

**HAWAII
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CONVENTION STUDIES
1978**

**Article VIII:
Public Health and Welfare**

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Article VIII PUBLIC HEALTH AND WELFARE

PUBLIC HEALTH

Section 1. The State shall provide for the protection and promotion of the public health.

CARE OF HANDICAPPED

Section 2. The State shall have power to provide for treatment and rehabilitation, as well as domiciliary care, of mentally or physically handicapped persons.

PUBLIC ASSISTANCE

Section 3. The State shall have power to provide assistance for persons unable to maintain a standard of living compatible with decency and health.

SLUM CLEARANCE, REHABILITATION AND HOUSING

Section 4. The State shall have power to provide for, or assist in, housing, slum clearance and the development or rehabilitation of substandard areas, and the exercise of such power is deemed to be for a public use and purpose. [Am HB 54 (1975) and election Nov 2, 1976]

PUBLIC SIGHTLINESS AND GOOD ORDER

Section 5. The State shall have power to conserve and develop its natural beauty, objects and places of historic or cultural interest, sightliness and physical good order, and for that purpose private property shall be subject to reasonable regulation.

Chapter 1

INTRODUCTION

Since the last Constitutional Convention in 1968, state social services and health programs have grown at a phenomenal rate. Today government programs in this area provide a broad array of services which are not necessarily limited to the "traditionally poor". Because it is difficult to predict future trends, some individuals hold the philosophy that constitutional provisions should remain broadly stated giving the legislature the flexibility to provide services and programs by enacting laws to meet changing needs. This general philosophy was held by the delegates to the 1968 Constitutional Convention.

At the same time, others attribute the increasing scope of government activities to vague constitutional grants of authority or definitions of responsibility. Provisions that are too broad can lead to undesirable policies or programs which could jeopardize fundamental rights of citizens or result in fiscal irresponsibility. Any grant of authority or assumption of responsibility implies action to be taken and with it, often financial consequences. Clearly, much of the criticism directed at expanding social, health, and housing programs involve the large expenditures of public funds. In Hawaii, for instance, state spending in the area of health and social services was approximately \$207 million in 1976 as compared to \$31 million in 1965.¹ While much of the increase in program expansion has been a result of federal mandates, states are still expected to provide their share of the costs. In some states, however, state constitutional provisions prevent state participation in certain aspects of federal programs. The provisions usually apply to optional programs and therefore do not jeopardize federal financial support.

Constitutional provisions provide a philosophical and legal framework in which legislative action and executive direction are developed to create solutions to the problems and needs of the public. The purpose of this constitutional study is to provide a basis for decision making on constitutional provisions affecting the health, public assistance, housing, care of the handicapped, and public sightliness and good order. In doing so, this study will provide a review

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of present governmental activities in these 5 areas, a discussion of pertinent issues which may affect convention deliberations, and constitutional alternatives for convention consideration.

Chapter 2 PUBLIC HEALTH

PART I. INTRODUCTION

Public attention and debate have focused on social services¹ programs during the last 10 years. This attention reflects the direct or indirect impact of social programs on a significant number of individuals in this state and the nation. Reports on program increases, cost overruns, and ultimately, program ineffectiveness have left public officials and private citizens questioning governmental responsibility in this area.

Historically, social services as a government responsibility developed out of the Depression of the 1930's. Before that period, private voluntary societies and foundations provided a major portion of the social services required for those persons who could not maintain a decent standard of living. Government's role was limited to regulatory functions such as licensing of services and facilities offering care and treatment, all of which were generally carried out at the state or local level. Some public funds were provided as they had been since colonial times; however, these funds were only an augmentation of an already existing pool of private money.

The 1930's brought economic upheaval and with it, the country experienced a basic shift in its philosophy and approach to social services. Depression demands for services could not be fulfilled by private foundations and societies or state and local programs. At its lowest point, 13 million persons, or 25 per cent of the labor force were unemployed.² With the election of Franklin D. Roosevelt, government's role in social services became one of active assistance. Programs such as the Federal Emergency Relief Administration, the Civilian Conservation Corps, the Public Works Administration, and the Work Progress Administration were established and funded by the federal government to alleviate the economic and social plight facing depression families. Then in 1935, the Social Security Act was enacted establishing a permanent social services program on the federal level. The law

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authorized such programs as unemployment compensation, old age insurance, Old Age Assistance, Aid to the Blind, Aid to Dependent Children, maternal and child health services, services for crippled children, and child welfare services.

Underlying the social legislation of the Depression era was a subtle shift in the philosophy of social services. Previously, social programs were designed as social welfare programs; that is, "to alleviate the distress of the poorest and most disadvantaged groups".³ The programs of the Depression era held within them the attitude of social reform. Social reform involved the reduction of the size of "the poorest and most disadvantaged" group and the elimination of some of the disadvantages present in them. Social reform, therefore, is a process of chipping away at the causes of poverty which contribute to poor health, substandard housing, and the need for social services.

It is particularly important to be aware of this subtle change from social welfare to social reform as it has been the basis for much of the health and welfare legislation during the 1960's and 1970's and has contributed to legitimizing expanded government participation in social services.

Constitutional Framework

Article VIII of the Hawaii State Constitution contains the provisions relating to public health and welfare. The Article defines the state's responsibility in the "protection and promotion of the public health",⁴ the "treatment and rehabilitation...of the mentally or physically handicapped",⁵ the provision of "assistance for persons unable to maintain a standard of living compatible with decency and health",⁶ the provision of or assistance in "housing, slum clearance and development or rehabilitation of substandard areas",⁷ and the conservation and development of the state's "natural beauty, objects and places of historic and cultural interest, sightliness and physical good order".⁸

Originally composed by the 1950 Constitutional Convention, the provisions are stated in the broadest language to "indicate the concept of the type of

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health and welfare assistance that should be undertaken as far as our present enlightenment permits".⁹ Convention delegates intended the provisions to "indicate state responsibility in health and welfare, leaving the legislature to implement the concept".¹⁰

Delegates to the 1968 Constitutional Convention agreed with the provisions in the Article and made no substantive changes. In adopting the provisions of the Article, a delegate noted that "the broad grant of legislative power contained in these five sections pinpoint state responsibility...." and "that under these broad grants the legislative and executive branches of our state government have been able to carry on very meaningful effective public health programs in cooperation with the federal and county governments".¹¹ Although the comment is specific to health programs, this observation is applicable to all the provisions under Article VIII.

The only substantive change to Article VIII occurred in 1976 when the legislature proposed an amendment to section 4, Article VIII, Housing, to broaden the state's responsibility in providing housing for its people. The original provision limited state housing programs to low-income housing and slum clearance. The amendment was ratified by the electorate in 1976.

PART II. DEVELOPMENT OF PUBLIC HEALTH

Prior to World War II, national health programs consisted of grants to states for communicable disease control, maternal and child health programs, sanitation, and care for specific groups. State health programs involved care for the mentally retarded and the mentally ill, as well as services to the poor. Local governments, such as counties, were responsible for the hospitals. The general context in which health services were held was essentially to reduce and cushion the impact of disability for individuals and families.

The 1950's brought a change in the national context for health care in recognition of the evolving concept of investment in human resources and the beginnings of a domestic program. Statistical data began detailing the social

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and economic costs of illness and disability. The nation became aware of the need to promote health, prevent illness, and rehabilitate disability. This same decade brought with it the beginnings of community awareness of the economic disparity between the rich of the nation and the poor. Affluence seemed unevenly distributed and a new mood of discontent began to develop along with the pressures for social action which emerged in the 1960's.

In 1965, the 89th Congress enacted more than 2 dozen pieces of legislation dealing with health needs, including the most important piece of health legislation since the New Deal--Medicare/ Medicaid. Medicare, Title XVIII¹² of the Social Security Act, as amended, authorized health insurance coverage for hospital and related care to persons 65 and over. Administered by the federal government, Medicare was financed through a mandatory employer-employee payroll tax which already supported retirement pensions. In addition to the basic benefit, Medicare included a supplemental program in which retirees could contribute an amount to be matched by the federal government to cover physician's fee costs.

Medicaid,¹³ a little known rider on the Medicare bill, provided federal grants to match state programs for hospital and medical services for welfare recipients and the medically indigent. In its original concept, Medicaid had been envisioned as the basis for a broader benefit package of federal-state partnership to offer comprehensive coverage of the working poor.

In addition to the Medicaid and Medicare programs, Congress passed legislation establishing the Regional Medical Program¹⁴ whose original purpose was to facilitate the dissemination of information and technology in the treatment of heart disease, cancer, stroke, and related diseases. Later, the program was expanded to include health care manpower and delivery problems and programs. The Health Professionals Education Assistance legislation¹⁵ authorized funds for health manpower development and the Comprehensive Health Planning law¹⁶ and Public Health Services amendments of 1966,¹⁷ also known as the "Partnership for Health Act" authorized federal funds for 3 types of planning: (1) statewide comprehensive planning; (2) areawide comprehensive health planning; and (3) state public health and mental health program planning.

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Federal health legislation in the 1960's marked a significant departure from previous health legislation. Direct government intervention in the health care industry was a result of major questioning of the health profession's domination of health affairs and the need to meet the health problems of the socially and economically disadvantaged. The major legislation establishing the Office of Economic Opportunity program¹⁸ and the Model Cities program included health components as part of its program services.

The Comprehensive Health Planning law and the Public Health amendments illustrated the federal government's move to directly affect the planning and development of health services. Health manpower training legislation was directed at those areas of health employment where shortages existed. Basic to all these legislative acts was the intention to meet new health resource and manpower requirements to enhance the individual's purchasing power for medical care.

If the 1960's represented the era of reform and social consciousness, the 1970's can be characterized by reassessment and retooling. Between 1968 and 1975, Medicaid and Medicare laws were amended to require quality control of professional services as a condition for federal reimbursement. Health Maintenance Organizations (HMO)¹⁹ were established and funded as an optimum model for the organization and delivery of health care services. Greater attention was given to support family and community medical training programs and physicians were encouraged to practice in medically underserved areas. Even with the continued expansion of government participation to promote more efficient, effective, and economical use and distribution of health care resources, certain basic differences in the strategy used to bring about change had emerged.

In the decade since Medicare/Medicaid, national health care expenditures had tripled to the point where Americans spent \$125 million a day for hospital services; \$60.5 million for physician services; \$20.5 million on drugs; and \$6.3 million on eyeglasses, hearing aids, and other appliances.²⁰ Medicaid and Medicare costs alone skyrocketed to \$13 billion and \$14.8 billion a year, respectively, in 1975.²¹

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To control the rising health care costs, much of the 1960's legislation was recast in a move to provide greater control of costs through planning and resource allocation. The result of this movement was Public Law 93-641, the Health Planning and Resources Development Act. This comprehensive body of legislation combined the Comprehensive Health Planning law, the Regional Medical program, and the Hill-Burton program²² to form a health planning system based on a network of health systems agencies which are responsible for developing community service plans, reviewing proposed federal health projects, assisting states in reviewing health service and facilities needs, curbing cost of health care, and preventing duplication of services. Through such controls the federal government hoped to control if not slow down the rising cost of health care. It was the first attempt at such a comprehensive approach to health care cost containment.

Public Health in Hawaii

Government responsibility for public health in Hawaii was first authorized under the Organic Act²³ which stated that the "legislative power of the territory shall extend to all rightful subjects of legislation not inconsistent with the Constitution and laws of the United States locally applicable".²⁴ Under this broad statement, the territorial legislature established among the state departments, a department of health to administer programs protecting, preserving, and improving the physical and mental health of the people.

The 1950 Constitutional Convention delegates included a provision on health in its constitutional draft as an indication of the type of health programs which should be undertaken and as a general recognition that health was an usually accepted state responsibility in the area of conserving and developing the state's human resources. In 1968, Constitutional Convention delegates retained the concepts of the existing provisions and no changes were made.

State Legislation and Programs. The broad mandate of the Constitution has given lawmakers and the executive great flexibility in fulfilling the health needs of the people of this state. As is the trend on the federal level, state

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participation in health has increased over the last 2 decades. Today, the department of health is the third largest state department operating a statewide network of health care services including physical health, mental health, mental retardation, community health, medical standards and enforcement, and overall program support such as public health nursing, health education, records and data collection, research and analysis, planning, evaluation, and budgeting. In addition, the department of health is responsible for the operations of the state/county hospital system which includes 12 facilities. For administrative purposes, the state's health planning and resources development agency is under the organization of the department of health.

In the fiscal year 1975-76, state health expenditures amounted to approximately \$90 million, excluding expenditures for Medicaid and other direct service reimbursement costs. Of the \$90 million, 30.7 per cent went to the state/county hospital system, 22.1 per cent to capital improvement projects, 14.4 per cent to mental health, 8.0 per cent to Waimano Training School and Hospital, 6.9 per cent to children's health services, 4.6 per cent to medical health services, 3.7 per cent to communicable disease, 3.4 per cent to environmental health, 2.7 per cent to general administration, and 2.4 per cent to subsidies. Of the total amount, \$31.4 million came from the state general funds (34 per cent), 30.4 per cent from special funds, and 12.2 per cent from federal sources.²⁵

Department of health responsibilities have grown with its budget. In 1965, Act 97 transferred responsibility for certain functions from the counties to the state. Among these functions were the planning, construction, improvement, maintenance, and operation of public hospitals and other public health and medical facilities.²⁶ Under Act 97, all county hospitals were transferred to the state with the department of health assuming responsibility for their financial support and operations. Act 205, 1967 Hawaii Session Laws, completed the transfer by authorizing personnel transfers and further clarifying state responsibility.

At the same time the hospitals were being transferred to the department of health, a new concept in mental health was developing. In 1963, Congress

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passed the Community Mental Health Centers Act of 1963 (P.L. 88-164) authorizing federal grants to construct community mental health centers. The Act was amended again in 1965 to provide for staffing grants to implement services being offered by the centers. Hawaii adopted this community mental health model and established a network of mental health centers and clinics to serve specific geographic units known as catchment areas. Since the implementation of the system, mental health has grown to include a children's mental health services system and a state substance abuse program.

Attention to the mentally retarded has also resulted in program growth. Waimano Training School and Hospital is now a \$7.1 million a year operation and with the implementation of the deinstitutionalization program²⁷ which will allow individuals to go out into the community to live under supervisory care, new services and support units are being developed.

The newest and largest area of growth in the department has been in environmental health. The concern for the environment came out of social concerns of the 1960's. Not only were human resources considered important, but the dwindling natural resources and the continued deterioration of the environment prompted legislative action. Sanitation became too small a context in which to hold these new laws. The department of health, therefore, established its environmental protection and health services division to promote health and safety in the most basic areas of our lives. This division is responsible for such diverse activities as the review of sewage treatment plants, pollution investigation and enforcement, vector control, noise and radiation control, sanitation, and food and drugs.

Administratively under the department, though not directly a part of it, is the new health planning and resources development agency which was created under the federal mandate of Public Law 93-641. The agency is responsible for health planning and development in Hawaii, affecting both public and private services and facilities. It is also responsible for the certificate of need program which reviews the construction, renovation, or expansion of new facilities and services to determine need for such services before any action can be taken.

Health Issues

Medicare/Medicaid. The most prominent health care issue has been the controversy over Medicare and Medicaid. Public expenditure in these 2 programs have surpassed all predictions. Reports evaluating each program have found abuses and cost overruns, and a presidential task force concluded that only one-third of all medically indigent or needy were being served.

Medicare is a federally financed, federally administered program through employee taxes and has minimal impact on the state in terms of actual public funds being appropriated to run it. Medicaid, on the other hand, is a joint state/federal matching program available to those over 65 who are not eligible for Medicare, those who are unable to make the various payment requirements of Medicare, those who have exhausted their Medicare benefits, and those who qualify for any of the categorical assistance programs under the state's public assistance program. Additionally, at the option of each state, Medicaid benefits may cover those persons who qualify under state standards as "medically needy" or "medically indigent". This latter provision is intended to pay the medical expenses of persons who might otherwise be forced onto the welfare rolls.

Administration of the Medicaid program is a state responsibility within the federal guidelines. In Hawaii, the Hawaii Medical Service Association acts as the fiscal intermediary for the state's program, determining and making reimbursements. Federal matching funds are available for 6 basic services: inpatient hospital services, skilled nursing home services for persons 21 or older, home health services for persons 21 or older, screening and treatment of persons under 21 as provided by regulation, family planning services, and physician services. Many other services can be offered to Medicaid recipients with federal cost sharing and the income level to cover medically needy can be set by the states. Hawaii covers such additional services as clinic services, prescribed drugs, dental services, prosthetic devices, eyeglasses, physical therapy and related services, other diagnostic screening and preventive services, emergency hospital services, skilled nursing services for patients under 21, optometrist services, and institutional services in intermediate care facilities.

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State expenditure for Medicaid reimbursements have come under great criticism in the last 2 years. Cost overruns, physician fee abuses, and payment delays have led to a legislative request for an audit of the program. In 1961, state costs were calculated at \$1.2 million for medical care.²⁸ By 1973, Hawaii's medical program had grown to a \$35.5 million program,²⁹ and by 1975, the figures had risen to \$41.2 million.³⁰ The total number of recipients per 1,000 was 88.6 and the average assistance per recipient was \$308.³¹ By 1976, the cost of Medicaid had risen to \$55 million.

Although the Medicaid program was originally offered as an optional program to the states, in January 1970, Congress made Medicaid mandatory by announcing withdrawal of all federal assistance to existing medical assistance programs if states did not institute the program.

There is a wide variety of Medicaid programs among the 50 states. Some cover a broad range of services, but only extend coverage to those persons receiving categorical public assistance. Others include the medically needy but do not provide a broad range of service coverage. Some provide minimal coverage and others go beyond what is required by the federal government. Hawaii ranks as one of the more generous states in medicaid coverage and benefits.

A 1975 report by the Center for State Legislative Research and Services had this comment about Medicaid costs:³²

Significantly, the Medicaid program was not financed like Medicare out of the dedicated payroll tax, but out of the general revenues of the federal, state, and sometimes local governments. When expenditures for this program rose rapidly, it became the subject of sharp criticism and severe budget cutting. Federal Medicaid expenditures alone grew more than ten fold in the five year period from FY 1966 to FY 1971, from \$193 million to \$3.2 billion. The impact on state governments, which collectively contribute nearly an equal share to the Medicaid program, was just as severe, especially in those states which had enacted generous programs. This drain on governmental revenues spurred a growing interest in seeking means to control health care costs--not just for Medicaid but across the entire industry.

