs. *Id.*

Specialized disease treatment programs usually address specific illnesses of public concern. *Id.* at 9. These illnesses include "tuberculosis, mental illness, alcoholism and drug abuse, kidney disease, cancer or hemophilia." *Id.* HIV-illness arguably belongs in this category.

Traditionally, public hospitals were "the primary providers of hospitalization for the poor and uninsured." *Id.* This mode of care is appropriate when the HIV-ill need to be hospitalized; however, many seropositive individuals do not require hospitalization, but need to be in a safe, infection-free environment to prevent the deterioration of their health. Drapkin, *supra* note 44, at 93 ("Once a homeless person acquires HIV infection, the development of AIDS is likely to be accelerated by malnutrition and the repeated infections he or she is prone to acquire . . ."). These individuals are not benefitted by public hospitals until their conditions become acute, and between relapses, the HIV-ill may not even require hospital care. Lambert, *supra* note 57, at E6, col. 1.

In a catastrophic illness program, coverage typically begins after medical expenses exceed a certain threshold. NATIONAL CLEARINGHOUSE, *supra* note 234, at 734-35. The average HIV-ill person easily exceeds such thresholds, and, thus, "[c]ost-sharing requirements may . . . prove burdensome." *Id.* at 735.

Similar to specialized disease treatment programs, public health departments provide care to people suffering from illnesses that threaten public health or safety. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 10. Often, the recipients of this type of "aid" are stigmatized and treated as outcasts. Moreover, the scope of these services traditionally does not extend as far as housing.

236. Gostin, *Traditional Public Health Strategies*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 47 (H. Dalton & S. Burris eds. 1987); Sullivan & Field, *AIDS and the Coercive Power of the State*, 23 HARV. C.R.-C.L. L. REV. 139, 142 (1988). *But see* Benjamin, *supra* note 45, at 415-16 (The health care delivery system in the United States has an established approach for dealing with the dangers of infectious diseases, generally, and new solutions may not necessarily be needed for HIV-related problems.).

237. *See* S. SONTAG, *supra* note 52, at 44-71.

238. Grad, *Communicable Disease and Mental Health: Restrictions of the Person*, 12 AM. J.L. & MED. 381, 395 (1986) (abstract).

239. *See infra* notes 240-60 & 279-301.

tect the public health by exerting control over human conduct, not to aid the indigent sick.²⁴⁰ The oldest field of public health law is the control of communicable diseases,²⁴¹ and these laws have been authorized by the states' police powers,²⁴² subject to constitutional limitations.²⁴³ Generally, "[w]hen a public health officer has proper grounds to believe that a particular person suffers from or [carries] a communicable disease, the officer is authorized to [act]."²⁴⁴ The officer may "issue an order requiring the person to submit to a medical examination"²⁴⁵ to determine whether isolation, detention in a hospital, or some other action, is warranted.²⁴⁶ "[C]ourts require that the statutory authority for compulsory examination bear a reasonable relationship to the public health purpose to be advanced"²⁴⁷ in order to protect individual rights. In light of contemporary attitudes and the stigmatization of the HIV-ill in general, however, compulsory HIV testing is an especially sensitive subject.²⁴⁸

Because HIV-infection is unique, special concerns regarding public health laws arise. For example, "the use of usual regulatory measures has become enmeshed with the issue of privacy relating to sexual preference."²⁴⁹ Moreover, as one commentator concludes, "[t]raditional methods of identifying cases and carriers and detaining them until no longer infectious are inapplicable to AIDS because there is neither a cure nor an immunizing agent, and because the cases are so numerous."²⁵⁰

A common suggestion for dealing with the AIDS crisis is for state governments to utilize their status as protector of the public health to isolate or quarantine all HIV carriers.²⁵¹ The laws of all fifty states "still authorize quarantine for a large number of common com-

240. Grad, *supra* note 238, at 381. Measures to prevent the spread of contagion and to prevent and control epidemics are within the province of these laws. *Id.* at 383, 391.

241. *Id.* at 381.

242. Gostin, *supra* note 236, at 48-49 (citing 16A C.J.S. *Constitutional Law* §§ 432-433 (1979) (defining police power as "the power reserved to the states in the Constitution to take necessary action to promote the public health and welfare, to foster prosperity, and to maintain public order").

243. *Id.*

244. Grad, *supra* note 238, at 384.

245. *Id.*

246. *Id.*

247. *Id.* (citing *Huffman v. District of Columbia*, 39 A.2d 558, 561 (D.C. 1944)).

248. Gostin, *Public Health Strategies for Confronting AIDS*, 261 J. A.M.A. 1621, 1624 (1989). Privacy and confidentiality issues add to the sensitivity of this subject matter.

249. Grad, *supra* note 238, at 394.

250. *Id.* As a result, "public health authorities can do little more than rely on public education" to learn how to identify and treat the HIV-ill. *Id.* For a brief description of the emphasis of this education, see *id.* at 394 n.77.

251. Sullivan & Field, *supra* note 236, at 139.

municable diseases,"²⁵² although these archaic laws do not generally represent contemporary attitudes toward epidemiological control.²⁵³ Usually, when quarantined, a patient is completely restricted "to the apartment or house where he or she is being cared for."²⁵⁴ For the homeless, the likely result is involuntary institutionalization in a hospital or shelter. Admittedly, this is a form of housing. However, this form of housing's overall negative effects—expense, probability of contagion from other residents who have common infectious ailments, stigmatization, and lack of privacy—outweigh any of its positive aspects in creating medically-appropriate shelters for the HIV-ill homeless. Today, although health officers "may impose quarantine on the basis of [their] reasonable belief that the person quarantined is infected with a contagious disease,"²⁵⁵ contemporary legislation calls for lesser restrictions than traditional quarantine. Thus, health officers are more likely to impose compulsory hospitalization and detention, instead of the more draconian quarantine.²⁵⁶

Although no state has seriously proposed general isolation policies to control HIV transmission, many states have enacted "behavior-based isolation statutes that authorize restrictions of liberty on 'recalcitrant[s].'"²⁵⁷ When persons are aware that they are HIV-positive, but continue to engage in activities likely to transmit the virus, some states expressly authorize isolation for these people because they pose a serious threat to the public health.²⁵⁸ Many commentators have discussed the constitutionality of restrictive measures regulating the HIV-ill²⁵⁹ and have concluded that isolation measures will not solve any problems, including the spread of the disease.²⁶⁰

252. Grad, *supra* note 238, at 387 (citing the statutory provisions of several states).

253. *Id.* at 381. AIDS is already a reportable communicable disease according to every state. *Id.* at 383.