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Cost of Health Care. The rising cost of health care has been a continuing health issue. Statistics on hospital costs, drug costs, physician services, and other attendant health services show phenomenal increases over the last decade. Health policymakers analyzing the causes attribute them to more people and a greater portion of whom are higher users of medical services, improved purchasing power for medical care and discovery of more health services and goods, and price increases.

Attempts at controlling health care costs have taken many forms and attitudes. Some people feel that only a major reform of the delivery system, the reorganization of medical services and improved health manpower utilization will make any major difference in this continuing trend. Others see national health insurance as an answer. Still others fear that simply removing fiscal barriers to health care will not achieve more equitable access to medical care and that prudent use of resources and controls over utilization and charges are required. Federal steps in this direction involve the Professional Standards and Review Organization legislation, the establishment of the National Health Planning and Resources Development program, and the encouragement of developing health maintenance organizations.

In Hawaii, health care cost increases have a specific impact in 2 areas of government expenditure--Medicaid reimbursements and hospital costs. The Medicaid issue has been previously discussed and it is recognized that much of the increased reimbursement levels are tied to increased health services costs.

Hospital operations is the second area where health costs have direct fiscal impact on state finances. In 1965, when the state took over the operations of the county hospital systems, it also assumed responsibility for the delivery of hospital care. Today, the state/county hospital system includes 8 general hospitals, 3 long-term care hospitals, and a medical center. The budget expenditures for operations of the system amounted to \$27.6 million in 1975-76 or 30 per cent of the department of health budget.³³ Hospital rates over the last 4 years have risen from an average of \$47 a day in 1975 to \$96 a day in 1978, over a 100 per cent increase.³⁴ Yet even with this increase hospitals have not been able to meet their own expenses and have been relying heavily on state general funds.

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A 1971 report on the management and operations of the county/ state hospital system undertaken by the legislative auditor revealed certain problems in policy formulation, planning, management control, and information systems, and recommended the establishment of a Hawaii Health Facilities Authority to assume complete responsibility for the public hospitals and upon achieving financial self-sufficiency to become managerially autonomous from the department of health. The 1974 report of the Governor's Ad Hoc Commission on Operations, Revenues, and Expenditures (CORE) recommended that favorable action be taken to establish such an authority. Thus far no action has been taken.

In addition to financing a public hospital system, the state has been increasingly involved in subsidies to private hospitals. Most of the subsidies have been for operations or capital improvements. Between 1968 and 1973, public funds for private hospitals ranged from \$89,000 to \$380,000 for operations and \$53,000 to \$1,971,000 for capital improvements.³⁵ By 1977, this amount had increased to \$450,000 for operations and \$1,800,000 for capital improvements.³⁶

The 1974 CORE Report noted that "identifying the appropriate role of state government needs consideration of the federal role. If the federal government through its control of funds continues to establish national policies and goals for health care, state government must serve as an effective manager to bring order and give direction to the health care system in the State and to make the best use of all health care funds--federal, state, public, and private".³⁷ It goes on further to cite a Wisconsin report on health which suggested that state management should involve:³⁸

- (1) A clear, up-to-date state health policy plan;
- (2) A well-ordered regulatory function which provides direction to providers of care through incentive and controls;
- (3) A means to mandate necessary services and prevent development of unnecessary or duplicate services;
- (4) Effective use of federal and state resources; and

- (5) Effective representation of state needs and priorities in Washington.

Right to Health Care. Public attention on the individual's right to health care has greatly expanded in the 1970's. Several factors have contributed to this. The first is the patient/doctor relationship and its depersonalization. Secondly, federal equal health opportunity legislation under Title VI of the Civil Rights Act of 1964 required changes in the system to ensure equal treatment of minorities. The civil rights issue has also brought attention to individual rights in health care, particularly the rights of the mentally ill, mentally retarded, and in relation to programs for low-income families.

The right to health care is fast becoming recognized as a fundamental human right and has been used as the programmatic base for efforts to allocate more health resources to increase accessibility and to equalize the distribution of services. This right, however, has never been constitutionally adopted. Special interest groups and public participation in health care issues have opened the doors to greater consumer participation and demands. News coverage of the treatment of the mentally ill and mentally retarded, as well as the aged in public institutions, has led to legislation protecting these persons from abuse. The recent enactment of the Developmental Disabilities Services and Facilities Construction Act of 1975 illustrates federal concern over the rights of this group of individuals. The law requires states to establish an advocacy system for institutionalized developmentally disabled persons and specifies the rights of these persons to humane treatment, services directed toward habilitation, and care in the least restrictive environment.

Court decisions have upheld the constitutional rights of individuals in their health care and the rise in malpractice suits, though negatively indicative, provides an expression of patients' individual rights.

In response to the patients' rights movement, hospitals and other health institutions established patient advocates, patient representatives, or ombudsman positions to improve communication between provider and consumer. These individuals provide information to help the community understand the

complexities of health care, identify sources of misunderstanding or hardship, and bring about changes resulting in better care. Attempts were also made to formalize and legalize a patients' bill of rights. The American Hospital Association adopted a "Patients' Bill of Rights" in 1973 and since that time fewer than half of the hospitals have endorsed or implemented it. The federal government has included a patients' bill of rights in the federal regulations for skilled nursing facilities and intermediate care facilities reimbursed under Medicaid and Medicare.³⁹

Most bill of rights address common issues. These include, the right to:

- (1) Considerate and respectful care;
- (2) Knowledge about the patient's condition or diagnosis and participation in treatment planning;
- (3) Give informed consent;
- (4) Refuse treatment;
- (5) Be free from mental and physical abuse or unnecessary strain;
- (6) Know the policies and regulations of the financial charges made by the facility;
- (7) Have information about the patient including records, treated with confidentiality;
- (8) Communicate with and have visits from whomever the patient wishes;
- (9) Receive treatment in privacy;
- (10) Voice grievances and recommend changes without fear of retribution or reprisal;
- (11) Not be required to perform services for the facility; and
- (12) Wear the individual's own clothing.

Recently, several states have enacted Patients' Bill of Rights statutes. Among them are Colorado, Florida, Indiana, Kentucky, Nevada, Ohio, and Virginia. Typical of this type of legislation, Indiana's law reads:⁴⁰

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A patient shall be entitled to reasonable living conditions, humane care and treatment, medical and psychological care and treatment in accordance with standards accepted by medical practice.

In addition to this basic right, the Indiana law enumerates 10 other rights including keeping possessions, being visited at reasonable times, correspondence without censorship, being allowed to practice a person's own religion, and being visited by an attorney. The law also affirms the rights of legally competent patients committed to institutions.

Constitutional Provisions in Other States

Constitutional provisions defining state responsibility in health include the authorization of bonds for facility construction, designation of taxes for public health, establishment of state health boards, authorization for state support of institutions, and general language establishing state responsibility for public health.

Nineteen states have no provisions relating specifically to health in their constitution.⁴¹ Of the remaining 31, 10 have language that reads similar to Arkansas:⁴²

It shall be the duty of the General Assembly to provide by law for the support of institutions for the education of the deaf and dumb and for treatment of the insane.

The language in these provisions reflects the state's role in the care of the less fortunate expressed in terms of pre-World War II philosophy of state responsibility in health.

The establishment of state boards of health to carry out state health responsibilities are provided for in 3 constitutions.⁴³ In Delaware, the Constitution authorizes the general assembly to establish a state board of health "which shall have supervision of all matters relating to public health, with such powers and duties as may be prescribed by law, and also for the establishment

and maintenance of such local boards of health...."⁴⁴ In Washington, an authorization is given to establish by law "a state board of health...with such powers as the legislature may direct".⁴⁵ The essential characteristic of this type of provision is that it designates the body to be responsible for health care and authorizes the legislative body to establish such an entity. Delaware's Constitution goes on to define the scope of the responsibility of the board of health and gives the legislature powers of discretion in determining other appropriate responsibilities for the board.

The Alabama Constitution gives the state the option to acquire, own, build, operate, or maintain hospitals, health centers, sanitarium, and other health facilities. The provision further authorizes the legislature and other political subdivisions to appropriate funds or establish an agency to administer and receive federal funds.⁴⁶ The Oklahoma, North Dakota, Ohio, and North Carolina Constitutions provide authorization for the state or its political subdivisions to issue bonds either through authorizing law enacted to that effect, or by giving direct authorization. Funds from the bonds are to be used for health purposes. In Virginia, Alabama, Georgia, and Mississippi, health responsibilities are found within expenditure and use of public funds provisions. The Georgia Constitution states that the general assembly shall use its powers of taxation for certain purposes, among which are "for public health purposes".⁴⁷ Missouri's Constitution designates the order by which appropriations of money are made. Public health and welfare ranks 6 in a group of 8 items.⁴⁸

Eight states, including Hawaii, use broad constitutional language to express health provisions. Alaska's reads:⁴⁹

The Legislature shall provide for the promotion and protection of the public health.

Louisiana's approach gives the legislature the authority to "establish a system of economic and social welfare, unemployment compensation and public health"⁵⁰ but does not mandate it to do so. New York's constitutional statement sets up protection and promotion of the health of the inhabitants of the state as matters

of public concern and "provision therefore shall be made by such means as the legislature shall from time to time determine".⁵¹ Michigan's Constitution declares public health as a matter of primary concern and requires the legislature to pass laws for the protection and promotion of public health.⁵² South Carolina's provision declares public health to be a matter of public concern and authorizes the general assembly to provide "appropriate agencies to function in areas of public concern and to determine the activities, powers, and duties of those agencies".⁵³

Both New York and California authorize in their constitutions a loan guarantee program for hospital expansion and construction. In California the legislature is given the power to guarantee loans "made by private or public lenders to nonprofit corporations and public agencies" for health facilities development and renovation.⁵⁴ New York's provision authorizes the state or its political subdivisions "to lend its money or credit to or in aid of any corporation or association..." for the purpose of providing facilities connected with the prevention, diagnosis, and treatment of human disease or any other attendant facilities as may be prescribed by law. Corporations or associations receiving funds or credit must be nonprofit.⁵⁵

This review of constitutional provisions of other states illustrates the diverse ways in which responsibility for public health is assumed. Yet in spite of the diversity, there seems to be basic patterns in expressing responsibility. The first is to have the constitution authorize the legislative body to provide services or facilities to specific groups of people such as the mentally ill, aged, disabled, mentally retarded, low income, and handicapped. Secondly, constitutional provisions authorize the establishment of a specific entity to be responsible for the state's health program. These include health boards or departments. Thirdly, state involvement in health programs is sanctioned through authorization for issuance of bonds for health purposes or designation of tax funds for health programs. Finally, health responsibility may be expressed in broad and general terms, such as Hawaii's, where the policy statement is made without reference to specific programs, responsibilities, or agencies. The common element in all of these diverse approaches, however, is the explicit or implicit assumption that the legislative body is responsible for carrying out the mandate of the Constitution.

Constitutional Alternatives

Program expansion, expenditure increases, government involvement in planning, and development of both public and private health resources and consumer involvement in all aspects of the health care system characterize the changes that have occurred over the last decade. The continuing ability of the state to respond to future demands can be influenced by any constitutional restrictions or mandates. Therefore, in presenting choices available to delegates, both advantages and disadvantages of each alternative will be discussed.

Expressing Policy with Respect to the Health of the People. Hawaii's Constitution clearly expresses state policy with respect to the health of the people. In fulfilling its responsibility, a department of health has been created to administer programs in hospital services, environmental health, children's health services, medical health services, communicable disease, dental health, and mental health and retardation. Impetus for new programs have come from new scientific technologies and from the federal government's increasing involvement in providing financial assistance and program encouragement. Future trends indicate continued expansion of government participation in health.

Retention of the present provision would maintain the basic responsibility for health and continue having the legislature enact law or authorize action as may be warranted.

- For:
- (1) The present provision offers a simple and direct statement of state responsibility. Within this context, the legislature has been able to respond to the needs of the last decade through appropriate legislation. Federal mandates for new programs have not conflicted with the provision or prevented the state from receiving federal financial support.
 - (2) The developing interest in health and the direct involvement of government in the planning and development, as well as the delivery of services

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seems to warrant a statement that health is a matter of public concern.

- Against: (1) Broad statements do not provide any real direction or meaning to the state's responsibility in the matter of health. Its vagueness may contribute to excessive legislation, conflicting goals, and excessive program development. Most importantly, vagueness leads to personal interpretations of the state's health responsibility which may be subject to change from legislature to legislature, or executive administration to executive administration.
- (2) The provision is redundant and not necessary since the legislature already has the power to legislate in the area of health under its plenary powers. In addition, the provision itself does not authorize any action to be taken, nor does it designate anybody to be responsible for undertaking any action.

The present provision could be modified to include health care as a "right" of the people. In the past, health programs have been offered and developed out of a concession to people's needs rather than a positive right to health services. A statement to that effect can be inserted in this Article or in the Article containing the bill of rights.⁵⁶

Several federal programs have as part of their authorizing legislation a statement of rights. These include Medicare and the Developmental Disabilities law.

- For: (1) Proponents of this stance argue that present health programs are reactionary in nature, responding out of a crisis situation. A shift in the constitutional posture to express health care as a right would change the ground of being from reaction to anticipation and planning ahead.
- (2) Any statement expressing the rights of an individual would provide a clear mandate to extend health care services to all individuals and ensure that obstacles to that goal are resolved.

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- Against: (1) Health care in Hawaii has generally been available to all persons either through private or public programs. While the costs of care may be prohibitive for some, public programs such as Medicaid or the prepaid health care insurance program for working persons has done much to reduce the cost barriers.
- (2) The expression of any benefit as a "right" may result in judicial relief if any individual felt the right was being denied. While bringing suit based on denial of an individual's right may focus attention to the issue involved, other balancing factors of cost, time, and ultimate result to be achieved must be taken into consideration.

Hawaii's constitutional provision has withstood the test of time. Since the 1950 Constitutional Convention, no changes to the health provision have been made. Between 1968 and 1978, environmental health was added to the public component. Environmental health expanded the concept of health by recognizing the relationship between the environment and an individual's health. State and federal programs in this area are designed to achieve a healthful condition in which individuals may live.

In some states⁵⁷ a healthful environment has been included as a public responsibility or an individual right.

- For: (1) Adding a reference to environmental health would legitimately recognize this area as a public concern or responsibility.
- (2) The term "public health" does not seem to be inclusive enough to account for the development of an environmental health field which includes noise pollution, air and water quality control.

- Against: (1) This article may not be the appropriate place to have a statement referring to the environment. It may be more appropriate to set environmental policy under Article X, Natural Resources.
- (2) To begin to specify areas of public health in the Constitution opens the door to include other

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programs. Constitutional provisions should be broad enough to encompass change and not be subject to revision each time a new program comes into being. Expression of a state policy in the environment should be handled on a statutory level.

Prescribing the Method by which Responsibility Is To Be Fulfilled. Broad constitutional mandates set the direction for legislation, leaving the actual method by which the goals are achieved to the legislative body. Some constitutions include the expression of the methodology as a means of conveying policy. This approach recognizes the factors which are part of protecting and promoting the public health and prescribes the method by which the purpose is to be accomplished. It could include activities such as planning to emphasize need for orderly development, regulatory controls to maintain quality standards in health services to individuals or in maintaining environmental conditions, coordination of effective utilization of resources, and provisions for private and public cooperation.

For: Constitutional provisions often state intent but leave executory aspects to the legislature for implementation. To add a prescriptive method to the policy statement would provide a specific framework for legislative action in which components of health care may be acted upon in consonance. This methodological statement seems to reflect development on the federal level where legislation is beginning to offer prescriptive programs with the states filling in the content.

Against: A statement of methodology is not necessary since state agencies are already involved in these areas and adding methodology does not necessarily spur action. Additionally, determining how to reach a goal or objective is often better left to professional and technical personnel. There is an inherent inflexibility to change approaches that may no longer be appropriate if they are embodied in a constitutional provision.

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Expressing Policy with Respect to Financing of Health Care Services and Construction. Governmental concern over the rising cost of health care has led to various types of intervention programs. The new health planning act is one approach in which the control is at the level of planning and development of resources to minimize those factors which contribute to health care cost increases. The certificate of need program⁵⁸ requires governmental approval before any new health facility can be built or existing health facility or service can be expanded, renovated, modified, or discontinued. The California and New York Constitutions take one step further by including as a provision the guaranteeing of loans for hospital expansion and construction or the lending of money or credit for the same purpose. The idea behind this concept is to maintain the viability of construction funds and credit to health care facilities so that they may be timely in meeting the expanding needs of health care. In New York, it was recognized that "[u]nder present conditions there is a great lack of sufficient hospitals and a great need for modernization of existing hospitals. Recent medical programs such as Medicare and Medicaid resulted in a great demand for hospital services and it is a known fact that too frequently these demands cannot be met."⁵⁹ The federal government provided a similar program of private and public partnership under its Hill-Harris Act⁶⁰ in which federal funds were given to public and private hospitals for construction and modernization. The New York provision authorizes a state counterpart to the program. Thus, the whole purpose of the program is to support the continuing ability of hospitals and health facilities in meeting the health needs of the population.

For: Such a provision ensures continuing support for health care facilities in meeting the needs of the population, ensures continuing quality and standards in health care services by offering incentives to modernize, and provides a method by which equality of health care services can be achieved.

Against: There is no need for this type of constitutional provision in Hawaii's Constitution. Presently, the majority of the state's hospitals and health care facilities are state-run as part of its responsibility. Secondly, through its grant-in-

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aid program to private hospitals, the state informally accomplishes the policy set forth in such a constitutional provision.

Chapter 3

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Development of Care of Handicapped¹

Mental Retardation. It is estimated that 3 per cent of the nation's population or 6 million children and adults are afflicted with some form of mental retardation. Of the 6 million, figures show 60,000-90,000 are severely and profoundly retarded, 300,000 are moderately retarded, and the remaining 5.5 million are mildly retarded.²

Prior to World War II, professional intervention into the care of the mentally retarded was very limited. For the most part, families with mentally retarded members kept those individuals at home, caring for their physical needs and watching over their activities or had them committed to state or private institutions where some care was available. After the War, an interdisciplinary group called the American Association on Mental Deficiency intensified its efforts in research, training, and program development for the mentally retarded. The National Association for Retarded Citizens was formed in the early 1950's by parents of mentally retarded persons to bring public awareness and interest to the problems of the mentally retarded. As a result of its efforts, the association now has over 1,000 local chapters actively participating in mental retardation issues.