254. *Id.*

255. *Id.* at 388 (citing *Ex parte King*, 128 Cal. App. 27, 16 P.2d 694 (Ct. App. 1932); and *State v. Rackowski*, 86 Conn. 677, 86 A. 606 (1913)). There are few recent cases on the subject of quarantine. *Id.* at 388-89.

256. *Id.* at 389.

257. Gostin, *supra* note 248, at 1626.

258. *Id.*

259. *E.g.*, Merritt, *Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N.Y.U. L. REV. 739 (1986) (adopting a new analysis for the equal protection clause, and arguing that many proposed public health regulations violate this clause); Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274 (1986) (concluding that the legislative threat of imposing severe restrictions on the personal freedom of AIDS carriers poses both practical and legal dangers).

260. Gostin, *supra* note 236, at 65. See generally Sullivan & Field, *supra* note 236.

2. PROPER DISCHARGE PLANNING

A fear of advocates for the homeless HIV-ill is that many HIV-ill individuals will be hospitalized pursuant to emergency care statutes and released without planned follow-up care or adequate facilities when their conditions become less acute and no longer warrant emergency status.²⁶¹ Essentially, these individuals will be deinstitutionalized or released without any discharge planning. Discharge planning is a "process for identifying and planning for the post-hospital care needs of . . . patients."²⁶² Generally, few states have explicit provisions for post-discharge care and treatment for all people, but states have enacted laws specifically providing for varying degrees of continuing post-discharge governmental responsibility for the mentally ill.²⁶³

Professionals in the HIV-care sector have begun to encourage the development of proper discharge planning to ensure the best use of nonhospital services and to reduce the length of hospital stays for the HIV-ill.²⁶⁴ Upon discharge from a hospital in a weakened state, an HIV-ill individual may need nutritional counseling, housekeeping help, social services, and more sophisticated medical care.²⁶⁵ Unfortunately, very few hospitals maintain proper discharge planning at

261. In Chicago, for example, hospitals discharge the homeless non-acute HIV-ill because they cannot afford to keep them. Traska, *Alternate Care: No Home Means No Home Care for AIDS Patients*, HOSPITALS, Jan. 5, 1986, at 69. At the other extreme, the HIV-ill who are not in immediate need of prolonged hospitalization have not been released when they lacked a home for after-hospital care. For example, in some cases, the homeless HIV-ill have been left in acute care hospital beds for more than 14 months. *Id.* This not only creates enormous medical costs, but intensifies their isolation as well.

262. NATIONAL SENIOR CITIZENS LAW CENTER, *Discharge Planning: Promises and Realities*, 22 CLEARINGHOUSE REV. 480, 480 (1988).

263. *E.g.*, ILL. ANN. STAT. ch. 91 1/2, para. 100.15 (Smith-Hurd 1990) (The statute describes in detail the evaluation process of a potential dischargee and the subsequent allowable placements in the community.); *id.* para. 100.15d ("Before any person is released from [a Department facility], the chief administrative officer of the facility shall assess such person's need for subsistence benefits and services including food, shelter, clothing and medical care. If a determination is made that a person will be unable to meet such subsistence needs after discharge, the chief administrative officer shall arrange for filing applications under appropriate benefits programs, unless the person expressly declines."); *id.* para. 100.16 (For conditionally discharged patients, the Department shall provide an after care program in which a qualified person visits or consults with the recipient and the recipient's family every six months after discharge to "advise the family of and determine the existence of the care and occupation most favorable for the recipient's continued improvement and return to the maintenance of mental health.").

264. Traska, *Proper AIDS Care Demands Better Discharge Planning*, HOSPITALS, Jan. 5, 1986, at 70.

265. *Id.* Hospitals often discharge the HIV-ill because their facilities allegedly cannot afford to keep them. Traska, *supra* note 261, at 69.

this time.²⁶⁶ Recently, however, some jurisdictions have realized the benefits of proper discharge planning and have passed laws explicitly governing the rights of patients to follow-up care upon release from hospitals and nursing homes.²⁶⁷

Legislative reform has begun at both the federal and state levels. At the federal level, under the Omnibus Reconciliation Act of 1986,²⁶⁸ Medicare patients are entitled to a timely discharge planning evaluation that focuses on a patient's probable need for appropriate post-hospital services.²⁶⁹ A hospital must arrange for the development and initial implementation of a discharge plan upon the request of a patient's physician.²⁷⁰ Hospitals must comply with the discharge planning process requirements as a condition of participation in the Medicare program.²⁷¹ Although most AIDS patients do not rely on Medicare funds because of the two-year eligibility requirement,²⁷² the discharge planning concept has been expanding beyond the Medicare program. At the state level,²⁷³ some states have mandated discharge planning requirements for all hospital patients, regardless of their Medicare eligibility.²⁷⁴ Other states' general health and welfare codes contain provisions enabling them to require discharge plans.²⁷⁵

Although existing federal and state laws can serve as a basis for implementing discharge planning, and, possibly, provide a basis for

266. Traska, *supra* note 264, at 70 (quoting Cliff Morrison, San Francisco General Hospital's assistant director of nursing and AIDS coordinator).