The Kennedy administration brought with it a commitment and personal interest in mental retardation. In 1962, a presidential commission issued a report entitled "A Proposed Program for A National Act to Combat Mental Retardation". The report focused on the planning and financial resources of the federal government which could be made available to mental retardation. As a result of the federal attention, activity to provide services and support for these individuals increased on the local, state, and national levels.

In 1963, federal expenditures for mental retardation were approximately \$130 million. By 1969, the amount had risen to \$510 million, and in 1975, \$1.7

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billion was allotted for mental retardation programs and services.³ The funds go to preventive services, basic and support services, training of personnel, research, construction of residential facilities, and income maintenance. Specifically, strengthened programs for prospective mothers in high risk populations, establishment of screening and early detection programs, extension of health and welfare services, and increased clinical and rehabilitative services were all part of the activities to improve services to the mentally retarded.

A 1968 Presidential Committee on Mental Retardation in an assessment of programs noted the increase in federal activity and financial support. However, the need for further increases in resources, staff, and program improvements still remained an issue and although more funds were available through Title IX, Social Security Act, and more flexible benefits through Medicare and Medicaid and workers' compensation, still more seemed to be required.⁴

Services to the mentally retarded traditionally include a state institution offering residential care which is often plagued with antiquated facilities, personnel shortages, and program inadequacies. Recently, news coverage of the conditions of mental retardation institutions and class action suits demanding that a full range of treatment and educational services be provided the mentally retarded, have focused attention on state responsibilities for the mentally retarded. In a 1963 report of the Task Force on Law of the President's Panel on Mental Retardation, the following statement was made:⁵

...it does not lie beyond the reach of justice to insist that no child be negligently born (without elementary pre- and post-natal care) or negligently exposed after birth to surroundings, physical or social, that alter his chances for rewarding maturity.... To fail to supply, as quickly as possible, as specifically as possible, and as efficiently as possible, any reasonable medical, social or legal remedy for retardation is to impose upon a child the greatest injustice of all.

In the intervening years, special state task forces have been established to study the issue of the rights of the mentally retarded in such areas as guardianship, education, commitment procedures, penal regulations, inheritance, and court and police procedures. Basic rights including marriage, sterilization, right to trial and contractual relations have also been discussed.

In 1973, the President's Committee on Mental Retardation called for the first National Conference on the Mentally Retarded Citizen and the Law. The result of the conference was a document issued in 1976 with the same title, discussing all facets of the issue.⁶ (A detailed discussion on the rights of the mentally retarded can be found under Mental Retardation Issues later in this chapter.)

Mental Health. Early mental health activities in this country involved removing mental patients from workhouses, almshouses, and prisons and placing them in mental hospitals. These institutions frequently were referred to as asylums and provided custodial care for the epileptic and the mentally defective. Although some reform activity occurred in the middle of the 19th century to draw attention to the conditions of these institutions, generally hospitals succumbed to the problems of increasingly larger populations, inadequate staff and programs, and growing isolation from the community.

It was not until the 20th century that a significant change in mental health programs and public understanding of mental illness began to take place. During World War I, an army doctor in charge of directing the psychiatric program of the American Expeditionary Forces, assigned a psychiatrist to each American division with instructions to treat all but the most severely afflicted. Prior to the end of the war, the doctor claimed that 65 per cent of the men had been treated for some psychological aberration and sent back to duty. During World War II, the Selective Service introduced a psychiatric assessment as part of its selection process and psychiatric services became a permanent part of the military program.

The Veterans Administration adopted the trend of the military and instituted psychiatric service programs in its nationwide hospital system. In 1943, the Barden-LaFollette Act⁷ expanded vocational and rehabilitative services to include mental as well as physical restoration. Legislation specifically designed to address the problems of the mentally ill civilian population began in 1946 with the passage of the National Mental Health Act⁸ which formally recognized this area as a public health problem. The Act provided funds for

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research and training programs and for states to establish community mental health services. In 1949, Congress established the National Institute of Mental Health (NIMH) to administer programs and promote further understanding of mental illness, as well as improve treatment and prevention programs.

The Mental Health Study Act of 1955, called for the first nationwide study in the field of mental health. The passage of the Act signified recognition of mental illness as a major health problem. The Joint Commission on Mental Illness and Health, which conducted the study, issued a 10 monograph report on their findings. Its final report, Action for Mental Health, prompted the President to appoint a task force to study the report and make recommendations for implementation. In a special message to Congress in 1963, President Kennedy recommended a new national program for mental health and another for mental retardation. It was the first time in history that a President addressed Congress on these subjects.

Public Law 89-97,⁹ which amended the Social Security Act, added another dimension to the mental health problem, children's mental health. The Act itself provided funds for the study of mental illness among children. In a report submitted in 1969, it was recommended that a broader range of mental health services be extended to children and their families.

The breakthrough in mental health services came with the enactment of the Community Mental Health Centers Act of 1963 (P.L. 88-164) and the adoption of a new approach to the treatment of the mentally ill emphasizing participation rather than isolation. Under the system, those who suffered from mild aberration and could normally function in the community were treated within a community setting, often on an outpatient basis. Only those who could not function on a daily level were assigned to mental institutions. The Act provided federal construction grants to public agencies and nonprofit community mental health centers. Amended in 1965, the law provided staffing grants to implement services. In 1970, an amendment (P.L. 91-211)¹⁰ provided longer periods of federal funding, increased support for centers in poor areas, and support services for children, drug addicts, and alcoholics.

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Public Law 94-63¹¹ enacted in 1975 rewrote the community mental health law to further define the scope of services and to provide performance monitoring of mental health centers to ensure their effectiveness in meeting the population needs, as well as an assessment of their alignment with national mental health goals.

Drug addiction became a major problem in the 1960's and 1970's. As a result, Congress passed the Narcotic Addiction Rehabilitation Act of 1966¹² which emphasized treatment rather than prosecution. In 1972, the Drug Abuse Office and Treatment Act (P.L. 92-255) established a National Institute on Drug Abuse which provides policy leadership in the federal government's effort to prevent, control, and treat drug addiction and abuse. The 1970 Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act¹³ provided for the establishment of a separate institute on alcoholism and alcohol abuse.

In other areas, federal legislation has affected mental health through planning programs and service standards. Office of Economic Opportunity and Model Cities programs, rules enforced by the U.S. Labor Department to reduce the number of hours an institutionalized patient may work, Law Enforcement Administration Agency efforts in adding mental health components as part of the crime prevention program, Higher Education Amendments of 1968, and related legislation providing specific mental health program functions in community services, education of the handicapped and vocational education, all have added to mental health services. Medicare and Medicaid include reimbursements for mental illness and through their rules, established standards for psychiatric facilities. Title XX of the Social Security Act (P.L. 93-64) replaced Title IV-A and VI service programs and provided funding of all social services including funds to finance certain mental health services for eligible persons. The emphasis was placed on a reduction of institutional care and an increase in home-based and community care. The Comprehensive Health Planning Act and Public Health Service Amendments of 1966 authorized grants for health service planning, specifying 15 per cent of the formula grants be used by states for mental health. In 1975, these formula grant provisions were amended and the Health Revenue Sharing and Health Services Act of 1975 (P.L. 94-63) and the

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Health Planning and Resources Development Act of 1974 (P.L. 94-641) were superseded.

As with mental retardation, the cost of mental health increased. In 1965, state and local governments spent \$669.1 million for the care of the mentally ill. By 1968, the amount had risen to \$1.62 billion and by 1971, it was \$3.4 billion.¹⁴ Generally states now devote approximately 11 per cent of their funds to mental health services.¹⁵ Federal financial participation in direct payments has expanded markedly to support state expenditures. In 1971, the Veterans Administration and the Medicaid Program spent \$2 billion for mental health services.

Along with the increasing attention on mental health services there has been a move to express the rights of the mentally ill. Since the 1970's, 2 rights have become standard: (1) the right to adequate, humane care and treatment; and (2) the right not to be hospitalized involuntarily unless 3 criteria are met. These criteria are: (1) the person involved is suffering from a mental disorder; (2) the person is in need of institutional in-patient care or treatment; and (3) the person presents a danger to the person's own life or the safety of others. Several court decisions on the rights of the mentally ill prompted states to review commitment laws in light of changing attitudes.

Physically Handicapped. In 1970, a Presidential Committee on the Employment of the Handicapped concluded that one out of every 11 adults under 65 had a handicapping condition which affected their ability to work. If children and elderly were included in the figures, it would reveal that there are 25.6 million handicapped persons of which approximately 20 million require some type of service for their condition. In 1974-75, the Bureau of Education for the Handicapped estimated there were 3.1 million physically handicapped children through age 19.¹⁶ The magnitude of the population with physical handicaps has led to several major governmental actions.

Programs which benefit the handicap fall into 2 major areas: direct payment for services under Medicaid and Medicare and rehabilitation and vocational training. Part A of the Medicare hospital insurance law provides for

the payment of extended care and rehabilitation services for those over 65 or those who are totally disabled, within certain service and fiscal limitations. Usually, care includes physical and occupational therapy, social work services, home health aide services, medical supplies, and guidance. Part B--medical insurance--the voluntary program, will pay for physician services, outpatient services, home health services, physical therapy, and communications services. Medicaid, on the other hand, leaves the scope of coverage up to the states so that the extent to which an individual receives coverage for services related to the handicapped varies. Some funds for services can be provided under Title XIV¹⁷ of the Social Security Act for those who are not eligible for Medicaid.

Probably the most active area providing assistance to the handicapped has been in vocational rehabilitation and training. The first Vocational Rehabilitation Act was passed in 1920 as an outgrowth of rehabilitation legislation for veterans of World War I. The Act provided federal grants-in-aid to the states to offer services directly to persons in need. At the same time, the law applied only to the physically handicapped and services were limited to training disabled individuals for employment. In the intervening years between World War I and World War II, no substantial changes in the law were enacted and funding stayed at a minimum level.

Under renewed interest in vocational rehabilitation of disabled World War II veterans, Congress enacted P.L. 78-113 in 1943, which applied to civilian rehabilitation programs and expanded it to include services to the mentally handicapped. The appropriations were open ended with the federal government paying for all services except one-half of the case service costs for which the states were responsible. The new legislation added impetus to the growth of vocational rehabilitation programs. In 1954, Congress passed a second piece of legislation, P.L. 83-565, which authorized generous appropriations for state/federal vocational rehabilitation programs. State allotments were based on population and per capita income and funds were provided for extension, improvement, and expansion of projects. Research programs were established on the federal level and grants were given to higher education institutions for personnel training. Construction funds were also made available for remodeling and expansion of facilities.

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Additional amendments enacted in 1965¹⁸ and 1968¹⁹ liberalized the programs by increasing federal support, by authorizing provisions for equipping, staffing, and constructing rehabilitation centers and workshops, and by authorizing a commission on architectural barriers. The 1968 amendments provided federal reimbursements to families of disabled persons for rehabilitation, authorized follow-up services to "rehabilitated" individuals, increased the federal share to 80 per cent and authorized a vocational evaluation and work adjustment program for the disadvantaged whether or not physically or mentally handicapped.

1973 brought the last major enactment in vocational rehabilitation. It required states receiving federal financing to give service priority to the severely disabled as defined in the Act.²⁰ The Act also established a National Architectural and Transportation Barriers Board to enforce legislation to remove barriers and an affirmative action program to facilitate and promote employment of the handicapped.

The federal and state partnership in vocational rehabilitation has been a topic of much discussion. It began as a federal grant-in-aid program and from the beginning, states were required to have state plans "describing the method and standard for services". However, no attempt was made to require uniformity among state programs. Once the Secretary of the Department of Health, Education and Welfare (HEW) approved the state plan, it became a contract between the state and the federal government. On the federal level, the program is administered through the Rehabilitation Services Administration. On the state level it may be administered through state boards, an independent agency, or within an already existing state department.

Although aware of the number of persons with handicapping conditions, government has not been as comprehensive in covering this area as in mental health or mental retardation. Nonprofit agencies provide the major services with government assistance. Recently, HEW rules prohibiting discrimination in the employment of the handicapped were approved by the Secretary of the Department of Health, Education and Welfare. However, approval was late in coming, 4 years after the authorizing legislation was passed and only after a

demonstration of handicapped persons and their families at the Department's headquarters in Washington, D.C.

Care of the Handicapped in Hawaii

Mental Retardation. Section 333-11, Hawaii Revised Statutes, authorizes the state department of health "to provide for the establishment and operation of community mental retardation programs" including programs for the prevention of mental retardation, information and educational services, consultation services to other state agencies, outpatient diagnostic and treatment services, day care services, short-term in-patient treatment in community facilities, rehabilitation services and construction and renovation of facilities for mental retardation services. In addition, the state statutes establish a mental retardation program comprised of community clinical services, Waimano Training School and Hospital, and protective services.²¹ Waimano Training School and Hospital is statutorily designated for persons "who because of mental retardation are incapable of independent self-support and self-management in the community or incapable of attaining independent self-support and self-management without proper treatment or training",²² and is the major state facility providing care for the mentally retarded. In the fiscal year 1975-76, 8 per cent of the department of health's budget went to Waimano. This amounted to approximately \$7.1 million.

Waimano serves as a multipurpose institution providing services to all ages and all degrees of retardation and associated handicaps and behavioral problems. In recent times, the institution has come under heavy criticism for being understaffed and using inadequate and dilapidated facilities. In 1974, the Sokoloff²³ report drew attention to Waimano's situation and the fact that the institution had previously applied for Medicaid certification and received a deficiency report from the survey team.

In response to the Medicaid deficiency report and increasing public pressure, plans were made to renovate Waimano to meet certification standards. At the same time, a total improvement plan was adopted with the following objectives:

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- (1) Renovate buildings to create a better physical environment;
- (2) Provide quality care to residents; and
- (3) Implement a policy of deinstitutionalization in the community.

Implementing the deinstitutionalization program requires development of community facilities and special wards for the treatment of the mentally retarded in several state/county hospitals so that patients may be taken care of within proximity to their families. The social services placement unit will be involved in placing some of the residents in adult family boarding homes or specially created care homes for the mentally retarded in the community. Interdisciplinary teams will prescribe and monitor treatment for community residents and by 1980, Waimano expects to have a population of 391, down from approximately 600.

Aside from Waimano, the state has assumed responsibility for several day activity centers for the mentally retarded. Originally a privately run program, these day activity centers have been statutorily transferred to the state. They include Hale Hauoli Day Activity Center on Maui and Kauai, and the Hilo Day Activity Center on the island of Hawaii.

In 1975, the state legislature passed a law establishing the developmental disabilities council. In its findings and purpose, the legislature noted that the state "has a responsibility to provide services for its developmentally disabled citizens in order to aid them in living as complete and normal lives as possible".²⁴ To achieve this goal, the legislature recognized the need to have a coordinative and planning body integrating all the services offered to the developmentally disabled through the departments of health, social services and housing, and education. The developmental disabilities council has been named as that body. The use of the term "developmentally disabled" comes from the federal statute and reflects the changes occurring in the field.²⁵ Although not a new term in the professional world, "developmental disability" is a new term in statutory language. Hawaii's statutes define developmental disability as "a disability of a person attributable to mental retardation, cerebral palsy, epilepsy, autism and other conditions of a person which result in similar

impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons...."²⁶

In 1977, at the request of the legislature and under an October 1977 federal deadline, the governor established an advocacy office to serve as the protector and the enforcer of the rights of the developmentally disabled as set out in part E of the law.²⁷ Hawaii's advocacy system which is presently being organized and developed represents a major commitment on the part of the state to protect the rights of the developmentally disabled.

Services for the mentally retarded are also purchased under a state purchase of services program from nonprofit private agencies. Among the services provided are fundamental skills training and vocational training through the Hawaii Association for Retarded Children's Wahiawa Activity Center and Fort Ruger Activity Center. Lanakila Rehabilitation Center offers a sheltered workshop situation for the mentally, physically, and emotionally handicapped through state support. State funds also go to support counseling and work placement programs at Lanakila Crafts for the physically and mentally disabled.

Mental Health. The department of health provides mental health services through a network of 8 community mental health centers and the Hawaii State Hospital. Chapter 334, Hawaii Revised Statutes, assigns the department this responsibility, as well as specific responsibilities such as informational and public education services, collaborative and cooperative services with public and private agencies, consultation services with the judiciary, educational, health, and welfare institutions, clinics and hospital facilities, research, statistics, coordination of services, standards, and evaluation services related to mental health.²⁸ In addition to the community mental health centers, the department of health is also responsible for a children's mental health program and an alcohol and substance abuse program.

The present community mental health centers program was established under Act 259, 1967 Hawaii Session Laws, in response to federal emphasis on community mental health and the availability of funds to construct and staff

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community mental health centers. Today, mental health services consume 14.4 per cent of the department of health's budget and in 1975-76, that amounted to \$12.9 million.²⁹ At the community mental health level, it is estimated that some 11,619 persons are being served³⁰ through the 8 mental health centers and their clinics.

In the case of the most severe conditions of mental illness where the patient is unable to function in the community, the Hawaii State Hospital provides acute and long-term psychiatric care. In 1975, the hospital was granted unconditional certification from the Department of Health, Education and Welfare as a result of improvements made in the facility to meet Medicare and Medicaid standards. A closed intensive care unit for dangerous patients was established in June 1976 to complete the major portion of the renovation and reorganization of the facility. The Hawaii State Hospital has an average daily census of 302, about one-half the number of persons in 1965, before the institution of the community mental health centers program.

Physically Handicapped. Programs for the physically handicapped in Hawaii are administered through 2 state agencies--the department of health and the department of social services and housing (DSSH). Within the department of social services and housing, programs are administered through the vocational rehabilitation division and under the purchase of services program for eligible persons. As stated in the law, the state's policy in vocational rehabilitation is to provide services to residents throughout the state and that the "vocational rehabilitation plan, formulated in conformance with the Federal Vocational Rehabilitation Act, as amended, and adopted pursuant to this chapter, shall be in effect in all political subdivisions in the State".³¹ Included as vocational rehabilitation services are diagnostic and related services, training, guidance, placement, maintenance of subsistence during vocational rehabilitation, equipment, books and other training related materials, transportation, and physical restoration.³² The financing of vocational rehabilitation programs is accomplished through a state/federal partnership.

According to the latest DSSH annual report,³³ the division "served 6,572 handicapped individuals in the state, an increase of 17 per cent or 940 cases

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over fiscal year 1975.³⁴ Expenditures rose from \$3.9 million in 1975 to over \$4 million in 1976. It is estimated that at this point in time, the division is serving 11 per cent of an estimated universe of disabled persons in Hawaii. A program profile for 1976 shows the following:

1. Rehabilitative Services: Total cost: \$2,327,233
 - a. Disabled public assistance recipients: 3,450 served, an increase of 89 per cent over 1975.
 - b. Disabled public offenders program: 378 served and 26 rehabilitated.
 - c. Alcoholic program: 374 cases handled, 50 rehabilitated.
 - d. Placement of the severely disabled: \$85,000 federal grant received for rehabilitation services including counseling and job readiness, training, intensive job development and placement and implementation of the affirmative action for the employment of the handicapped.
 - e. Rehabilitation facilities: 1,600 persons placed and provided with workshop services, 763 more than 1975.
 - f. Services to the hearing impaired: One year project begun to serve the hearing impaired community through an information and referral center.

In addition to vocational rehabilitation, state statutes also provide for services to be given to the blind and the visually handicapped. It is stated as the policy of the state "to encourage and enable the blind, the visually handicapped, and the otherwise physically disabled to participate fully in the social and economic life of the state and to engage in remunerative employment".³⁵ State policy also gives the handicapped the same right as the able bodied individual in the full and free use of public facilities and places and provides that they shall be employed by the state, the counties, the schools, and all publicly supported organizations without discrimination.

The department of health provides services to the handicapped through contracts with private groups for rehabilitative services and through its crippled children's program and concentrates on the physical and medical aspects of handicapped individuals.

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In addition to these 2 state departments, the legislature established a commission on the handicapped which is responsible for:³⁶

- (1) Reviewing and assessing the problems and needs and availability of adequate services and resources for the handicapped;
- (2) Advising the state and counties on matters relating to the handicapped;
- (3) Educating the public on the needs, problems, and rights of the handicapped;
- (4) Seeking funds from public and private sources to provide improved conditions for the handicapped; and
- (5) Setting short- and long-range goals to fulfilling needs of the handicapped.

The commission is essentially a coordinative and policy setting body. Its significance is an indication of the state's commitment to improving and developing services for the handicapped.

Issues Concerning the Physically and Mentally Handicapped

Civil and Personal Rights. A major issue in the field of mental health and mental retardation has been the "right to treatment". The concept of the "right to treatment" evolved through a series of court cases, with the most recent definition being:³⁷

...a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such treatment as will give him a realistic opportunity to be cured or to improve his mental condition.

In simple terms, "the right to treatment [of an individual] is the opportunity, obliged by the State, to receive a good faith attempt at treatment under humane conditions".³⁸ In the first case to recognize the right to treatment, Rouse v. Cameron,³⁹ the decision suggested that there were constitutional objections to involuntary commitment without treatment which could violate the due process and equal protection clauses.

An extensive discussion relating to the constitutional right of the civilly committed mental patients to receive treatment is found in Wyatt v. Stickney⁴⁰ and its related cases. The original suit filed related to the reinstatement of 99 employees who were terminated without notice or hearing because of budgetary constraints. As a result patients did not receive adequate treatment. The judge noted that the employees could gain relief under state courts, but emphasized his concern for the plight of the patients in the institution who now did not have adequate treatment available to them. This shifted the focus of the case from the effects of employee termination to the general question of adequate treatment afforded at Alabama State Hospital. The original complaint was amended to include "prayers that the defendants be enjoined from operating Bryce in a manner that does not conform to constitutional standards of delivering adequate mental treatment to its patients";⁴¹ that the Court order defendants to prepare a "comprehensive constitutionally acceptable plan to provide adequate treatment in any state mental health facility";⁴² and that the Court declare that patients confined to a state mental health facility are entitled to "adequate, competent treatment".⁴³ In its decision, the Court found that treatment programs were inadequate, failing to conform with any minimum standards established for providing treatment to the mentally ill. Most of the patients in the hospital were involuntary commitments and when persons are so committed for treatment, they have a constitutional right to receive individual treatment which will give them a realistic opportunity to be cured or improve their mental condition. The Court further noted "[t]he purpose of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment."⁴⁴ Any citizen deprived of liberty upon the benevolent theory that the confinement is for therapeutic purposes and that adequate treatment is not provided, has a fundamental right of due process violated.

In a follow-up case⁴⁵ on the plan submitted by the institution, the Court established 3 basic standards for adequate and effective treatment programs in public mental institutions:

- (1) A human psychological and physical environment;
- (2) Qualified staff in numbers sufficient to administer adequate treatment; and

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(3) Individualized treatment plans.

In general, the themes presented in the Wyatt case have served as a basis for other court decisions.

The U.S. Supreme Court handed down a landmark decision regarding patient's constitutional right to liberty in the case of O'Connor v. Donaldson.⁴⁶ The Court held that "a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsive family members or friend".⁴⁷ The opinion further noted that:⁴⁸

A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custody confinement. Assuming that term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.

The effect of this decision on the states may involve several actions:

- (1) Re-evaluation of non-dangerous involuntarily hospitalized patients to identify those being held in custodial confinement against their will;
- (2) Procedures to periodically review patient's status in the system; and
- (3) Review of state commitment procedures for possible unconstitutional vagueness suggested by the decision.

The third basic right which has emerged through court cases and through federal law is the right to the least restrictive alternative. The most frequently quoted principle in the argument for least restrictive alternative comes from a U.S. Supreme Court decision in Shelton v. Tucker:⁴⁹

In a series of decisions this court has held that even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of

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legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.

In the case of Lake v. Cameron⁵⁰ the Court held that the commitment statute required judicial inquiry into less drastic arrangements than full-time mental institution confinement. The statutory language authorized the Court to decide hospitalization for an indefinite period, or any other alternative treatment which the Court determined is in the best interest of the person and the public. The decision noted that the provision did not contain adequate safeguards to ensure that the Court would in fact conduct an exhaustive search for the least restrictive alternative, and therefore, could be interpreted as unconstitutional in light of the principle of the least restrictive alternative.

In the case of Covington v. Harris,⁵¹ the Court found that "[t]he principle of the least restrictive alternative consistent with the legitimate purpose of a commitment inheres in the very nature of civil commitment.... A statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly even grudgingly construed in order to avoid deprivations of liberty without due process of law."

In another important case⁵² dealing with all aspects of commitment, 3 obligations were established which must be determined by a committing agency prior to a commitment order:

- (1) What alternatives are available;
- (2) What alternatives were investigated; and
- (3) Why the investigated alternatives were not deemed suitable.

The alternatives include voluntary or court-ordered out-patient treatment, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home aide services.

Hawaii's mental health commitment law has undergone several changes within the last 3 years to accommodate federal court decisions. Chapter 334,

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Hawaii Revised Statutes, details procedural standards for emergency examination and hospitalization, voluntary hospitalization, involuntary hospitalization pursuant to a judicial hearing, and the transfer of patients between facilities.

Under the requirements for involuntary commitment, the law requires a finding of 3 things (1) that the person is mentally ill or suffering from substance abuse; (2) that the person is dangerous to self or others or to property; and (3) that the person is in need of care or treatment and there is no suitable alternative through existing facilities and programs which would be less restrictive than hospitalization. If there is a finding of all 3, a court hearing is held to determine whether in fact the individual does meet the criteria. If the individual does meet the criteria, then an order is issued for the individual to be retained or taken to a psychiatric facility for a period of not longer than 90 days unless the facility obtains an order for commitment under procedures set by law. The law also provides for the patient to be transferred to another psychiatric facility provided the patient and others entitled to receive notice of the transfer are informed. Finally, it specifies that a patient's civil rights are not jeopardized by admission to a psychiatric facility.

Several court decisions have been issued against Hawaii's mental health commitment procedures. In 1976, in Suzuki v. Quisenberry,⁵³ the federal district court ruled that Hawaii's mental health law was unconstitutional because it violated substantive due process rights of those individuals involved in involuntary commitment procedures. At the time, the law authorized "nonconsensual institutionalization of individuals upon certification of two physicians that [the] individual is 'mentally ill or habituated to excessive use of drugs or alcohol' to [the] extent requiring hospitalization"⁵⁴ without requiring any showing of 'dangerousness'. The Court further noted that the law not only violated substantive due process, but also procedural due process. "Due process in connection with the nonemergency, nonconsensual commitment of persons...requires that the person sought to be committed receive at a minimum the following procedural safeguards: adequate legal notice, prior hearing before a neutral judicial officer; the right to effective assistance of counsel; the right to be present at the hearing; the right to cross-examine witnesses and to

offer evidence; adherence to the rules of evidence applicable in criminal cases; the right to assert the privilege against self-incrimination; proof beyond a reasonable doubt; a consideration of less restrictive alternatives; a record of the proceedings and written findings of fact; appellate review; and periodic redeterminations of the basis of confinement".⁵⁵

In 1977, the state's mental health law was challenged again after being rewritten in the light of Suzuki on the basis that it authorized involuntary commitment to a psychiatric facility in nonemergency situations if the person is found to be dangerous to self and others or dangerous to property.⁵⁶ According to the federal district court, dangerousness to property is not a constitutional basis for commitment in either an emergency or nonemergency situation. "The State's interest is not so compelling to justify commitment"⁵⁷ where use of criminal statutes regarding property damage may be used to protect the state's interest. The Court further ruled that to be "dangerous to himself and others", a specific "finding of imminent and substantial danger as evidenced by a recent overt act, attempt, or threat"⁵⁸ is required. Therefore, Hawaii's law was ruled unconstitutional.

The provision regarding involuntary commitment of up to 5 days of an individual who refuses to be examined to determine need for hospitalization if sufficient evidence exists to believe commitment is necessary was also ruled unconstitutional. The Court noted that the statute denied due process because it permitted temporary commitment of an individual based on "sufficient evidence" rather than "proof beyond a reasonable doubt".

Procedures for the commitment of the mentally retarded are spelled out in part III, chapter 333, Hawaii Revised Statutes. Any person who meets the statutory criteria of being mentally retarded is subject to commitment to Waimano Training School and Hospital. A "mentally retarded person" is defined as an individual who is afflicted with: (1) a deficiency of general mental development associated with chronic brain syndrome; (2) a deficiency of intelligence arising after birth, due to infection, trauma, or other disease process; or (3) a person who is afflicted with general intellectual subnormality not due to known organic factors.⁵⁹

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The family court has jurisdiction over all commitments to Waimano. An adult relative, guardian, or custodian of an individual or a government department or bureau may petition the court for commitment. A certification procedure is then instituted in which a panel of 3 individuals qualified to make diagnosis, examines the individual to determine whether the individual should be committed to Waimano. The court then conducts a hearing on the petition for commitment; and, if the person is found to be in need of commitment, an order is issued. Any person who is committed may appeal the commitment; however, unless specifically ordered by the Supreme Court, the appeal "shall not operate as a stay of the order of commitment which shall be executed notwithstanding the appeal, subject to the release of the individual sought to be committed...."⁶⁰ The law goes on to provide that any person committed to Waimano shall not be detained for a period of more than 60 days unless the person has been examined by one or more qualified physicians other than the signers of the certificate used in the commitment application. Upon the filing of a certificate based on the findings of a fourth qualified person, the court may issue a final order of commitment and the individual then remains at Waimano until discharged, conditionally released, granted leave, or transferred.⁶¹ The court maintains the discretion to request further examinations and review until it is satisfied that commitment is appropriate and necessary. In involuntary commitments, the detention period can be no longer than 30 days for minors or 60 days for adults unless an application for commitment has been filed or in the case of minors, the court finds that an extension is in their best interest.

Patients or wards of Waimano, or their parents, relative, guardian, or friend are entitled to apply to an appeals committee of 2 licensed physicians and one licensed attorney for a hearing on the question of whether a ward or patient falls within the group of persons subject to commitment at Waimano. If the patient is found not to fall within the category of mentally retarded as defined by the law, then the committee will report its findings to the director of health who will begin the procedure for absolute discharge of the patient.

During the period an individual is confined to Waimano, the director of health assumes natural guardianship of a minor and all the powers and duties of any guardian of the person. However, the law explicitly states that the

guardianship of the director does not permanently terminate the parental rights of the legal parent or parents of a minor, and the director's guardianship powers apply to the protection and treatment and promotion of the best interests of the ward.⁶²

In its report, The Mentally Retarded Citizen and the Law, the President's Committee on Mental Retardation noted that "stronger procedural protections clearly are required than typically have been provided in the past...."⁶³ There is merit in setting up realistic procedures to protect against erroneous decisions without submerging the courts into a meaningless routine which assumes that the mentally retarded citizen and the state are in an adversary position. As an example of a model procedure, the report cited California and New York which place emphasis on voluntary placement through regional treatment centers working with the parent or guardian to determine the most suitable habilitative setting.

The rights of the mentally retarded and the mentally ill have been emphasized by the courts, particularly in the area of right to treatment, right to liberty, and right to the least restrictive alternative. As individuals within this society, the mentally ill and mentally retarded are already granted those rights provided under the Constitution. However, extenuating circumstances, namely their mental condition, lend themselves to usurpation of those rights albeit in their "best interest". It may be that the only way to fully insure the rights of these individuals is to include a constitutional reaffirmation of their rights with respect to the treatment of their condition. On the other hand, statutory provisions outlining basic rights of mentally retarded and mentally ill individuals can offer the necessary protection so that these rights are not violated. The key to resolving this issue, lies in the interpretation of "rights".

One definition of "rights" assumes that they are "individual possessions which the state should protect as in the classic libertarian view of the inalienable rights to life, liberty, and the pursuit of happiness in the Declaration of Independence".⁶⁴ On the other hand, many of the rights connected with the right to health and the right to treatment, are defined as "claim".⁶⁵ Under this concept the individual has a claim on the state for

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treatment and the state has an obligation to treat the individual, and not an opportunity for treatment. Any statement of right serves a purpose, and that is, it questions whether state purposes are legitimate, procedures fair, conditions in an institution humane and suitable for any effort toward treatment, and the state is acting in good faith.

A resolution to the issue of the right to treatment involves the decision on whether the right is a theoretical concept or a practical means of guaranteeing proper and humane treatment of the individual while guaranteeing protection to both the individual and society.

The rights of the physically handicapped have also been a recent issue particularly in the area of employment and accessibility. The right of handicapped persons to be free from architectural and transportation barriers has not received the public attention other issues have. Yet, Congress enacted the Architectural Barriers Act of 1968 (P. L. 90-480) to provide for equal access to public buildings for the physically handicapped. The federal law states that buildings constructed or leased in whole or in part with federal funds must be made accessible and usable by the physically handicapped. It also covers adequate access to curbs and sidewalks. In another congressional act, Public Law 93-112,⁶⁶ no qualified handicapped person can be excluded from participation in any program or activity receiving federal funds or denied benefits of any program receiving federal funds or be discriminated against in any federally funded program.

In employment, federal law provides for an affirmative action program for hiring, placement, and advancement of handicapped individuals. In instances where an employer has a contract in excess of \$2,500 with the federal government, the employer must take affirmative action to employ and advance employment of the handicapped. A federal interagency Committee on Employment of the Handicapped was set up to review the adequacy of hiring, placement, and advancement practices relating to handicapped individuals.

As in the case of the rights of the mentally ill and the mentally retarded, rights for the physically handicapped may be perceived in terms of a claim or

obligation on the part of the state to ensure that these individuals are actually receiving those rights which are constitutionally guaranteed them under the United States Constitution and under the Bill of Rights in the Hawaii Constitution. In the case of the handicapped, a statement of rights can serve as a guideline on monitoring state programs and activities and support community awareness of the problems of the handicapped.

Constitutional Provisions in Other States

State constitutional provisions relating to the handicapped, mentally retarded, or mentally ill are often presented as an educational responsibility or in terms of state responsibility for institutions serving these groups of individuals. In Arizona, the legislature is authorized to support and establish institutions for the benefit of the insane in the manner prescribed by law.⁶⁷ In California, the legislature is given the power to "grant aid to needy physically handicapped persons, not inmates of any institution under supervision of the California Department of Mental Hygiene and supported in whole or in part by the State or by any institution supported in whole or in part by any political subdivision of the State".⁶⁸ Michigan's Constitution reads:⁶⁹

Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are mentally, physically or otherwise seriously handicapped shall always be fostered and supported.

This language in the Michigan Constitution was updated from a provision which included such terms as "deaf", "dumb", "feeble-minded" and "insane". It further recognizes the recent developments in the field of physical and mental rehabilitation so that "programs and services" are added as a broader concept not necessarily confined to institutional treatment.

Missouri's Constitution establishes a department of mental health, a director appointed by the commission with the advice and consent of the senate, and a commission on mental health. The department is responsible for the treatment, care, education, and training of persons suffering from mental illness or retardation.⁷⁰

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The Montana Constitution includes as one of its provisions a statement relating to the rights of persons committed to institutions. It ensures that committed persons shall retain all rights "except those necessarily suspended as a condition of commitment". The suspended rights are to be restored upon termination of commitment and the state's responsibility.⁷¹ New York's Constitution provides the state and local governments with the option to provide care and treatment for persons with mental disorder or defects and the protection of the mental health of the inhabitants of the state as the legislature may determine. It also authorizes the head of the department of mental hygiene to inspect all public and private institutions.⁷²

For the most part, constitutional provisions relating to the mentally ill or physically handicapped are antiquated. Archaic terms such as "insane" and "feeble-minded" are still being used. The constitutional statements reflect an obsolete approach to the treatment and care of the mentally and physically handicapped which generally means confinement in an institution. Where provisions are updated as in Michigan, the terminology used reflects the advances in treatment.

Constitutional Alternatives

Changing attitudes toward the treatment of the mentally and physically handicapped and the advocacy of their personal and civil rights have brought about many changes in state laws and programs. The following discussion presents the constitutional alternatives available in light of these recent changes.

Retain the Existing Provision. The present statement in Hawaii's Constitution reads: "The State shall have power to provide treatment and rehabilitation, as well as domiciliary care of mentally and physically handicapped persons."