267. GA. CODE ANN. § 31-8-116 (1990) (The residents of long-term care facilities shall be assisted "in finding a reasonably appropriate alternative placement prior to the proposed transfer or discharge. The plan for such transfer or discharge shall be designed to mitigate the effects of transfer stress to the resident."); ILL. ANN. STAT. ch. 111 1/2, para. 147.09 (Smith-Hurd 1990) (Whenever a Medicare patient is hospitalized, "the patient shall be notified of discharge at least 24 hours prior to discharge from the hospital" and "shall receive written information on the patient's right to appeal the discharge pursuant to the federal Medicare program."); MICH. COMP. LAWS ANN. § 333.21773(9) (West 1980) ("The patient shall receive counseling services before and after the [involuntary] transfer [from a nursing home] to minimize the possible adverse effect of the transfer."); N.Y. COMP. CODES R. & REGS. tit. 10, § 405.22(j) (1987) (This section provides for rights to follow-up care for all patients.); TEX. HEALTH & SAFETY CODE ANN. § 81.192 (Vernon 1991) ("The health authority or department, in consultation with the person, shall prepare a continuing care plan for a person who is scheduled to be discharged if the person requires continuing care.").

268. Pub. L. No. 99-509, § 9305(c)(1)-(2), 100 Stat. 1989 (codified at 42 U.S.C. § 1395x (1988)).

269. 42 U.S.C. § 1395x(e)(6) (1988); NATIONAL SENIOR CITIZENS LAW CENTER, *supra* note 262, at 480 (discussing 42 U.S.C. § 1395x(e)(6)).

270. 42 U.S.C. § 1395x(ee)(2)(B).

271. NATIONAL SENIOR CITIZENS LAW CENTER, *supra* note 262, at 484.

272. *See supra* note 231.

273. NATIONAL SENIOR CITIZENS LAW CENTER, *supra* note 262, at 486.

274. *See, e.g.*, N.Y. COMP. CODES R. & REGS. tit. 10, § 405.22(j) (1987).

275. For a compilation of relevant statutes, see NATIONAL SENIOR CITIZENS LAW CENTER, *supra* note 262, at 486 n.92.

medically-appropriate housing for the homeless HIV-ill, more explicit legislation, or regulations issued pursuant to existing legislation, would better meet the specific needs of the HIV-ill. If adequate services and funding are not available, however, authorities can do very little to enforce a statute.²⁷⁶ Absent community-based resources, such as "skilled nursing facility beds,"²⁷⁷ no amount of federal or state legislation will make discharge planning a reality.²⁷⁸

3. MENTAL HEALTH LAWS: INTERPRETING EXISTING LEGISLATION

Mental health is a newer legal field than communicable disease law. It attempts to balance an individual's right to be free from undue restrictions,²⁷⁹ "society's right to protect itself from persons who may endanger others, and society's obligation to care for those unable to care for themselves."²⁸⁰ These same concerns apply to the homeless HIV-ill, and mental health laws may be an additional tool in the advocate's arsenal to secure medically-appropriate housing for the homeless HIV-ill.

Mental health care advocates have begun recently to apply mental health legislation to the homeless because a large proportion of this population is mentally ill.²⁸¹ This societal problem resulted partly from the "massive deinstitutionalization"²⁸² movement, where for three decades, mental hospitals discharged mentally ill people at a rapid rate.²⁸³ Mental health care reformers, like HIV-ill care reformers, believed that treatment in the community would be more effective

276. *Id.* at 482.

277. *Id.*

278. *Id.* at 482-84 (discussing problems already encountered by discharge planners assisting Medicare patients).

279. Grad, *supra* note 238, at 382.

280. *Id.*

281. *E.g.*, Comment, *supra* note 113, at 197. An estimated "33% to 50% of the approximately 2 million homeless are . . . mentally ill." *Id.* at 198 (discussing various numerical estimates of the homeless population).

As with the rights of the HIV-ill, only a few state constitutions provide rights for the mentally ill. Note, *supra* note 21, at 1158. There is no constitutional right to treatment, although, arguably, involuntary commitment without treatment violates substantive due process. See Comment, *supra* note 113, at 203-04 (discussing *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974) (relying unsuccessfully on *parens patriae* theory and *quid pro quo* theory), *vacated*, 422 U.S. 563 (1975)). In *Donaldson*, the United States Supreme Court refused to address the constitutionality of the right to treatment. See *Donaldson v. O'Connor*, 422 U.S. 563, 573 (1975).

282. Comment, *supra* note 113, at 199.

283. *Id.* at 199-201; see Note, *supra* note 21, at 1155-58. From 1955 to 1980, "the number of patients in state mental hospitals dropped from 559,000 to 132,000." *Id.* at 1156.

than treatment in the dehumanizing conditions of institutions.²⁸⁴ Deinstitutionalization was intended to achieve the two similar, but independent, goals of decreasing inpatient populations, while increasing provision of mental health care in the community.²⁸⁵

Deinstitutionalization failed in the mental health care context. The emerging crisis of the growing number of the homeless HIV-ill provides parallels to the deinstitutionalization movement in that housing and community care are desperately needed. Those involved in the care of the HIV-ill, therefore, should make a conscious attempt to learn from the failure of deinstitutionalization so that proper planning and legislation will provide necessary resources, housing, and community services before the crisis reaches epidemic proportions.²⁸⁶

The primary reasons for deinstitutionalization's failure were the lack of adequate community facilities,²⁸⁷ "the lack of a central 'delivery system' of services for the mentally ill,"²⁸⁸ and the "lack of planning for such fundamental resources as structured living arrangements and adequate treatment and rehabilitative facilities in the community."²⁸⁹ Because deinstitutionalization was not an articulated goal in the beginning, governmental entities did not plan in advance for adequate facilities upon patient release. Moreover, states and communities resisted community mental health centers and were

284. Comment, *supra* note 113, at 198-99. Mental health institutions are analogous to public shelters for the homeless.

285. Note, *supra* note 21, at 1156 (citing Kanter, *A Brief History of Deinstitutionalization*, in PROTECTION & ADVOCACY FOR PEOPLE WHO ARE LABELED MENTALLY ILL 79 (Mental Health Law Project ed. 1987)).