<u>For:</u>	This provision has served as a basic policy for the mental health, retardation, and physically handicapped programs for the last 28 years. In
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that time, it has provided an adequate base for continually expanding state programs. Without conflict, the legislature has been able to enact laws and authorize programs to fulfill its responsibilities.

Against: Terminology used in the provision is fast becoming antiquated. Recently, the federal government passed a law for the developmentally disabled, which is a much broader term for those persons afflicted with a condition which resembles the mentally retarded, and includes cerebral palsy, epilepsy, and a number of chronic conditions.

If a constitution is to remain relevant, then at opportunities to amend the constitution, such as a convention, appropriate action should be taken. Clearly, the constitution sets the philosophical approach to any statute or program.

Modify the Existing Provision. With the changes in terminology, philosophy, and approach to treatment, the constitutional provision now in the Hawaii State Constitution requires some assessment as to its ability to continue to meet the needs of the people.

For: As mentioned in the previous discussion, the federal law and professional circles have created new terminology requiring updating of the provision.

Against: Terminology in any given professional area often is a result of a passing trend. In the area of mental health and mental retardation, this pattern is particularly true. New approaches and methods are always being developed and words of art being coined. The terms presently used in the constitutional provision have withstood 28 years of changes and continue to be applicable. Therefore, change is not necessary.

Add to the Existing Provision. In addition to the statement of the state's responsibility for the treatment, rehabilitation, and domiciliary care of the mentally and physically handicapped, a provision clearly establishing the rights of these individuals to care may be appropriate at this time.

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For: The activism in the area of the rights of the developmentally disabled, mentally ill, and the handicapped reflects the concern over the deprivation of rights, particularly among those in institutions. A constitutional statement in this area would clearly set the policy on the rights issue and guarantee adherence to the concept of equal rights under the law. This guarantee would be self-operative and not require additional legislation to be enforceable.

Against: Including the rights of the mentally ill, mentally retarded, and handicapped in the constitution may set up a group with special rights and privileges. Moreover, since basic individual rights are guaranteed under the constitution, any additional rights would only be repetitive. A statutory statement of rights would serve to emphasize the particular problems of these groups without constitutionally treating them as special.

Chapter 4

PUBLIC ASSISTANCE

Development of Public Assistance

The current public assistance program came out of the Depression crisis of the 1930's. Prior to that time, public assistance contained overtones of "social welfare" of which the major component was "charity" and a religious sense of helping the less fortunate. The evolution of social and economic theory as expressed by John Locke, Adam Smith, de Tocqueville, and Darwin¹ had a profound effect on the approach to social welfare, secularizing its basic tenets. By the 1930's it became clear that the nation was facing economic and social chaos which could not be dealt with from the context of charity and helping the less fortunate.

At the outset of the Depression, states took immediate action. Over one-half of them initiated some type of emergency relief program. Soon after, the federal government responded to the immediate needs of the nation with the creation of the Civilian Conservation Corps, Public Works Administration, National Youth Administration, and Work Progress Administration. By 1934, however, it became apparent that these short-term solutions could not effectively deal with the continuing economic conditions. On June 8, 1934, President Roosevelt sent a message to Congress in which he called for a nationwide system of permanent measures to protect American citizens from the most disruptive crisis of life. A committee was appointed to develop legislation to implement the program and in January 1935, the committee submitted its report. The result was the passage of the Social Security Act. The new Act contained an Old Age Insurance Program and grants to states for assistance in 3 areas--aged, blind, and dependent children. Probably the most significant piece of social legislation of the century, the Social Security Act marked the beginning of federal participation in the nation's welfare.

Since its inception the Social Security Act has been amended numerous times, including adding the totally disabled as a need category (1956), optional

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inclusion of unemployed fathers under Title IV, Aid to Families with Dependent Children program (AFDC) (1961), social services (1962, 1967, 1974), Medicaid (1965), and Supplemental Security Income (1972).

The 1960's brought the second major influence on the nation's public assistance program. The War on Poverty and the Great Society legislation encouraged greater participation among categories of persons receiving public assistance and legal activism which began examining the public assistance laws, regulations, and administration. Several United States Supreme Court decisions challenged the laws under the due process and equal protection provisions of the Constitution. Among the key decisions were:

- (1) Shapiro v. Thompson:² elimination of durational residency requirement.
- (2) King v. Smith:³ struck down the rule of withholding assistance due to the fact that a man lived in the home.
- (3) Wheeler v. Montgomery⁴ and Goldberg v. Kelly:⁵ overturned the rule that assistance may be discontinued prior to a hearing, in favor of continuing aid until an evidentiary hearing is held.

Other court decisions have dealt with public assistance policy, administration, and operations:

- (1) Dandridge v. Williams⁶ and Jefferson v. Hackney:⁷ insure that each state has the right to set benefit levels for assistance payments.
- (2) Rosado v. Wyman:⁸ prevents states from eliminating certain items in determining their standard of need.
- (3) Philbrook v. Glodgett:⁹ gives persons eligible for both AFDC-UP and unemployment compensation the choice of which benefits they wish to receive.
- (4) Burns v. Alcala:¹⁰ states receiving federal financial participation in the AFDC program are not required to provide assistance for the unborn child of women pregnant with their first child.

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Since 1935, the public assistance program has grown at a phenomenal rate, remaining relatively unchecked until the early 1970's. However, the slow down in the trend during 1970 and 1973 was only temporary and beginning in 1973, the number of persons receiving public assistance has again been on the rise.¹¹

Aid to Families with Dependent Children (AFDC). The Aid to Families with Dependent Children is a cash assistance program for children lacking adequate parental support. Federal and state statutes govern eligibility benefit levels, and treatment of income. Because of its size and cost, AFDC has become one of the most controversial of the public assistance programs.

Between 1968 and 1975, the AFDC program experienced a growth of 85 per cent. The most dramatic period occurred between 1968 and 1971 when the program rolls increased 75 per cent. Between 1971 and 1973, the numbers increased by less than 3 per cent and between 1973 and 1975, the increase was 7 per cent.¹²

Most AFDC qualified families are headed by females (75 per cent). The rest of the 25 per cent are headed by men. In 25 states families with an unemployed father may also be eligible for AFDC benefits.

The actual amount of assistance per family is determined by each state on the basis of its standard of need. States are not required to pay the full amount of its standard of need and in 1974, only 20 states were doing so. The lowest paying state provided only 22 per cent of its standard and the highest amount paid was less than one-half the poverty level.¹³

Supplemental Security Income (SSI). In October 1972, Congress enacted a program of uniform national minimum cash income to the aged, blind, and disabled individuals.¹⁴ The program replaced the state-administered programs of Old Age Assistance, Aid to the Blind, and Aid to the Disabled and the combined Aged, Blind and Disabled program. Assuming responsibility for the administration of the SSI program was the Social Security Administration and fiscal responsibility lay with the federal government through open-ended federal grants. SSI has no work requirements although the aged, blind, and disabled

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under 65 must be referred to state-administered vocational rehabilitation services. Any refusal to accept recommended services makes the applicant ineligible for SSI.

SSI beneficiaries must be United States citizens or lawfully admitted resident aliens and must reside in the United States. Benefits are suspended in cases where the recipient is absent from the United States for more than a month. In addition, an individual is not eligible for benefits while a resident of a public institution that is not accredited as a medical institution under Medicaid.

In July 1973, under an amendment to Public Law 92-605, states were required to make supplemental payments to all persons receiving assistance whose incomes were reduced as a result of the transfer from a state to federal program. All states except Texas which is barred by its constitution from doing so have some form of supplement to the SSI payment. Any additional supplements were left to the states at their option. By 1975, the total amount spent for SSI was \$5,878,224,000. Of this amount the federal government paid \$4,313,538,000 with state supplements amounting to \$1,564,686,000.¹⁵

Since its inception, the SSI program has been praised and criticized. Two major criticisms are directed at its early implementation:

- (1) Too little time between enactment and the effective date of the law; and
- (2) Continual changes in the law during the planning period prior to the effective date of the law.

However, in many cases, SSI recipients are no worse off than under state programs and, in fact, some may receive higher benefits than they would have under the state administered programs.

Certain administrative and policy issues have yet to be resolved and in some cases the linkage between income payments and referral services on the state level has not been developed. Simplification of administration has not been

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achieved and there still is an uneasy mix of federal, state, and local involvement in the program. Moreover, the level of payment has not been adequate to support recipients and states have had to supplement federal payments. It is this supplemental payment by the states that signifies the program has not reached its goal of providing adequate income for the aged, blind, and disabled.

General Assistance. General assistance is designed for those persons who do not qualify under the AFDC or SSI programs. It receives no federal support and is administered by states and local governments. The eligibility standards vary from state to state. General assistance may include financial support in emergency situations only, in-kind or voucher payments, or financial support for intact families.

Public Assistance in Hawaii

In 1976 the department of social services and housing reported in its annual report for fiscal year 1975-76, that the public welfare division's costs increased by 31 per cent over 1975 to \$168.5 million. The total number of persons served by the division with money and medical payments increased from 91,892 in fiscal year 1975 to 116,208, a 25 per cent increase. There were 34,832 persons who received social services through the division; of these approximately 40 per cent were income eligibles or nonwelfare clients.¹⁶ Within the various sections of the division's programs, the department reported that the annual cost for money payments was \$87.9 million, \$65.3 million for AFDC, \$17.2 million for general assistance, \$3.5 million for SSI supplement, \$.8 million for Aid to Aged, Blind, and Disabled (AABD) state supplement; and \$1.0 million for Child Welfare and Foster Care. Medical assistance cost was \$60.3 million during fiscal year 1976 and the number of cases handled each month averaged 47,849. Food stamps served 105,133 individuals in fiscal year 1976 at a cost of \$59.8 million.¹⁷

The cost to deliver social services was approximately \$12 million; of this, \$7.2 million was expended through the purchase of services program. Social services reached 34,832 persons during the year.¹⁸

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Hawaii's public welfare program began in 1937. During that year, less than 2 per cent of the civilian population received financial assistance. The total program costs were \$1,096,179.¹⁹ The categories of persons receiving assistance included aged or blind, general assistance, and AFDC. By the end of the year 2 additional programs were instituted--foster parents and child care institutions for neglected, abused, and delinquent children. After World War II, the program experienced unprecedented growth. By July 1950 the caseload had reached a high of 11,860 cases involving 29,000 individuals. This program expansion required the governor to authorize raising the compensation and dividends tax rate which was earmarked for public welfare, transfer \$1.4 million from the governor's contingency fund, and request \$1.7 million from the legislature. The legislature, in return, granted the department's request for general funding instead of earmarked tax revenue.

By statehood in 1959, the basis for the modern public assistance program had been set by policies established by the public welfare board.²⁰ In 1961, the medical care program was transferred from the department of health to the department of social services and housing which added to the expenses of the program.

The period between 1965 and 1975 shows another era of unprecedented growth. "From 1965-66 through 1975-76, money and medical recipients increased 348 per cent from 19,873 monthly recipients to 89,178 and costs were up 12 fold from \$13.8 million to \$160 million."²¹ When food stamps only recipients are added, the total comes to 120,000 persons a month, or 15 per cent of the civilian population.

State legislative policy and federal laws contributed to the expansion of the program during these 10 years. In 1965, the assistance standard level was increased and in 1966, Hawaii became one of 6 states to implement Title XIX, Medicaid and Food Stamps. Under federal mandate Hawaii also adopted an income disregard program for Aid to the Aged, Blind, and Disabled (AABD) and Aid to Families with Dependent Children (AFDC) recipients. This provision was later extended to General Assistance recipients.²²

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With the cost of public assistance increasing at a steady rate, the department of social services and housing instituted a cost reduction program which was designed to revise the eligibility standards and improve administration. Policy revisions were made on General Assistance eligibility and standards and the income disregard component was discontinued for those persons on General Assistance who were fully employed. Partial flat grant was instituted effective July 1973, vendor payments were eliminated on all but exceptional cases, better medical utilization reviews encouraged deferment of elective surgery, and the use of a housing location program reduced excessively "high" rents paid by the department.²³

In 1974, the single able bodied caseload under general assistance had increased 50 per cent in 3 months from 2,541 to 3,802 cases a month. This prompted the legislature to enact Act 1, 1974 Hawaii Session Laws, which sets strict eligibility and work requirements for certain groups under general assistance. The program was named the Temporary Labor Force and provided that the department refer able bodied persons to work in public service jobs as a condition of receiving assistance.

A major shift in departmental policy occurred with the passage of flat grant. The traditional approach to public assistance was to provide payments for each benefit category under which a person was eligible. In 1965, the department began looking at instituting a flat grant system whose basic purpose was to:

- (1) Provide more equitable distribution of welfare benefits since the benefit amount will be the same for each person in the same category.
- (2) Improve efficiency and effectiveness in program administration by making the eligibility process more simple and economical.
- (3) Provide a valid yardstick for measuring who is eligible for income maintenance consistent with Supreme Court decisions.
- (4) Promote recipient's independence in budget planning and management and respect for the individual's dignity.

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- (5) Allow the legislature to select standard and benefit levels which Hawaii's fiscal resources can support.

The department began a partial flat grant system in 1973 which included a lump sum payment for 6 basic items and several special items based on size of family.²⁴ Expenses such as moving costs, shelter, rental deposits, and travel back to the mainland were excluded and placed on an "as needed" basis. Partial flat grant was applied to all categories of recipients except for General Assistance to single persons and childless couples.

Immediately after the program began, the department had a suit filed against it in court charging that it had no authority to initiate a flat grant program. The lower court agreed with the contention of the suit, but the Hawaii Supreme Court reversed that decision and in 1975, the legislature enacted Act 145, 1975 Hawaii Session Laws, authorizing a flat grant program leaving the question moot. The Legal Aid Society challenged the law in a court suit asking for an injunction to permit continuance of the shelter allowance in opposition to the department's policy revision to discontinue the benefit under flat grant beyond December 1975. The court denied the motion for a preliminary injunction.

Under a 1976 amendment, the legislature provided for a shelter allowance for cost paid up to a maximum of \$360 for 7 or more persons.²⁵

Child Support Enforcement Program. Title IV-D, Social Security Act, as amended, mandated states to establish a federal/state/county Child Support Enforcement program. The legislature responded with the passage of Act 137, 1975 Hawaii Session Laws. The program impetus comes from the "need to stabilize the escalating cost in the AFDC program" and equally important, "the conviction that children's rights to be supported by their legally responsible parents should be protected and familial relationship strengthened".²⁶

The program's activities include: paternity establishment, parent location, child support enforcement through law enforcement agencies, and collection of child support. Since its inception, the program has grown from a

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\$250 a month collection in January 1975 to a total of \$20,288 in June 1976. In terms of the potential for collection, this program still remains small. Ultimately, however, it is expected to have an impact on the AFDC costs by reducing the number of cases in which parental support is available and not being paid.

Comprehensive Annual Services Plan. Under Title XX, Social Security Act, as amended, a comprehensive annual service plan was developed to provide a legal base for the state to receive 75 per cent federal moneys for its 25 per cent share of the costs. Title XX has also demanded the state to do extensive program planning, monitoring, and evaluation, as well as provide for greater citizen participation in the department's social services program.

Money Payments. During the 1960's the department reorganized its operations and separated the income maintenance or cash payment function from the social services function. Cash payments cover the basic necessities of life such as food, clothing, shelter, and personal essentials. Within this program there are 4 categories: Aid to Families with Dependent Children and Aid to Families with Dependent Children-Unemployed Parents (AFDC-UP), Child Welfare and Foster Care, General Assistance, and Supplemental Security Income-state supplement. In addition to payments and eligibility determination, the division also is involved in monitoring errors in eligibility, child support activities as provided under the Child Support Program, Work Incentive Program,²⁷ and the Temporary Labor Force (TLF) Program.²⁸

Medical Assistance. Although discussed as a financial factor in the state's health care costs, medical assistance, and in particular Medicaid, is administered through the department of social services and housing on contract with the Hawaii Medical Services Association (HMSA) as the fiscal intermediary. This means that HMSA is responsible for all cash payment disbursements under Medicaid and for keeping records and information on Medicaid recipients.

There are basically 2 categories of persons qualifying for medical assistance, (1) those who qualify under welfare programs; and (2) those determined to be "medically needy".²⁹ Between 1975 and 1976, payments under

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the medical assistance program increased by 27 per cent to \$60.3 million. Most significant was the rise in the number of persons receiving benefits under the "medically needy" group which increased by 30 per cent between 1975 and 1976.

Federal matching funds are provided for certain categories of persons: AFDC, AFDC-UP, GA clients under 21 years, SSI-AABD clients in medical related cases. The state provides 100 per cent of the funding for GA clients over 21 years and for SSI-AABD clients utilizing family planning services, the federal government contributes 90 per cent of the costs.

Food Stamps. Food Stamps, administered through the United States Department of Agriculture and the state department of social services and housing provide low-income persons with a greater food purchasing power through a coupon system. In Hawaii, the number of individuals receiving food stamps benefits at the end of fiscal year 1976 was 105,133. Much of the increased costs are due to increased caseload especially among General Assistance recipients and the increase in the price of food and the cost of living. In addition, costs can be expected to continue their growth trends with the institution of an outreach program mandated by the federal government.

Social Services. Aside from the income payments, the department provides social services to families and individuals eligible under welfare programs. The services are delivered through a purchase of services delivery system in which private and public agencies are contracted to provide services to eligible persons. Exceptions to this are Foster Care, Adoption, Child and Adult Protective Services, and Veteran's Services which the department offers as a direct service. The total cost of the social services program was approximately \$12 million in fiscal year 1976, for some 34,832 persons. Of this amount, \$7.2 million went to the purchase of services program.³⁰

Constitutional Provisions in Other States

Over 30 states have no constitutional provision providing a public policy statement on public assistance. For most states, public welfare still remains a

county or local function and states may be involved as a conduit for receiving federal funds and disbursing them among the local governments. Where state involvement does occur, laws are enacted and constitutional authorization for such laws can be found under provisions relating to the plenary powers of the legislature or specific constitutional statements of responsibility.

Of the states that do have provisions referring directly to state responsibility for public assistance, many of them express that responsibility through financial provisions. For instance, in Georgia, the General Assembly may exercise its powers of taxation for "the payment of old age assistance to aged persons in need, and for the payment of assistance to the needy blind and to dependent children and other welfare benefits".³¹ North Carolina's Constitution provides that "proceeds of state and county capitation tax shall be applied to the purposes of...the support of the poor, but in no fiscal year shall more than 25 per cent thereof be appropriated"³² to welfare. This limitation on the expenditure level in the North Carolina Constitution presents a new element in constitutional provisions.