286. AIDS is a disease of epidemic proportions. Gostin, *supra* note 236, at 47; Sullivan & Field, *supra* note 236, at 140. The success of society's long-term approach to this situation depends upon the response of governmental officials at this crucial, early stage in the development of AIDS law. Analogizing the AIDS crisis to the pattern observed with the mentally ill shows that it makes sense to save time, money, and lives, by passing legislation to provide for appropriate community resources, housing, and supportive services *before* a crisis situation reaches the point of no return.

287. Comment, *supra* note 113, at 200.

288. *Id.* Arguably, advocates for the HIV-ill could prevent many of these negative results by engaging in adequate planning and by providing adequate funding. Redmon suggests possible solutions to the difficulties encountered by the mentally ill population that can be applied prospectively to the HIV-ill situation. *Id.* at 201-03. For example, case management programs might provide a beneficial treatment program for an HIV-ill individual. *See id.* at 202 (discussing case management programs for the indigents and homeless). For a more thorough discussion of case management programs in the context of the HIV-ill, see *infra* notes 333-39 and accompanying text. On the other hand, quarterway and halfway houses, board-and-care homes, foster care, and crisis or temporary hostels are not satisfactory initial goals because of their similarities to public shelters, where infectious diseases run rampant and where an HIV-ill person has less of an opportunity to maintain health and privacy.

289. Comment, *supra* note 113, at 200-01 (citing Dr. Richard Lamb, the American Psychiatric Association's Task Force chairman).

reluctant to allocate funds for community-based services.²⁹⁰ Finally, local governments thought that federal programs would finance community care, while the federal government thought that local governments would provide funding and services.²⁹¹

Although many negative effects resulted from deinstitutionalization—most notably, a rapid increase in homelessness—states acted to refine their mental health laws to provide community-based treatment. Many of these laws now authorize specialized housing for the mentally ill population.²⁹² For example, California's mental health care system would likely authorize specialized housing because the goal of its program is treatment in the community.²⁹³ Even where such an explicit statute does not exist, one commentator suggests that courts interpret broadly state welfare laws to include a right to community mental health treatment.²⁹⁴ The strong potential for success of this type of interpretation may be inferred from a line of New York cases in which the New York Court of Appeals removed the justiciability obstacle for plaintiffs who are either discharges or current inmates of state mental health hospitals seeking residential placements in the community.²⁹⁵ However, courts may limit their substan-

290. *Id.*

291. *Id.*

292. Langdon & Kass, *supra* note 18, at 330. In fact, supporters of deinstitutionalization "have turned to legal remedies to improve the process of transition to community care." Note, *supra* note 21, at 1157.

293. CAL. WELF. & INST. CODE § 5450 (West 1984 & Supp. 1987) ("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.").

294. See Comment, *supra* note 113, at 208 (discussing California welfare laws).

295. The companion cases of *Klostermann v. Cuomo*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 247 (1984), and *Joanne S. v. Carey*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 247 (1984), address the basic issue of whether persons treated for mental illness in New York state institutions can assert claims on behalf of themselves for a declaration of their rights against the state under the state's Mental Hygiene Law. *Klostermann*, 61 N.Y.2d at 532, 534, 463 N.E.2d at 591, 592, 475 N.Y.S.2d at 250, 251. In *Klostermann*, the plaintiffs had been treated in a state psychiatric hospital and discharged as part of the state's deinstitutionalization policy of releasing patients to less restrictive, community-based residences. *Id.* at 531, 463 N.E.2d at 591, 475 N.Y.S.2d at 250. All of these plaintiffs, however, were relegated to the streets. *Id.* In *Joanne S.*, the main difference was the status of the plaintiffs who brought the action. The plaintiffs were patients in a state psychiatric hospital who had been "found ready to return to the community, but [had] not been discharged or released because of the lack of adequate residential placements." *Id.* at 534, 463 N.E.2d at 592, 475 N.Y.S.2d at 251.

Both the *Klostermann* and the *Joanne S.* plaintiffs contended that they were "entitled to appropriate residential placement, supervision, and care, including follow-ups," *id.* at 531, 463 N.E.2d at 591, 475 N.Y.S.2d at 250, upon their release from the state institution. In addition, the *Joanne S.* plaintiffs requested "orders directing [the] defendants to release them into community treatment settings and . . . to develop and provide sufficient community treatment settings to provide needed shelter and aftercare to the remainder of the plaintiff class." *Id.* at

tive holdings to situations where the mentally ill person has been or is presently under the state's care.²⁹⁶ If so, these mental health statutes

534, 463 N.E.2d at 592, 475 N.Y.S.2d at 251. The plaintiffs' main claim was based on the New York Mental Hygiene Law, N.Y. MENTAL HYG. LAW § 29.15 (f)-(h), which, among other things, required: (1) a written service plan to be prepared for each patient before his release, setting forth the minimum requirements to be met by the patient upon discharge; (2) a recommendation of the type of residence in which the patient should live; and (3) a listing of services available to the patient in the community. *Id.* In addition, the plaintiffs relied on arguments based on the fifth, eighth, and fourteenth amendments to the United States Constitution, on various federal statutes, and on a common law duty to provide reasonable care and protection from foreseeable harm to state hospital patients. *Klostermann*, 61 N.Y.2d at 531-32, 463 N.E.2d at 591, 475 N.Y.S.2d at 250.

In both *Klostermann* and *Joanne S.*, the New York Court of Appeals held that the plaintiffs' claims were justiciable. *Id.* at 541, 463 N.E.2d at 596, 475 N.Y.S.2d at 255. The government in both cases presented a separation of powers argument. It argued that relief could not be granted where a court is required to become involved in the decisionmaking functions of other governmental branches and where resource-allocation is necessarily involved. *Id.* at 535, 463 N.E.2d at 593, 475 N.Y.S.2d at 252. The court rejected these arguments, and concluded that the plaintiffs in both cases had "properly petitioned the courts for a declaration of their rights." *Id.* at 540-41, 463 N.E.2d at 596, 475 N.Y.S.2d at 255.