Oklahoma and New York have relatively elaborate constitutional statements on public welfare. Oklahoma's Constitution authorizes the legislature to provide by appropriate legislation for the relief and care of needy persons and to cooperate with the federal government on any plan to provide care and relief for the needy. An ad valorem tax is authorized to carry out legislation in public welfare and the Constitution establishes a public welfare department to effect the policies set forth in the constitution.³³

New York's welfare provisions are similar to Oklahoma's. The first section involves a statement of public concern on the "...aid, care, and support of the needy and the state's responsibility in the matter".³⁴ The article goes on to establish and empower a state board of social welfare to be responsible for state public assistance programs, inspection of institutions receiving state money, and all other duties assigned to it by the legislature.

California's public assistance provision authorizes the legislature under its plenary powers to "amend, alter, or repeal any law relating to the relief of

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hardship and destitution...."³⁵ Missouri lists public welfare as one of the areas in which state funds may be allocated.³⁶ It goes on to establish a social service department charged with promoting improved health and social services...."³⁷

Alaska's constitutional statement for public welfare simply states that the legislature shall provide for public welfare.³⁸

States run the 2 extremes in describing state responsibility for public welfare. On the one hand, most states do not have any explicit statement of responsibility for public welfare since direct programs have traditionally been the responsibility of the counties or local governments. Where constitutional provisions are explicit, descriptions are detailed of boards, departments, and program responsibilities. In some cases, fiscal limitations are set on expenditures for welfare or are at least listed as authorized expenditures under the taxation and budgetary powers of the legislature.

Constitutional Issues

Because of heavy federal participation in welfare and the increasing control the federal government is developing, states have less flexibility in determining an approach to welfare which may be innovative, unless that approach does not conflict with federal laws and rules. For the most part, state policies deal with the content of programs such as benefits, eligibility, and certain policies affecting standards for performance. Therefore, in considering constitutional changes, attention must be directed to federal program trends.

Entitlement to Public Assistance Benefits. The issue of welfare recipient's rights became prominent during the 1960's at the height of the War on Poverty and the Great Society Programs. Inherent in both was the underlying philosophy that client participation in developing policies and programs affecting them was important for program effectiveness in dealing with the problems of poverty. Out of that idea, the person eligible for services under the program actually worked in program administration jobs and sat on boards of directors and community boards making policy decisions. Citizen participation was

heavily emphasized and funds were provided for projects which enhanced the social, educational, and political awareness of the client group. It was out of this milieu, that activism among welfare recipients developed. By the late 1960's welfare rights groups had been formed and demands for higher benefits, changes in procedures and rules, and more self-determination on the part of the recipient were being heard all over the country. Evidence of political activism among welfare recipients can be seen in the number of court cases in which recipients charged public welfare departments with denial of privacy and denial of equal rights.

In 1966, the congressionally appointed federal Advisory Council on Public Welfare recommended that the Social Security Act be amended to provide, in cooperation with the states, a "new nationwide program of basic social guarantees".³⁹ The report went on to state that "welfare provisions must be based upon the premise that the statutory requirements governing the dispensation of public welfare services cannot be construed to supersede the constitutional rights that belong to every citizen."⁴⁰

The issue involved is entitlement, or whether a person or family with insufficient resources to maintain a decent standard of life is entitled to public assistance as a matter of right. In a broad sense, the federal government has provided for this right in the Social Security Act which contains entitlement provisions under federal eligibility requirements for assistance and care.⁴¹ These entitlement provisions are further reinforced through the United States Department of Health, Education and Welfare's rules and regulations.

Generally, the moral right of citizens to receive support in times of need is an accepted principle. However, states have established eligibility requirements which classify the types of individuals to receive public assistance. The constitutional issue is whether entitlement to public assistance should be specified in the constitution. If this right is specified, then the questions of to whom the right applies and under what conditions require resolution. Due process is another issue within the scope of the rights of public assistance recipients. Specifically 3 areas of due process are involved: right to information, right to privacy, and right to counsel. Court decisions

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and federal regulations have underscored the rights of public assistance recipients and applicants to due process of the law in their relationship to social service agencies. Presently, both federal and state statutes provide for the right to privacy. The federal law provides in part:⁴²

A State plan for aid and services to needy families with children must....(9) provide safeguards which restrict the use of disclosure of information concerning applicants or recipients to purposes directly connected with (A) the administration of the plan of the State approved under this part, the plan or program of the State under Part B, C, or D of this subchapter or under subchapter I, X, XIV, XVI, XIX, or XX of this chapter, or the supplemental security income program established by subchapter XVI of this chapter.

State law under section 346-10, Hawaii Revised Statutes, prohibits the department of social services and housing or its agents from divulging any information concerning the application and records of recipients and applicants. The only time information may be used would be as required in the administration of the program. Violation of the provision is punishable by a \$1,000 fine.

State statutory provisions make no mention of a recipient's right to information or counsel. Essentially, these rights are provided under the state constitution's bill of rights. However, since public assistance recipients fall into a category of persons who are eligible for public assistance, specific provisions concerning rights under those conditions may require consideration.

Residency. Imposition of a residency requirement for eligibility in welfare benefits has been seen as a solution to cut program costs. In his 1977 State of the State Address, Governor Ariyoshi proposed:

A constitutional amendment permitting states to establish residency requirements for new arrivals for publicly supported programs such as welfare assistance, public employment, and housing.

The legislative response to the governor's request was Act 211, 1977 Hawaii Session Laws, which imposed a durational residency requirement for public employment in Hawaii. A law suit was filed by the American Civil Liberties

Union (ACLU) on behalf of 4 individuals challenging the constitutionality of the law. Federal district court Judge Samuel P. King issued a temporary injunction restraining enforcement of the statute.

Durational residency requirements for public benefits or programs are not new to Hawaii's public assistance program. In 1971, the legislature passed a law requiring one year residency as a condition of eligibility for general assistance benefits. The ACLU filed a suit in federal court on the constitutionality of the law and the court issued a temporary restraining order. An appeal was sent to a 3-judge federal panel in the Ninth Circuit Court of Appeals, where the case died.

At the time of the appeal, the United States Supreme Court handed down its decision in the case of Shapiro v. Thompson.⁴³ The case involved applicants who had been denied public assistance in various jurisdictions because they had not been residents for one year prior to filing applications. In its decision, the Court held "that such a distinction created an invidious classification violating the equal protection clause. Since the underlying basis for the classification was the length rather than the fact of residency, the statutory schemes necessarily penalized the recent exercise of interstate travel..."⁴⁴ The Shapiro case recognized 2 principles relating to the right to travel: (1) there is a constitutionally protected fundamental right to travel that encompasses migration; and (2) the scope of the right to travel was significantly broadened by invoking the equal protection clause to encompass indirect infringements such as denial of benefits. In its adoption of the equal protection approach, the Court carefully distinguished between durational residency (waiting period requirements) and residence requirements.

Since the Shapiro case, other court decisions of the Supreme Court have struck down other durational residency requirements but the Court has refused to hold that all durational residence requirements unconstitutionally penalize the right to travel.⁴⁵ Most recently, in the case of Sosna v. Iowa,⁴⁶ the Court affirmed a lower court ruling that Iowa's one-year residency requirement for filing of divorce action was not unconstitutional.

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While solutions to the constitutional issue of residency remain clouded, the Supreme Court has been sympathetic to state policies on growth and the importance of "aesthetic, cultural, and social values that are preserved and promoted by limitations on population...."⁴⁷ Moreover, in 2 other subsequent cases the Court recognized the "importance of a state's articulation of its essential state functions".⁴⁸ For further discussion on this issue, see Hawaii Constitutional Convention Studies 1978, Article I: Bill of Rights.

Constitutional Alternatives

Constitutional changes in the area of welfare seem limited in view of increasing federal participation. However, there are some areas in which constitutional changes may be appropriate in anticipation of the evolution of public assistance in this country.

The present statement provides a general policy statement broad enough to accommodate changing programs. Yet, since the time this provision was written in 1950, social problems have changed as have the factors contributing to them. Essentially, public programs are designed to mitigate the harmful effects of these trends on persons who are unable to care adequately for themselves and return them to self-sufficiency as soon as possible. What needs to be decided is the degree to which public concern for social welfare will be specified in the Constitution.

Retain the Present Provision. The present provisions may be retained as it now reads:

- For:
- (1) The statement provides basic support for legislation by giving flexibility to the legislature to act within the best interest of the people.
 - (2) It provides an assurance of minimum programs by the nature of its assumption of responsibility and power to "provide assistance for persons unable to maintain a standard of living compatible with decency and health".

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- Against: (1) The broad policy statement seems too vague and lends itself to supporting a limitless number of programs and benefits creating a continually expanding program.
- (2) Broad statements also provide no specific direction or way of ensuring that the legislature or the executive will carry out the intent of the Constitution. Specificity which allows for identification of a goal or objective will provide greater program control and financial accountability.

Include Entitlement as a Matter of Right, as Well as Affirmative Guarantee of Rights. Entitlement as set forth in the federal laws may be adopted by the states as may an affirmative guarantee of a recipient's right to information, privacy, and right to counsel.

- For: (1) It would insure that persons in need of public welfare programs would be treated according to standards of procedural due process.
- (2) Welfare recipients should have the same information as others so that they may make intelligent choices in services and payments concerning their lives. A statement in the Constitution would insure that administrative rules and procedures follow the policy statement.
- (3) The state should ensure the rights of welfare recipients without regard to conditions imposed upon the state by the federal government. To maintain the privacy of an individual recipient, the Constitution should provide a statement which guarantees the rights of recipients to privacy.
- (4) The right to counsel would allow many individuals who are not familiar with the language or the procedures an opportunity to operate on par with welfare officials.

- Against: (1) Entitlement provisions are unnecessary since statutes can prescribe mandatory standards for welfare administration.

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- (2) If a situation does in fact exist concerning a recipient's right to information, present constitutional protection and guarantees allow for it to be remedied.
- (3) Constitutional action is not required as the federal government has a provision in its laws which provides protection against invasion of privacy and state statutes already afford confidentiality of records.
- (4) Having the right to counsel may lead to unnecessary demands for counsel causing great complications in welfare administration and increases in cost. At the same time, the presence of counsel implies that the recipient and the welfare administrator have an inherently adversary role.

Include a Residency Provision. While some type of residency provision has become popular as a way to control in-migration and expanding dependency on welfare, the key remains to find a residency provision which is not in violation of the United States Constitution and the Hawaii Constitution due process and equal protection clauses.

For: It would discourage persons coming into the state from depending on public assistance as a form of financial support. According to a department of social services and housing study, 33 per cent of the welfare recipients were in-migrants, accounting for 32 per cent of the total cost of welfare in Hawaii, or \$32.4 million.

Against: It is unnecessary, since statutory enactments could serve the same purpose. At the same time, the risk of imposing residency requirements involves the possible loss of federal funds.

Chapter 5 HOUSING

Development of Housing in the United States

Housing, as with other socially oriented programs had its roots in the Depression of the 1930's. Since that time, the government's role in housing has developed into an intricate and tangled system. Three broad principles have guided all action, however, during the years:¹

- (1) Recognition that it (federal government) had the responsibility to maintain and promote economic stability.
- (2) A social obligation to help provide for those in need.
- (3) An emerging interest in how the country's communities develop.

In December 1931, President Herbert Hoover called a conference on home building and homeownership. Part of the conference, a fact-finding body, identified the weaknesses and inadequacies in home financing but without recommending any specific legislation. It also became apparent that the nation suffered from inadequate home construction and rehabilitation and that further research was needed to understand the total housing system.

Meanwhile, the Depression brought chaos to the housing market. Approximately 50 per cent of all home mortgages were in default, foreclosures neared an astronomical rate of nearly 1,000 a day, and new mortgage lending or building was sharply reduced. As a response to this crisis, Congress enacted laws creating 3 emergency and 4 permanent agencies to exercise influence over the housing industry. The 7 agencies included the Reconstruction Finance Corporation,² the Federal Home Loan Bank,³ and Federal Home Loan System,⁴ the Federal Deposit Insurance Corporation,⁵ the Homeowners Loan Corporation,⁶ the Public Works Administration,⁷ the Federal Savings and Loan Insurance Corporation,⁸ and the Federal Housing Administration.⁹ The major thrust of the depression housing legislation was to stimulate the private sector to build housing and help individuals retain or acquire housing.

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Emergency loans went to faltering financial institutions through the Reconstruction Finance Corporation for housing projects benefitting low-income families and for reconstruction of slum areas. Long-term mortgage institutions received encouragement under the Federal Home Loan Bank System. The Federal Deposit Insurance Corporation and the Federal Savings and Loan Insurance Corporation provided new protections for small depositors dispelling fears of financial collapse.

New emergency loans to refinance defaulted and foreclosed home loans were made on a long-term self-amortizing basis by the Homeowners Loan Corporation. Jobs under the Public Works Administration provided for slum clearance and construction or repair of low-cost housing. Finally, the Federal Housing Administration offered long-term home mortgage loans for new construction, resale, and rehabilitation previously provided under the Home Owner's Loan Corporation.

The enactment of the National Housing Act of 1934 marked the beginning of a permanent involvement in mortgage credit and insurance by the federal government. Its provisions, however, did not allow for the necessary credit required by private lenders. In 1938, the Federal National Mortgage Association was created to fill the gap in the housing credit market. Its major function involved providing a conduit between savings and borrowers in need of new construction funds and encouraging the circulation of capital in the nation.

The U.S. Housing Act of 1937 represented the second major piece of housing legislation to come out of the Depression. It provided financial assistance to local public bodies for the construction of housing for low-income families. The Act made permanent on a modest scale the goals of slum clearance and low-cost housing as public policy. Through federal contract financing to pay the annual principal and interest on long-term tax exempt bonds and authorization of state and local property tax exemption, rents on the units built could be set at lower rates. Programs under this Act were administered by semi-autonomous local housing authorities established by state law.

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Using his emergency war powers, Franklin Roosevelt established the National Housing Agency in 1942 to centralize all federal housing authorities under a single administrator. Under this agency nearly 853,000 units of defense and war housing were provided by direct federal construction. Construction of private housing for war and defense efforts was authorized under the first special purpose Federal Housing Administration programs enacted in 1941 and 1942 as sections 603 and 608. The programs provided mortgage insurance to builders providing housing in "critical defense areas".

After the war, the federal government embarked on the "largest program ever enacted for a single target group--the homeownership program for veterans. Between 1944 and 1973, 8.7 million veterans loans were given totaling almost \$100 billion.¹⁰

The Housing Act of 1949 provided the clearest statement of a national commitment to housing. Section 2 of the Act states:

The Congress hereby declares that the general welfare and security of the nation and the health and living standards of its people require housing production and related community development sufficient to remedy the serious housing shortage, through the clearance of slums and blighted areas and the realization as soon as feasible of the goal of a decent home and suitable living environment for every American Family, thus contributing to the development and redevelopment of communities and to the advancement of the growth, wealth and security of the nation.

The Act continued the Urban Redevelopment Program (Title I), increased funds available for public housing (Title III), and established new programs for rural housing (Title IV).

Housing policies in the 1950's focused on meeting the needs of special groups and refining the operations of the housing program to prevent fraud. A presidential commission appointed by Eisenhower to study the situation made major recommendations which were to culminate in the Housing Act of 1954. The 1954 Act redirected and broadened the scope of urban development to include rehabilitation of existing structures and changed the name of the program to urban renewal. The Act further required communities to have urban renewal plans as a condition for receiving urban renewal and related federal aid.

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Congress also enacted a new mortgage insurance program under section 220 of the 1954 Act to stimulate housing credit and production in urban areas. Mortgage insurance terms were liberalized and the Federal National Mortgage Association was authorized to purchase mortgages.

Urban renewal, however, brought the problem of family displacement. Often buildings were cleared and families required to move without consideration of their need for shelter. Moreover, when new buildings were constructed on the same site, the cost of units often were above the level the displaced families could afford. To remedy the situation, section 221 of the 1954 Act provided for programmed occupancy in which displaced families received priority of opportunity to purchase or rent units in completed dwellings. In addition, consumer protection measures designed to avoid further frauds and abuses were also enacted, frauds under the various titles were identified, and legal loopholes closed.

Housing legislation in the 1960's took still another step in the evolution of government participation. Congress in 1961 passed a Housing Act whose principal feature was "the subsidized, below-market interest rate mortgage insurance program to assist rental housing for moderate income families".¹¹ This was the first time a direct loan program was instituted under the federal housing program. The 1961 Act further expanded the subsidy concept by allowing payments of up to \$120 a year on housing units occupied by the elderly poor in public housing projects. Again, this subsidy was the first ever given to finance the operating costs of housing projects.

The 1964 Housing Act extended the housing subsidy to families displaced by urban renewal and in 1965 it expanded to include large families with unusually low incomes in public housing projects. Two additional subsidy programs were begun under the Housing Act of 1965. The first was to provide a rent supplement program for federal payments to meet a portion of the rent for low-income families in privately owned housing built with FHA mortgage insurance. The other was a leasing program which authorized local housing authorities to lease units in privately owned structures and make them available to low-income families who qualify for regular public housing. In 1967, a

"turnkey method" was adopted in which private developers entered into a contract with local authorities to develop a project which upon completion was turned over to such local authorities.

The Department of Housing and Urban Development was established in 1965 providing a watershed in the development of public housing programs. Recognized for the first time on a cabinet level, the new department was charged with the duties of administering the federal housing programs and maximizing its effectiveness through cooperation with state and local authorities.

Urban disturbances of the 1960's again redirected federal housing policies. From reports submitted by 2 presidential commissions it was clear that renewed efforts needed to be directed toward the poor and a national 10-year goal set on the number of new and rehabilitated housing units to be developed. Out of these recommendations came the Housing and Urban Development Act of 1968 in which Congress reaffirmed the national housing goal and determined that it could be "substantially achieved within the next decade by construction or rehabilitation of twenty-six million housing units, six million of these for low- and moderate-income families".¹² This represented the first time that Congress had quantitatively expressed its national housing goal, affording a much clearer direction.