On remand, the *Klostermann* trial court, in ruling on the defendants' motion to dismiss the complaint, favorably recognized the equal protection arguments that some patients were refused residential placement, care, and supervision, while others—whose illnesses were less severe—had received such placement, care, and supervision. *Klostermann v. Cuomo*, 126 Misc. 2d 247, 251, 481 N.Y.S.2d 580, 584 (Sup. Ct. 1984). It is an equal protection violation where "the more severely handicapped are allotted, *for that reason*, less assistance than to others in the same class." *Id.* The trial court also declined to dismiss the claims grounded on the state statutory requirement to furnish a proper written service plan for each patient. Noting that the defendants essentially conceded their duty to provide such a plan and their failure to comply with this duty, the court held that "the scope of the parties' entitlements . . . should not be resolved summarily." *Id.* at 252, 481 N.Y.S.2d at 585.

Klostermann serves to settle the justiciability issue in cases of a similar nature. Thus, claims by the HIV-ill in search of medically-appropriate housing under a statute are justiciable.

296. In *Klostermann*, the relevant statutory claims were treated partially unfavorably on remand. *Klostermann*, 126 Misc. 2d at 254, 481 N.Y.S.2d at 586. The court emphasized that the discharges from psychiatric care were no longer in the care or custody of the state, and certain claims were dismissed on those grounds. For example, the alleged right to receive treatment under the fifth and fourteenth amendments was rejected because "[i]t is only confinement of the patient that triggers a Federal constitutional obligation upon a state to provide him with treatment." *Id.* at 250, 481 N.Y.S.2d at 584. Similarly, the court responded to allegations grounded on state law by suggesting that "plaintiffs . . . not presently in the care or custody of the State . . . have no general claim to a particular type of care and treatment." *Id.* at 251, 481 N.Y.S.2d at 584.

In a more recent case, *Love v. Koch*, 554 N.Y.S.2d 595 (App. Div. 1990), the plaintiffs were not limited to past or present recipients of treatment. They were "a class of seriously mentally-ill persons . . . in need of psychiatric care and treatment." Complaint at para. 1, *Love v. Koch*, No. 4514/88 (N.Y. Sup. Ct. 1988), reprinted in PRACTISING LAW INST., THE RIGHTS OF THE HOMELESS 1988, at 483 (1988). The plaintiffs sought a declaration of their rights and an injunction requiring the City of New York to cease refusing to provide appropriate care and treatment. *Id.* In response to requests for treatment, the City regularly claimed a lack of facilities as grounds for refusal, despite its "affirmative obligation to provide adequate care and treatment." *Id.* at 484. The plaintiffs alleged that mentally-disabled persons seeking assistance at municipal psychiatric hospitals were shackled or hand-cuffed to

would still benefit a certain percentage of the HIV-ill population—homeless HIV-ill people with mental disorders, such as AIDS dementia,²⁹⁷ who have a history of treatment in state-run psychiatric facilities—and may provide a basis for medically-appropriate housing.

The homeless HIV-ill with mental disorders appear to be the only HIV-ill subgroup to benefit from *direct* application of the mental health laws, and, even then, the extent of available remedies are limited because of vague statutory language that fails to mandate directly community care services.²⁹⁸ However, advocates for the homeless HIV-ill should look to existing laws and precedents that have been applied to the homeless mentally ill and analogize them. The problem with this approach is that with the existing attitudes toward the HIV-ill in general, the analogy to mental health laws might add to the stigma already associated with the disease.²⁹⁹ However, if the analogy to mental health laws succeeds in the courts, the benefits in the form of community care and medically-appropriate housing may outweigh the societal costs.

wheelchairs while they awaited admission, and that in most cases, the hospitals failed to provide services. *Id.* at 486.

Love attempts to extend the class of plaintiffs entitled to government care to those who have not been in the custody of the government. Although this argument is rarely successful, if the outcome of *Love* results in a justiciable claim, then the argument for a right to residential treatment for the HIV-ill will be even stronger.

The plaintiffs sought an order declaring that the defendants had "mandatory obligations to provide appropriate care and treatment to the mentally ill and mentally disabled people of New York, and that . . . appropriate care and treatment for a homeless mentally-ill person [who] is in need of treatment . . . must include in-patient hospitalization or residential care." *Love*, No. 4514/88, slip op., reprinted in PRACTISING LAW INST., THE RIGHTS OF THE HOMELESS 1988, at 505 (1988) (denying the defendants' motion to dismiss). The trial court recognized that the general statutory scheme mandated that the government provide appropriate services to the mentally ill in need of such services. *Id.* at 509. Further, it held that the lack of resources was not a defense for failure to comply with the statutory mandate and that plaintiffs had raised a triable issue of fact with respect to whether the admissions decisions were unlawfully premised on the availability of limited resources, or legally premised on need-based medical determinations. *Id.* at 509-10. Finally, the court recognized that the plaintiffs had failed to allege in the complaint that there was a right to residential placement as to the homeless mentally ill persons. *Id.* at 510. Accordingly, the court reserved comment and gave the plaintiffs leave to serve an amended complaint that specifically set forth the nature of the relief sought. *Id.*

297. AIDS dementia is a neuropsychological disorder presumably caused by "direct involvement of the brain by the neurotropic human immunodeficiency virus (HIV)." Schofferman, *Care of the Patient with AIDS*, in AIDS PRINCIPLES, PRACTICES, AND POLITICS 106 (I. Corless & M. Pittman-Lindeman eds. 1989). It involves a loss of intellectual capabilities such as memory, concentration, and impulse control. *Id.* Symptoms include anxiety, sleeplessness, hallucinations, forgetfulness, and apathy. *Id.* at 107. Although the time course of AIDS dementia varies with the individual, many patients suffer from a significant deterioration in mental status over a period of months. *Id.* at 106.