In 1969, an important change in the low-rent public housing program was made by section 213(a) of the Housing and Urban Development Act of 1969. The amendment limited rents charged by local authorities to 25 per cent of the tenant's income and authorized public housing subsidies for operations to assure the rental limitations were followed.

A subsidy program for persons displaced or relocated by federal housing programs was enacted under the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970. Persons being displaced by federal or federally assisted programs were given the right to receive relocation expenses and ensured having replacement housing before any move was effected.

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The Demonstration Cities and Metropolitan Development Act of 1966, more popularly known as "Model Cities" authorized government grants and technical assistance to city demonstration agencies to enable them to plan, develop, and improve their physical environment and increase the supply of moderate- and low-income housing.

An amendment to the Housing and Urban Development Act under Title IV in 1968 brought federal loan guarantees of principal and interest to private developers, if developments were sold to investors or at public sale as approved by the Department of Housing and Urban Development after they had met all other prerequisites with respect to development. This program has been re-enacted in a broader scope in Title VII of the Housing and Urban Development Act of 1970. The major function for the program was placed under a "New Community Development Corporation" which required that community development projects meet certain standards including requirements of providing substantial housing for low-income people.

Today the federal housing program has become a maze of laws, administrative procedures and programs often with conflicting goals or duplicate services. Yet, government participation in housing continues to grow.

Housing in Hawaii

The development of housing programs in Hawaii closely parallels the federal housing law. In its Housing Act of 1947, the legislature declared that "there is an acute shortage of housing within many areas of the State...it is imperative that action be taken immediately to assure the continued availability of housing developed and administered under" state law and "to authorize the Hawaii Housing Authority to do any and all things necessary or desirable to develop and administer housing..."¹³ under state or federal laws. The Act gave the Hawaii Housing Authority responsibility to develop and administer housing and property, borrow money and accept grants, cooperate with the federal government, and do anything necessary to carry out the purposes of the statute.

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In 1949, the legislature passed the Housing Act of 1949 which reiterated the acute housing shortage facing the state and provided for immediate development of "permanent housing to meet the particular needs of the emergency that exists and when such emergency no longer exists the permanent housing projects so constructed will be used to house persons of low-income...."¹⁴ Specific provisions included providing the Hawaii Housing Authority with powers to construct, operate, and maintain housing projects where the housing is insufficient and private enterprise is not meeting the need; the extension of powers to cooperate with the counties; the authorization of a rental program including tenant selection; and the authorization to borrow federal funds.

Since that time housing has been one of the most active areas of legislative concern. Probably the most important piece of legislation in the field is Act 105 known as the Omnibus Housing Act of 1970. In the purpose section of the law, the legislature cited studies which showed the need for 40,000 to 50,000 housing units while noting the fact that since 1961, less than 10,000 units had been produced annually. To conclude, the legislature "determined that the problem of providing reasonable priced housing in Hawaii is so complex that existing institutions cannot solve it without a comprehensive overview and direction. The legislature has determined that the problem must be resolved for the general well-being of the State and that the legislature has the duty to provide the overview and the direction".¹⁵

Under Act 105, the Hawaii Housing Authority has the power to raise money through the sale of general obligation bonds to:¹⁶

- (1) Acquire private land by condemnation, negotiation, or exchange and to pre-empt state lands for housing.
- (2) Develop lands for housing, either alone or in partnership with private developers. It may also sell, rent, or lease the completed units.
- (3) Provide long-term mortgages and interim construction loans to public agencies or persons.

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- (4) Experiment with training programs and building materials.
- (5) Seek building authorization directly from city councils.

The legislature strengthened Act 105 by giving it greater flexibility through an amendment in 1974.¹⁷ The amendment:

- (1) Permitted the state to consider the condition of the unit and other factors before buying back housing from a purchaser who wished to sell. Under the original "buy back" provision, the state had no such option.
- (2) Consolidated all housing funds into a single fund.
- (3) Defined eligibility for housing as low-income families. Those owning any land suitable for dwelling were declared ineligible under Act 105.

In addition, the Act provided for contractual staff, implemented an interest assistance program called the "Housing Opportunity Allowance Program", allowed the authority to land bank, and included commercial and industrial uses in authority projects.

Land reform acts have also played a major role in Hawaii's housing program. While there is no scarcity of land per se, in Hawaii, availability of land for housing purposes has been a major problem. According to a 1971 study by Marshall Kaplan, Gans, Kahn, and Yamamoto,¹⁸ much of the available land is on mountainous terrain, the neighbor islands, and remote areas of Oahu. Major ownership of lands in Hawaii falls into 3 groups: State of Hawaii--39 per cent; federal government--10 per cent; and large private ownership--45 per cent, tying up 95 per cent of the available land. This leaves only 5 per cent of the land for small private owners.

To allow for more individual ownership of land, especially residential lots, the legislature passed a series of 4 acts. The first was Act 307, 1967 Hawaii Session Laws, which gave the Hawaii Housing Authority the power to compel a landowner to sell homesites to leaseholders under the condition that there must be a minimum 5-acre development with at least 50 per cent of the lessees in favor of purchase. Attempts to implement this law led to legal action and in 1975, the legislature clarified the legal issues through Acts 184 and 185.

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Act 184 outlined the condemnation procedure by:¹⁹

- (1) Establishing a new and simplified method of determining the value of the owner's leased fee interest;
- (2) Requiring only 51 per cent or 25 lessees, whichever is less, to make a commitment to purchase the fee simple interest in their lands.
- (3) Specifying the necessary format commitments each lessee must make in advance, including a written contract with the Hawaii Housing Authority, proof of ability to make financing arrangements, and a posted bond.
- (4) Including a "first refusal" clause to prevent speculation.
- (5) Specifying the landowner's obligation to the lessee upon lease termination, without conversion, to include compensation at fair market value for all improvements owned by the lessee.
- (6) Guaranteeing that trust officers would not be in violation of their office to permit conversions under the law.

An appropriation of \$1.3 million for use under Act 307 and Act 184 was also provided.

In Act 185,²⁰ the legislature established a procedure for the renegotiation of lease rents not converted to fee, with a maximum rate increase determined by fair market value of the land. The law also set a 15-year minimum period between renegotiations and assigned the Hawaii Housing Authority as the arbitrator for deadlocked negotiations.

Act 242 was passed by the 1976 legislature to eliminate the original method of appraisal for condemnation and offer 2 alternatives. The law was specifically applicable to a land area in Manoa Valley slated for purchase in fee by the leaseholders. By the end of the fiscal year 1976, the issue had been taken to court to be resolved.

The Hawaii Housing Authority administers 5 major housing programs:

- (1) Federally aided low-rent housing involves the development of housing for low-income families with rent being set at a level to cover the cost of operations only. The U.S. Department of

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Housing and Urban Development provides a subsidy to the state to cover the bond amortization and interest payments.

- (2) Elderly housing has received special emphasis by the Hawaii Housing Authority and the legislature. In 1976 new programs for elderly housing were enacted including a redefinition of "elderly" to persons 62 years and older, authorization of special elderly housing projects similar to projects under Act 105, increase in the maximum supplement for elderly persons in the state rent supplement program, and authorization to use available money in the general building fund to complete federal projects whose appropriations have run dry.
- (3) State nonsubsidized projects provide the Hawaii Housing Authority the power to offer low-rent housing without reliance on federal subsidies. Nonsubsidized housing tenants have the option to become homeowners by dedicating 20 per cent of their rent to downpayment on a future home.
- (4) Federal leased housing program leases out housing units in communities with a 3 per cent vacancy factor to low-income families at 25 per cent of their adjusted gross income. If the rents do not cover the cost of the lease, then the U.S. Department of Housing and Urban Development reimburses the state for the difference.
- (5) Hawaii state rent supplement program authorizes the Hawaii Housing Authority to help families who do not qualify under federal housing requirements with rental assistance up to \$70 paid directly to the landlord. The Authority certifies each individual family and provides up to 20 per cent of their adjusted gross income for rent.

In addition to these basic programs, the Hawaii Housing Authority has also been involved in some innovative programs including the housing management improvement program designed to provide more efficient and effective management, maintenance, repair, and rental services at the housing projects. Two other experimental projects involved the Minimum House built by nonprofessionals at a cost of \$6,000 and the Hawaii Energy House which is testing the use of natural energy to provide up to 75 per cent of all utility needs.

In its examination of the state's role in housing, the CORE Report noted that the state government was able to affect the housing supply and demand in Hawaii. As a result, it went on to recommend that the state "continue to act as

fiduciary for low-income housing by making land available from land banking or by providing funds to qualified developers.... The State should be prepared to increase the funds for this purpose in Act 105, Session Laws of Hawaii 1970".²¹

Moreover, the report noted that:²²

The state government [should] facilitate the development of housing by (a) ensuring that appropriate land is made available even if some land use boundaries will have to be changed and provide impact statements therefor; (b) providing land in large parcels in accordance with master planning for mixed income populations and community development and provide impact statements therefor; (c) controlling the cost of land for future development by coupling price restraints with urbanization of agricultural lands, outlawing "sandwich" leases, and purchasing by the State of available, centrally located land [land banking] for subsequent lease to developers; (d) providing some of the public improvements necessary to the development of new subdivisions, and (e) petitioning the federal government for the release of surplus lands.

The Commission on Organization of Government in its report to the Ninth Legislature in February 1977 recommended that the "[c]ounties should have responsibility for the administration of rent supplement programs and have primary responsibility for actual development of housing for both sale and rental. The Hawaii Housing Authority while continuing to be responsible for low-income housing, should provide financial assistance to County programs which conform to the Hawaii State Plan. Its development role should be limited to instances where a County elects not to develop housing in accordance with the State Plan."²³

Housing: A Constitutional Amendment

Among the sections in Article VIII, the housing provision is the only one that has been amended. In 1975, the Hawaii electorate voted to amend the housing provision in the Constitution to delete the phrase "including housing for persons of low income" and substituted the phrase "and the exercise of such power is deemed to be for public use and purpose". The reason behind the change was the intention to expand the constitutional authorization to include

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programs for persons other than those who qualified under low-income definitions and to give the Hawaii Housing Authority flexibility to respond to the state's overall housing needs. As it previously stood, the Constitution seemed to imply a limitation on activities engaged in by the state to low-income families.

The amendment resulted from a ruling by bond counsel that the Hawaii Housing Authority could not issue general obligation bonds for the "gap group", those who are not in the low-income group yet do not qualify for private financing, housing projects. In Hawaii, a substantial number of persons fall into this group and their need for housing is as real as those of the low-income group. The 1975 CORE Report cited a 1970 lieutenant governor report on housing which stated that an annual income of \$15,000 would be required for eligibility for a typical mortgage and only one-eighth of the families on Oahu would qualify. In the last 8 years since that report was filed, the amount has risen in relation to the rate of inflation.²⁴

Passage of the amendment has provided Hawaii Housing Authority the power to develop housing for both low- and middle-income families. Even beyond that, the implication of the new amendment is the state's commitment to continue to expand its participation in the area of housing.

Constitutional Provisions in Other States

Besides Hawaii, only 6 other states have specific constitutional provisions on housing. The simpler provisions provide for slum clearance and rehabilitation. The more complicated ones include the creation of a housing program. In California, for instance, the public housing project law was adopted by initiative and provides that the majority of the electorate of a city, town, or county must approve a low-income housing project before it can be developed, constructed, or acquired by any state public body.²⁵ The Article goes on to state that the provision is self-executing but legislation not in conflict may be enacted to facilitate its operation.

Probably the most comprehensive and detailed provision on housing is found in New York's Constitution. The Article begins by providing that the New York state legislature may provide low-rent housing as defined by law or for the "clearance, replanning, reconstruction, and rehabilitation of substandard and insanitary areas".²⁶ The Article goes on to authorize actions of the legislature including: subsidies to cities, counties, towns, or public corporations from the general fund; loan guarantees and loans for providing housing facilities or rehabilitating multiple dwellings for occupancy by low-income individuals; granting of tax exemptions; cooperating with the federal government; and granting power of eminent domain.

Section 3 authorizes the state to contract indebtedness up to \$300 million without electorate approval over a period of not more than 50 years. After January 1, 1942, additional debts may be incurred upon approval by popular vote. The legislature is authorized to make capital or periodic subsidies not exceeding \$1 million in new contracts in one year or \$5 million in aggregate payments in one year, except as authorized by popular vote.

Section 4 gives the legislature the power to authorize political subdivisions to "contract indebtedness for housing purposes not to exceed 2 per cent of the assessed valuation of real estate in that unit, averaged over the five preceding years".²⁷ In addition, another 2 per cent indebtedness is allowed, provided the legislature arrange repayment by means other than ad valorem taxes on real estate.

Section 6 limits state loans to those purposes stated in section 1 and gives preference to low-income families living in the project under redevelopment. Section 7 defines "indebtedness contracted" in cases where a loan guarantee is made by the state or its political subdivision on behalf of a public corporation.

Sections 8 and 9 permit the legislature to grant powers of eminent domain to political subdivisions and public corporations to acquire property for the purposes stated in section 1. Section 10 enables the legislature to enact laws "necessary and proper for carrying into execution"²⁸ the powers provided for in the Article.

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This Article was drafted in 1938 by a constitutional convention wishing to close any loopholes that would hinder maximum development of a comprehensive housing program and to "circumscribe the legislature's powers somewhat to prevent any rash bursts of legislation that would favor urban areas generally and New York City in particular;..."²⁹ The fear was that the legislature might allow excessive accumulation of debt adding heavy tax burdens on the population.

A 1958 reassessment of the constitutional provision was done from the point of view of statutory implementation, judicial interpretation, and administrative operations. It was concluded that the fears of the 1938 constitutional delegates seemed unfounded. Yet, the trend in housing development on the federal level had been to provide greater latitude and flexibility to the state legislatures to experiment in the methods of developing housing to promote the public good. The report concluded that in New York's case, it would be prudent to review the provisions with the intention of allowing more flexibility on the part of the legislature to act in response to housing needs without sacrificing certain basic controls now provided for. These include authorization powers regarding loans to private housing corporations and excess debt authorization. The major recommendation involved re-evaluating the constitutional debt limitations to ensure that it does not frustrate programs having access to federal funds and not requiring real estate tax support.

Both New Jersey and Rhode Island Constitutions contain a statement of public purpose which declares "the clearance, replanning, redevelopment, rehabilitation, and improvement of blighted and substandard areas shall be a public use and purpose for which the power of eminent domain may be exercised, tax monies and other public funds expended, and public credit pledged".³⁰

Housing Issues

Provisions in Hawaii's Constitution since the 1976 amendment have considerably broadened the scope of state responsibility in housing. Previously, the statement contained reference to low-income families which clearly limited state activity to a specific client group. The addition of the phrase "the exercise of such power is deemed to be for a public use and purpose" eliminates the client group limitation and allows discretion on the part of the legislature and the executive to determine standards of public good and act within that standard to remedy housing problems.

In 1975, the federal government instituted a housing allowance program akin to the Food Stamp program. The idea behind housing allowances was to give people enough cash to make up the difference between what they could afford to pay and what decent housing cost. The program was begun as an experimental pilot project involving 15,000 to 20,000 individual families at a cost of \$230 million. In a message to Congress in 1973, former President Nixon stated that:

To make decent housing available for all low-income families without the housing "project" stigma, the loss of freedom of choice and the inordinately high costs of current programs...direct cash assistance is the most promising approach to help such families.

Four principles provided the foundation for the program:

- (1) Expansion of consumer choice;
- (2) Providing landlords with sufficient revenues to remove housing code violations and maintain and upgrade their properties;
- (3) Administrative simplicity through elimination of intermediaries which administer local housing programs; and
- (4) Greater economy in providing benefits in this manner than through public housing construction.

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By definition, all households falling in categories of persons who are presently not living in decent housing and those paying excessive portions of their income for housing, such as public assistance recipients living in available housing which may be exorbitant or expensive, are entitled to the housing allowance. Its implications are that the program establishes the "right" of all Americans to live in decent housing and guarantees the right through providing necessary subsidies.

In a 1976 report by the U.S. Department of Housing and Urban Development (HUD), the Experimental Housing Allowance Program (EHAP) concluded that the "equal opportunity policy in EHAP is viewed by the National Urban League as the most positive step yet undertaken by HUD in the area of equal opportunities. While the EHAP equal opportunity policy may be interpreted merely as establishing a required HUD standard for affirmative action, it can also be viewed as a commitment by HUD to obtain equal access results in any contemplated national housing allowance program".³¹

Federal policy has always been concerned with providing equal access for all groups. The 1968 Civil Rights Act prohibits discrimination in the sale or rental of private housing and several federal agencies have taken administrative steps to equalize access to mortgage credit, federally insured housing, and subsidized housing. During 1966, Congress considered the creation of a Fair Housing Board with powers similar to the National Labor Relations Board. If the board had been established, it would have relevance in today's situation. Evidence to date shows that state and local governments tend to ignore the federal government's equal housing opportunity responsibility.

Hawaii's constitutional provision presents the state's responsibility in the matter of housing, but does not necessarily ensure a "decent home" for all. Legislative acts, in their findings and purpose clauses, describe conditions which require correction. Yet nowhere in the law is there an affirmative statement of right to a decent home. The clearest statement of the legislature's responsibility in housing is the one found in Act 105:³²

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The Legislature of the State has determined that the problem of providing reasonable priced housing in Hawaii is so complex that existing institutions cannot solve it without a comprehensive overview and direction. The legislature has determined that the problem must be solved for the general well-being of the State and that the legislature has a duty to provide overview and the direction.

Constitutional Alternatives

Alternative provisions in housing deal with 2 basic issues: (1) the right to a decent home; and (2) a prescription of the method by which the responsibility is to be fulfilled.

Expressing Policy with Respect to the Needs of the People. The housing problem in Hawaii is clear. There are not enough housing units available which people can afford to purchase. The question facing the Convention is the state's role in solving the housing problem.

1. Retain the present provision. Retention of the present provision will continue the direction of the present housing program and its approach to the issue.

For: Hawaii's housing provision provides a clear definition of the state's role in housing which includes providing and assisting in housing, slum clearance, and the rehabilitation of substandard areas which are considered areas of public interest.

Against: The statement does not provide a broad enough perspective for housing program development over the next 10 years. Clearly from national housing trends, the idea of community development is becoming more prominent. Community development includes the basic activities of housing development, slum clearance, and rehabilitation of substandard areas but goes beyond to allow for the inclusion of such factors as the environment, land use, social, health, and economic considerations.