298. Note, *supra* note 21, at 1158.

299. See *supra* note 73.

Mental health laws, which typically are the most well-developed areas of health-related law, are therefore useful as a basis for comparison to statutory reform in the AIDS context. Legislators working to provide housing for the homeless HIV-ill can rectify the vagueness and incompleteness of mental health laws by creating new laws that are specifically defined to apply to the homeless HIV-ill and that clearly require residential placements in the community. If legislators act quickly to plan for community health care and adequate housing for the homeless HIV-ill, perhaps it is not too late to prevent a catastrophe such as was caused by deinstitutionalization. Because many of the treatment needs of the mentally ill and the HIV-ill are the same,³⁰⁰ the existing services should be readily adaptable to the homeless HIV-ill. Advocates agree that AIDS legislation is desperately needed in the form of direct mandates in clear, precise statutes using a broad-based approach.³⁰¹ It is through this type of reform and appropriate funding that states will begin to realize their duty to provide medically-appropriate housing to the homeless HIV-ill.

4. MENTAL HEALTH LAWS: ARGUMENTS FROM THE COMMON LAW

Mental health statutory and constitutional provisions are much more developed than corresponding AIDS legislation. Some commentators opine, however, that the best recourse for lack of explicit legislative support is to turn to common law arguments, especially in the areas of patient release and transition from inpatient care to community care.³⁰² State constitutions and statutes may remain limited in their ability to address the inadequacies in community care that currently confront a large number of the homeless mentally ill.³⁰³ Similarly, the homeless HIV-ill are not explicitly protected by any current statutes. Until legislators act, a powerful mode of attack is the common law principles employing medical assistance as the basis for a future right to appropriate residential accommodation.

The common law theory of negligent patient release "recognizes a *continuing* duty of care that extends beyond the termination of a patient's institutional stay and accompanies the patient's return to the community."³⁰⁴ A health care provider breaches this duty of care

300. For example, there is a similarity in their abilities to maintain particular lifestyles without needing confinement or constant supervision, while at the same time requiring a stable, clean place to live.

301. See McKittrick, *supra* note 31, at 423.

302. See, e.g., Note, *supra* note 21, at 1157-67.

303. *Id.* at 1157.

304. *Id.* at 1161.

when he exposes a patient to reasonably foreseeable harm.³⁰⁵ A health care provider must consider the circumstances of a patient's release, "along with their potential prospective effect on the [patient] being released."³⁰⁶ This theory is applicable to the subgroup of the homeless HIV-ill who have been in the custody of the state (even in its capacity as a health care provider) and are ready to be released. Arguably, this theory is applicable not only to involuntarily confined patients, but also to patients in public health hospitals who are in the state's custody.³⁰⁷

Another common law theory that may be applicable to the homeless HIV-ill is the tort of abandonment. Courts have applied principles of abandonment³⁰⁸ in the context of mental health medical malpractice to the circumstances of release of a patient under the policies of deinstitutionalization.³⁰⁹ In a parallel analysis, the same theories are applicable to the release of the HIV-ill into the community after various stages of treatment. This parallel may apply only if some form of involuntary confinement has occurred.³¹⁰ Even though there may not be constitutional or statutory provisions that mandate an original affirmative obligation to provide minimally adequate discharge planning, once a relationship between a state and patient is commenced, the state is bound "to proceed with due care."³¹¹ "[T]he common law can be [a] most effective [tool] in recognizing violations

305. See *id.* at 1161 & nn.44-46. "It is ancient learning that one who assumes to act, even though gratuitously, may thereby become subject to the duty of acting carefully, if he acts at all." *Id.* at 1161 n.44 (quoting *Glanzer v. Shepherd*, 233 N.Y. 236, 239, 135 N.E. 275, 276 (1922)); see also RESTATEMENT (SECOND) OF TORTS § 324 comment g (1965) ("Good Samaritan" doctrine).

306. Note, *supra* note 21, at 1162 (citing *Parvi v. City of Kingston*, 41 N.Y.2d 553, 362 N.E.2d 960, 394 N.Y.S.2d 161 (1977)).

307. This subgroup includes a substantial amount of people if "custody" is expansively defined. At least some type of confinement or detention is required to constitute custody. BLACK'S LAW DICTIONARY 347 (5th ed. 1979).

308. Note, *supra* note 21, at 1162 n.52, 1164 n.57 (discussing *Le Jeune Road Hospital Inc. v. Watson*, 171 So. 2d 202 (Fla. Dist. Ct. App. 1965); and *Christy v. Saliterman*, 288 Minn. 144, 179 N.W.2d 288 (1970)); see also *Banks*, *supra* note 3, at 159.

309. See Note, *supra* note 21, at 1162. It is interesting to note that this type of common law claim on behalf of the homeless mentally ill was already argued by the plaintiffs in *Klostermann*. *Klostermann v. Cuomo*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 247 (1984). The *Klostermann* trial court rejected the argument, citing two cases that suggested that similar claims had been rejected in the past. *Klostermann*, 126 Misc. 2d at 253, 481 N.Y.S.2d at 585. One commentator argues that these cases were inapposite. Note, *supra* note 21, at 1166 n.65. The *Klostermann* court further stated that even if such a common law claim were recognized, thereby creating the possibility of future claims, its denial of jurisdiction precluded discussion of the claim. *Klostermann*, 126 Misc. 2d at 253, 481 N.Y.S.2d at 585.

310. Although confinement is not advocated, if it does come to pass, arguments under the tort of abandonment is a suggested approach.

311. Note, *supra* note 21, at 1163.

of due care,"³¹² especially in the clearest cases of negligence. Such cases include circumstances in which hospitals make no reasonable attempt to locate necessary community after-care services prior to a patient's discharge, but rather release the patient to the streets.³¹³

B. *The Scope of Health Care Services*

The right to health care laws call for the government to provide a reasonable scope of services to eligible recipients.³¹⁴ Courts have expansively interpreted these provisions under the existing indigent health care programs.³¹⁵ Although housing traditionally has not been included as a part of the services or treatment that agencies must provide,³¹⁶ many states provide shelter in the form of hospitalization to those in need of emergency care.³¹⁷ Homeless individuals in an acute stage of HIV-illness, therefore, can obtain temporary shelter in conjunction with emergency hospital treatment.³¹⁸ Following the emergency hospitalization, however, HIV-ill individuals often recover temporarily, thereby requiring less-intensive care.³¹⁹

Advocates for the homeless HIV-ill seeking state aid can employ an argument stemming from a provision of the Health Maintenance Organization Act of 1973.³²⁰ The Act lists basic services allegedly necessary to maintain the health of an average individual, including physician services, inpatient and outpatient hospital services, emergency medical care, limited outpatient mental health services, alcohol and drug abuse treatment and referrals, laboratory and x-ray services,

312. *Id.* at 1164.

313. *Id.* at 1164 & n.61.

314. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 11.

315. NATIONAL CLEARINGHOUSE, *supra* note 234, at 734. For example, "[s]everal courts have required the provision of dental care to the medically indigent." *Id.* (citing California state cases).

316. *See supra* note 235.

317. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 53-54 (1989) ("Almost half of the states have legislation requiring hospitals to provide emergency care regardless of ability to pay . . ."). The Hospital Survey and Construction Act, ch. 958, 60 Stat. 1040 (1946) (codified as amended in scattered sections of 24, 31, 33, 42, 46, 48 & 49 U.S.C.), establishes community service obligations for hospitals, including uncompensated emergency medical care services to every individual within a hospital's area, regardless of the recipient's ability to pay. *Id.* In exchange, the federal government provides funds to build and modernize public and private nonprofit health care facilities. Rothenberg, *supra*, at 57-59; *see also* Perkins & Boyle, *AIDS and Poverty: Dual Barriers to Health Care*, 19 CLEARINGHOUSE REV. 1283, 1286 (1986).

318. *See supra* note 235 and accompanying text.

319. Perkins & Boyle, *supra* note 317, at 1284.

320. Pub. L. No. 93-222, § 2, 87 Stat. 914 (current version at scattered sections of 12 & 42 U.S.C.).

and preventative health services.³²¹ The totality of these services, therefore, arguably constitutes the minimum acceptable level of care that meets federal statutory or constitutional mandates to maintain the health of the indigent.³²² The inclusion of home health services in the Act's list³²³ poses special issues for the treatment of the homeless HIV-ill. Apparently, the Act, and probably most health care laws, was not drafted with the homeless population in mind. To accommodate today's realities, therefore, either legislatures should draft new statutes or courts should interpret present legislation with the needs of the homeless population in mind.

VI. ECONOMIC ARGUMENTS IN FAVOR OF LEGISLATIVE REFORM

Advocates in and out of the courtroom increasingly employ economically-based arguments. Litigators sometimes rely on the science of economics in an attempt to sway the courts in matters of public policy. Similarly, legislators often respond with enthusiasm to arguments that appear to bring about savings for their constituents.³²⁴ Thus, the legislative route to the provision of medically-appropriate housing for the homeless HIV-ill may depend not on legal theory, but on economic realities.³²⁵

Interestingly, the most compassionate and appropriate care-giving alternatives to hospital care tend to be more cost-effective than

321. *Id.*

322. NATIONAL HEALTH LAW PROGRAM, *supra* note 26, at 14.

323. Pub. L. No. 93-222, § 2, 87 Stat. 914 (current version at scattered sections of 12 & 42 U.S.C.).

324. *See, e.g.*, Letter from Representative Jim McDermott (Washington) to his colleagues (Oct. 18, 1989) (requesting support for H.R. 3423, 101st Cong., 1st Sess., 135 CONG. REC. 6746 (1989)).

325. In cases of specified care for targeted subpopulations such as the "homeless, intravenous drug users with AIDS," Benjamin, *supra* note 45, at 428, alternatives to hospital care are more likely to be successful as a cost containment measure. "[B]roader (i.e. less targeted) approaches[, however,] are unlikely to reduce utilization [of hospitals] or costs." *Id.* (citations omitted). Moreover, implied support for AIDS-specific legislation can be found in "the Medicaid waiver program for Home and Community Based Services." Makadon, *supra* note 230, at 126. This waiver allows states to provide services using federal funds especially for AIDS patients, but not for other Medicaid beneficiaries. *Id.* The state must show that the offered services "will be cost effective, community based, and prevent institutionalization." *Id.* The administratively burdensome tasks of filing for a waiver and documenting the continued effectiveness of the program have hampered states' widespread adoption of these programs. *Id.* Many states, moreover, apparently feel that their programs are already effective enough to meet the needs of their residents. *Id.* Those individuals ineligible for Medicaid under the strict eligibility requirements will not benefit from this program at all. *Id.*

hospital care³²⁶ when they are well-established in a community.³²⁷ Although the existence of savings provided by these alternative programs is the subject of some controversy,³²⁸ most commentators agree that the cost of hospitalization greatly exceeds home health, hospice, and community-based care.³²⁹ In community-wide public discussions, participants propose the development of outpatient and community care services as a cost-reduction method designed to limit the utilization of inpatient hospital care for the homeless HIV-ill.³³⁰ Moreover, these alternative forms of care frequently serve the needs of the homeless HIV-ill better than unnecessary and excessive inpatient care.³³¹ Hospitals in New Jersey, for example, have estimated

326. Lambert, *supra* note 57, at E6, col. 1. The personal medical care costs of the HIV-ill include hospital, physician, nursing home, home health care, counseling, and drug costs. In sum, "[t]he economic, personal, and social costs [of HIV-illness] are staggering and recommendations to ease these problems are being made and debated." Drapkin, *supra* note 44, at 92 (citations omitted). The use of hospitals as residences is very uneconomic. Chevront, *supra* note 17, at 14 (citing Barbara Van Buren, former director of the AIDS Services Delivery Consortium, a coalition of agencies that work with the HIV-ill). Regarding costs generally, one activist sarcastically claims "that he can place nonacute AIDS patients in first-class hotel rooms and throw in around-the-clock nursing care for the same price that . . . [New York City] pays to keep these patients hospitalized." Traska, *supra* note 261, at 69 (quoting an unidentified speaker).

327. The success of community care is predicated on the assumptions that: (1) the "home- and community-based service alternatives that will substitute for hospital care are, in fact, available," Benjamin, *supra* note 45, at 428 (emphasis added); and (2) "the length of hospital stays is primarily determined by the availability of service alternatives." *Id.*

328. See, e.g., Crowley, *The Hospice Movement: A Renewed View of the Death Process*, 4 J. CONTEMP. HEALTH L. & POL'Y 295, 309 (1988) (discussing the cost-ineffectiveness of the hospice alternative for cancer patients); see also Benjamin, *supra* note 45, at 428-29. Drawing on the experience gained from the provision of long-term care for the elderly, Benjamin argues that complex issues must be addressed before implementing a new system of delivery of nonhospital health care services for the HIV-ill. For example, the initial costs of establishing community services in cities which have none must be taken into account. Benjamin concedes, however, that the differences between the HIV-ill and the elderly provide grounds for optimism in implementing community care for the HIV-ill. *Id.* at 426-27.

Actual cost savings estimates vary. For example, one commentator compares the average daily hospital cost for an HIV-ill individual—\$681—to the cost of a home health nursing visit—\$70 to \$75—and concludes that the "difference is significant." Carney, *AIDS Care Comes Home: Balancing Benefits and Difficulties*, 8 HOME HEALTHCARE NURSE 32, 36 (1990). Other sources are consistent in their reports of costs for the HIV-ill; for example, hospitalization is reported to cost between \$600 and \$900 per day. Benjamin, *supra* note 45, at 427. This simple comparison, however, does not take into account the likelihood that patients will utilize institutional services as a supplement to community and home health services. *Id.* (based on experiences with the elderly population). Nonetheless, because the divergence between the two figures is so great, some savings will ostensibly result from reduced inpatient stays.

329. NATIONAL CLEARINGHOUSE, *supra* note 234, at 732 & n.64; see also H.R. 3423, 101st Cong., 1st Sess., 135 CONG. REC. 6746 (1989); Chevront, *supra* note 17, at 15; Lambert, *supra* note 57, at E6, col. 1.

330. Benjamin, *supra* note 45, at 426.

331. Traska, *supra* note 261, at 69.

that twenty-five percent of their patients with AIDS could be discharged to a lower level of care and still have their needs satisfactorily met.³³²

Another cost-savings approach that has recently attracted the attention of the medical community is the case management method. Case management, a relatively new approach for providing health care,³³³ describes a variety of coordinating activities that health providers undertake on behalf of patients.³³⁴ These activities range from purely social services, to a combination of medical and social services.³³⁵ Although case management appears to be an extremely effective cost-containment tool, private insurers who offer case management programs report varying results.³³⁶ In fact, case management alone is not a panacea. Problems include financing,³³⁷ volunteer burn-out,³³⁸ and discrimination by nursing homes against the HIV-ill.³³⁹ Thus, advocates for the homeless HIV-ill should thoroughly investigate the available options and cost-savings in their communities before approaching legislators for one cost-savings approach over another.

VII. CONCLUSION

State and federal legislative reform is desperately needed to address the needs of America's homeless population—especially those with HIV-illness. Although use of existing laws may lead to inconsis-

332. Perkins & Boyle, *Health Benefits: How the System Is Responding to AIDS*, 22 CLEARINGHOUSE REV. 724, 732 (1988) (citing Laudicina, *Financing for AIDS Care*, 11 J. AMBULATORY CARE MGMT. 55 (1988)).

333. Silverstein, Halpern, Dean & Palmer, *Confronting the Medical-Legal Issues of AIDS*, 10 WHITTIER L. REV. 401, 436 (1988) [hereinafter Silverstein].

334. Makadon, *supra* note 230, at 127.

335. *Id.* Makadon describes case management, as utilized by insurance companies, to be a system where a case manager analyzes the clinical needs of each patient at "high risk for catastrophic health care costs . . . to determine whether high-quality care could be provided to this patient at a lower cost," *id.*, by making use of a range of services rather than the standard benefits package. *Id.*

336. Silverstein, *supra* note 333, at 436. Blue Shield of California, for example, "states that it has saved \$8,000 per AIDS patient in the past eighteen months." *Id.* Moreover, John Hancock of Boston claims savings of approximately \$56,000 per AIDS patient. *Id.*

337. "[F]ew home care services are available to AIDS patients in general." Traska, *supra* note 261, at 70 (noting the observations of Charles Flood, director of the hospice crisis care service at the Albert Einstein Medical Center in Philadelphia, Pennsylvania). Even worse, under Virginia law, home health aides may "refuse to care for Medicaid patients with contagious diseases," *id.* (noting the observations of Caitlin Ryan, a Washington D.C.-area consultant), including AIDS, even though it is *infectious not contagious*. *Id.*

338. Silverstein, *supra* note 333, at 437 (discussing the experience of San Francisco volunteers, some of whom were HIV-ill themselves).

339. Traska, *supra* note 261, at 70.

tent results, advocates for the homeless HIV-ill should search their state statutes for legislation that provides a basis for shelter or a basis for health care. Further, state mental health laws may provide an avenue for temporary medically-appropriate housing for certain segments of the homeless population—those with AIDS dementia. The existing mental health laws may also be useful as a basis for comparison in developong HIV-specific legislation. Until new legislation is forthcoming, advocates should urge courts for the broadest interpretation possible of existing laws in an attempt to stem the growing tide of the homeless HIV-ill. The courts and legislatures alike must respond to this emerging crisis before it burgeons uncontrollably, much like the deinstitutionalization program of the 1970's.

Many citizens have expressed the sentiment of helping those less fortunate than themselves. Their reluctance to reach into their pockets, however, is strong; thus, courts and legislatures must continue to seek new solutions. Legislators should pursue humanistic and economically-based arguments to provide community health care to the homeless HIV-ill at the most cost-effective level possible. Creative utilization of non-hospital based, less expensive alternatives should help legislators garner popular support for statutory assistance to the HIV-ill.

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