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2. Modify the present provision. Modification of the provision involves an affirmative statement of the state's responsibility expressed in terms of the right of the people to a decent home.

- For:
- (1) Declaration of rights are essentially self-operative provisions requiring no legislative or executive action. It offers a stronger commitment to solving the housing issues which is manifested in a stronger role by the state. Where necessary and not in conflict, statutory provisions may be enacted to carry out the constitutional intent.
 - (2) A statement of rights provides for accountability of government action. The clarity of the statement gives the citizenry the option to monitor state actions to see if the constitutional obligation is being fulfilled. Where the obligation is being neglected, under a statement of rights, citizens have the power to bring suit in the courts demanding the state fulfill its obligation.

- Against:
- (1) Any statement of rights, particularly in the case of the right to a decent home involves fiscal repercussions. With the magnitude of the housing problem in Hawaii it may be fiscally irresponsible to declare a decent home as the right of every citizen unless some provision for the financial consequences of fulfilling such a promise is provided.
 - (2) Expressing an essential "benefit" as a "right" could lead to judicial relief if any individual felt rights were being denied. Although instituting a suit is a way of drawing attention to the issue, its ultimate accomplishment may detract from the issue at hand. Too many suits will most likely place a heavy burden on court calendars, not to mention the possible hiatus in any program activity under injunction.

Prescribing the Method by Which Responsibility is to be Fulfilled. Broad constitutional mandates set direction for the legislature but leave the specific method or approach to statutory language or program development. If the Constitution is considered to be a prescriptive document, then some specificity will be required to give the legislature the basic direction in fulfilling its responsibility.

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- For:
- (1) In response to the report by the Governor's Commission on the Organization of Government, reference should be provided to clarify state and county partnership in the development of housing programs. Previously, counties play little or no part in the development of housing projects except those which they may develop on their own initiative. The only areas most counties were active in are urban redevelopment and slum clearance and rehabilitation. Since 1974, however, each county has established a county housing department and federal trends seem to be moving in the direction of providing more housing funds to local governments.
 - (2) Expanding county participation in housing could relieve the state of some fiscal liability and indebtedness. Moreover, it would change the role of the Hawaii Housing Authority from an agency involved in actually developing and running housing development to a planning and coordinative policy making agency with the counties involved in the actual development and operations of housing.
- Against:
- (1) Act 105, the State's Omnibus Housing Act, through Act 179, 1974 Hawaii Session Laws, provides the counties with the same powers as the Hawaii Housing Authority in the development of housing in their respective counties. Consequently, constitutional provisions would be redundant.
 - (2) General obligation bond indebtedness for housing projects are not considered as part of the state's constitutional debt because these bonds could qualify as self-sustaining from project revenues; therefore, any fiscal relief for bond indebtedness would be negligible.

Chapter 6

PUBLIC SIGHTLINESS AND GOOD ORDER

Development of Public Sightliness and Good Order

Concern for the environmental aspects of life in Hawaii is found in section 5, Article VIII. According to the proceedings of the 1950 Constitutional Convention, the purpose of including the article was to emphasize that "in order to maintain the proper health of a people, it is necessary that they have available to them parks, playgrounds, and beaches where everyone may obtain fresh air, sunshine, and the opportunities for recreation...." The described purpose of the section is to "emphasize that public sightliness is basic to the total health program of a community".¹

The 1968 Constitutional Convention Study reviewing Article VIII made the following observations of section 5:²

Section 5 is subject to a variety of interpretations. In some respects the provision is a conservation article, especially with its specific attention to "natural beauty" and "places of historic and cultural interests". Viewed in this light, the state's activity in billboard regulation, park and beach development, and preservation of historic sites falls well within the perimeters of this article. In other respects, the section may be seen as one of environmental appearance control under which building codes and regulations, housing and sanitation codes, junk car disposals, garbage and trash regulations are covered. Finally, Article 5 may be viewed as designed to protect total environmental health, directed not only to appearance of the environment but its safety as well. Support for this view could be found in the references during the debates to the citizen's right to "fresh air and sunshine". Accepted in these terms, the section provides supplementary support to the conservation article authorizing the State's anti-pollution measures in air, water, and land use.

During the 1968 Convention, deliberations on section 5 included specific language calling for "a constitutional basis for positive action in such specific areas of concern as air and water pollution, noise abatement, environmental health and welfare, and fish and wildlife control".³

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Some members of the Committee on Public Health, Education, and Welfare, Labor and Industry "felt very strongly that the state's responsibility in the area of environmental health should be specified somewhere in Article VIII". However, a majority did not agree with this viewpoint. Yet the committee made note that it was "fully cognizant of...the growing problems of contamination, noise abatement and other aspects of environmental health".⁴ It concluded that "all proposals for changes in section 5 are unnecessary because the recommended public health programs are already being carried out and others can be initiated under the broad grant of legislative power in Article VIII, sections 1 and 5."⁵

Standing Committee Report No. 32 submitted by the Committee on Agriculture, Conservation, Land and Hawaiian Homes, commented that the "language in Article VIII is broad enough to provide a basis for implementing the ecological, geological, and archaeological interests and other problems relating to environmental well-being by legislative enactment. These specifics⁶ should not be included in the basic guidelines contained in the Constitution. Section 5 sets the policy and selection of specific objects and places should be consistent with this policy. Details are not the function of a constitutional provision and should be left to the legislature."⁷

In the 1967 case of State v. Diamond Motors, Inc.,⁸ the Supreme Court ruled:

We accept beauty as a proper community objective obtainable through the use of the police power.... The term "sightliness and physical good order" does not refer only to junk yards, slaughter houses, sanitation, cleanliness, or incongruous business activities in residential areas as appellants argue.

The Court made clear that the language of Article VIII, section 5, is a broad grant of legislative power. Moreover, Article VIII, section 5, provides for the reasonable regulation of private property for the purposes stated in the section.

Public Good and Sightliness in Hawaii

Historic Preservation. In 1976, the state legislature enacted a comprehensive historic preservation law making historic preservation mandatory for the state. Previously, the program was limited to public activities and historic preservation of public lands. The new law reorganizes the provisions in the old law and expands historic preservation to include the preservation of artifacts, sites, and other historically significant items found on private property.

Most significantly, the new law declared historic preservation as a matter of public policy that the state:⁹

- (1) Provide leadership in preserving, restoring, and maintaining historic and cultural property;
- (2) Ensure the administration of such historic and cultural property in a spirit of stewardship and trusteeship for future generations; and
- (3) Conduct activities, plans, and programs in a manner consistent with the preservation and enhancement of historical and cultural property.

Historic Preservation in Hawaii, the state plan, was published in February 1976 providing a philosophical, planning, problems and survey, inventory, and registration of sites overview. According to the plan, the primary goal of the program is to "integrate historic preservation planning into public and private planning and actions".¹⁰

Environmental Preservation. Environmental preservation activity has increased over the last 10 years. The department of health's environmental protection division has been the fastest growing unit and is now responsible for handling reviews of sewage treatment plants, pollution investigation and enforcement, vector control, noise and radiation control, sanitation, and food and drug. It is also responsible for environmental planning which involves coordination of state and county plans.

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In addition to the department of health, the state has an office of environmental quality control¹¹ responsible for stimulating, expanding, and coordinating efforts to determine and maintain the optimum quality of the environment of the state.

Probably, the most important provision in the statutes is the state environmental policy statute, chapter 344, Hawaii Revised Statutes, which establishes "a state policy which will encourage productive and enjoyable harmony between man and his environment, promote efforts which will prevent or eliminate damage to the environment and biosphere and stimulate the health and welfare of man and enrich the understanding of the ecological systems and natural resources important to the people of Hawaii".¹²

The policy statement itself provides a commitment of the state to safeguard its "unique natural environmental characteristics in a manner which will foster and promote the general welfare, create and maintain conditions under which man and nature can exist in productive harmony, and fulfill the social, economic, and other requirements of the people of Hawaii".¹³ In enhancing the quality of life, the policy includes methods of accomplishing the goal. These include population limitation, economic diversification, social satisfaction, and a commitment to preserve the natural environment. The guidelines provided in the law cover a series of areas including population, land, and natural resources, flora and fauna, parks, recreation and open space, economic development, transportation, energy, community life and housing, education and culture, and citizen participation.

In addition to these major provisions other departmental programs contribute to public sightliness and good order. These include the department of land and natural resources and its programs in natural resource development and conservation, and the department of planning and economic development through land use planning activities, state policy plan, coastal zone management program and other programs designed to create a balance between the consumption needs and conservation of the environment.

Environmental Rights and the Constitution

Constitutional protection of the environment has become a major policy issue, particularly in Hawaii where the tension between the consumption needs of the people appear to be in conflict with the preservation and conservation forces. While this discussion will focus on constitutional declarations concerning the physical environment, it should be kept in mind that "public sightliness and good order" encompass not only the physical, but the social, economic, and aesthetic environment. Therefore, the whole discussion should be considered within this broad context.

Constitutional rights to environmental protection provide a higher level of commitment than common statutes and can be viewed as the "ultimate repository of a people's considered judgment about basic matters of public policy".¹⁴ In all states that have included environmental declarations in their constitutions, the proposals have won by overwhelming margins.¹⁵

The impact of a constitutional declaration is that it guarantees citizens the right to a decent environment and requires all state agencies to consider the impact of their decisions on the environment. Moreover, constitutional declarations offer goals and guidelines for legislative and executive action. Once a declaration is part of a constitution, citizen challenges in the courts hold the government responsible for its obligations.

Constitutional Provisions in Other States

For the most part, constitutional provisions dealing with the environment are general policy statements, lacking specificity. Unlike the basic bill of rights whose generality such as "freedom of speech" acquires meaning and definition out of a specific historical experience which created a common understanding of that right in the community, an environmental bill of rights lacks that historical experience.

PUBLIC HEALTH AND WELFARE

In Illinois, the constitutional provision reads:

The public policy of the State and the duty of each person is to provide and maintain a healthful environment for the benefit of this and future generations. The General Assembly shall provide by law for the implementation and enforcement of this public policy.

Each person has the right to a healthful environment. Each person may enforce this right against any party, governmental or private, through appropriate legal proceedings subject to reasonable limitation and regulation by law.

The key to this provision lies in the definition of "healthful". Depending on the interpretive standards of "healthful", this provision could include mental or physical injury or be as general as "that quality of physical environment which a reasonable man would select for himself were a free choice available".¹⁶

Pennsylvania and Massachusetts mandate "clean air" and "pure water". The Massachusetts provision recognizes the "right of the people to clean air and water, freedom from excessive and unnecessary noise and natural, scenic, historic, and aesthetic qualities of their environment; and the protection of the people in their right to the conservation, development and utilization of the agricultural, mineral, forest, water, air, and other natural resources is hereby declared to be public policy".¹⁷

New Mexico's Constitution states that the "protection of the state's beautiful and healthful environment is hereby declared to be of fundamental importance to the public interest, health safety and the general welfare".¹⁸

In New York, North Carolina, and Virginia the constitutional statements express environmental and aesthetic responsibilities in terms of public policy.

Constitutional Alternatives

Campaigns to include an environmental bill of rights in constitutions have been increasing over the last 10 years. With the developments in environmental health, historic preservation, and natural resource development, a review of section 5, Article VIII, may be in order.

PUBLIC SIGHTLINESS AND GOOD ORDER

Retain the Present Provision. Retention of the present wording will continue the direction of environmental and historic, scenic, and cultural development without much change.

For: Constitutional proceedings from 1950 and 1968 show that delegates in both conventions intended for this provision to be a broad grant of legislative power to protect total environmental health.

Against: The terms "public sightliness and good order" seem vague and out-of-date. Changes to reflect the present view of environmental conservation are necessary to support the state in its goal of having a socially, economically, aesthetically, and physically balanced environment.

Establish an Environmental Bill of Rights.

For: (1) A constitutional bill of rights provides a strong commitment and basis for state activity by establishing state goals and guidance for state agencies.

(2) Adherence by state agencies to the principle set forth in the environmental bill of rights would be mandatory thereby assuring total state commitment. Moreover, the provisions would also extend over the private sector offering a basis for enforcement of environmental policies.

Against: (1) Hawaii has already adopted an environmental policy statement which provides the goals and guidelines of the state.

(2) The experience of other states with provisions relating to the environment shows the difficulty in having such a provision be effective particularly since language used to describe that environmental condition to be achieved has remained vague. Moreover, unless it is a self-executing provision, any statement will be only as effective as the commitment of the legislature to the state's environment.

FOOTNOTES

Chapter 1

1. Tax Foundation of Hawaii, *Government in Hawaii*, 1976 (Honolulu: 1976), pp. 40-41.

Chapter 2

1. The term "social services" as used in this discussion includes health and housing programs.
2. National Association of Social Workers, *Encyclopedia of Social Work* (Washington: 1977), p. 1310.
3. *Ibid.*, p. 1304.
4. *Hawaii Const.* art. VIII, sec. 1.
5. *Hawaii Const.* art. VIII, sec. 2.
6. *Hawaii Const.* art. VIII, sec. 3.
7. *Hawaii Const.* art. VIII, sec. 4.
8. *Hawaii Const.* art. VIII, sec. 5.
9. Hawaii, Constitutional Convention, 1950, *Proceedings*, Vol. I, p. 60.
10. *Ibid.*
11. Hawaii, Constitutional Convention, 1968, *Proceedings*, Vol. II, p. 427.
12. 42 U.S.C.A. secs. 1395c to 1395w (1965).
13. 42 U.S.C.A. secs. 1396a to 1396d (1965).
14. 42 U.S.C.A. secs. 299 to 299j (1965).
15. 42 U.S.C.A. secs. 295f to 295g (1965).
16. *Comprehensive Health Planning and Public Health Services Amendments of 1966*, Pub. L. No. 89-749, 80 Stat 1180.
17. *Ibid.*
18. *Economic Opportunity Act of 1964*, Pub. L. No. 88-452, 78 Stat. 508.
19. Health maintenance organizations are organizations providing medical care developed along the lines of a prepaid group practice or individual practice.
20. National Association of Social Workers, *Encyclopedia of Social Work*, Vol. 1 (Washington: 1977), p. 529.
21. U.S., Department of Health, Education and Welfare, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement 1975* (Washington: 1976), p. 187.
22. The Hill-Burton Act authorized federal funds for the construction of hospitals and medical facilities.
23. The Organic Act provided for the Government of the Territory of Hawaii. It was enacted on April 30, 1900 by the Congress of the United States.
24. *Organic Act*, sec. 55.
25. Hawaii, Department of Health, *Annual Report, 1975-76* (Honolulu: 1977).
26. 1965 Haw. Sess. Laws, Act 97, sec. 1.
27. Details of the deinstitutionalization program can be found under discussion entitled "Care of the Handicapped".
28. Hawaii, Department of Planning and Economic Development, *Data Book 1976, A Statistical Abstract* (Honolulu: 1976), p. 135.
29. *Ibid.*
30. *Ibid.*
31. Eagleton Institute of Politics, Center for State Legislative Research and Services, Rutgers University, *Health Programs in the States: A Survey* (New Jersey: 1975), p. 16.
32. *Ibid.*, p. 14.
33. Hawaii, Department of Health, *Annual Report, 1975-76*, p. 20.
34. Hawaii, Department of Health, *Report on S.R. No. 25 (1975) Relating to the Rate Structure of the County/State Hospital*.
35. Hawaii, Governor's Ad Hoc Commission on Operations, Revenues and Expenditures, *CORE Report to the Governor* (Honolulu: 1974), p. B-77; hereinafter referred to as *CORE Report*.
36. 1977 Haw. Sp. Sess. Laws, Act 9.
37. *CORE Report*, p. B-81.
38. *Ibid.*
39. Patients' Bill of Rights found in Rules and Regulations of the U.S. Department of Health, Education and Welfare.
40. *Indiana Code*, sec. 16-14-1.5-2.
41. States include Connecticut, Florida, Illinois, Iowa, Kentucky, Kansas, Maine, Maryland, Massachusetts, Minnesota, Nebraska, New Hampshire, Oregon, Pennsylvania, Tennessee, Vermont, Virginia, Rhode Island, and Montana.
42. States include Arizona, Colorado, Idaho, Indiana, Nevada, New Mexico, Ohio, Oklahoma, South Dakota, and Utah.
43. States include Delaware, Oklahoma, and Washington.
44. *Delaware Const.* art. XII, sec. 1.
45. *Washington Const.* art. XX, sec. 1.

46. *Alabama Const.* art. IV, amend. 53.
47. *Georgia Const.* art. VII, sec. 2.
48. *Missouri Const.* art. III, sec. 36.
49. *Alaska Const.* art. VII, sec. 4.
50. *Louisiana Const.* art. XVIII, sec. 7(1).
51. *New York Const.* art. XVII, sec. 3.
52. *Michigan Const.* art. IV, sec. 51.
53. *South Carolina Const.* art. XII, sec. 3.
54. *California Const.* art. XVI, sec. 5.
55. *New York Const.* art. XVII, sec. 7.
56. See *Hawaii Const.* art. I.
57. States include Florida, Illinois, Massachusetts, Michigan, Montana, New Mexico, New York, North Carolina, Pennsylvania, Rhode Island, and New Jersey.
58. The certificate of need program is federally mandated under Pub. L. No. 92-603 (1972), section 1122, permitting states to designate agencies which will determine the consistency or inconsistency of a provider's proposed capital expenditure with areawide or state plans for health services and facilities.
59. New York, Constitutional Convention, 1967, *Proceedings*, Vol. XI, document 48 (New York: 1967), p. 8.
60. 42 U.S.C.A. secs. 257c, 291 to 291o.
10. 42 U.S.C.A. secs. 2681, 2682, 2687 to 2688a, 2688c, 2688d, 2688f to 2688h, 2688j-1 to 2688l, 2688o, 2688r to 2688v, 2691, 2693, 2697b (1973).
11. 42 U.S.C.A. sec. 246 (1973).
12. 18 U.S.C.A. secs. 4251 to 4255; 28 U.S.C.A. secs. 2901 to 2906; 42 U.S.C.A. secs. 3411 to 3426, 3441, 3442 (1966).
13. 42 U.S.C.A. secs. 218, 246, 2688h, 2688j-2, 2688t, 4551, 4552, 4561, 4571 to 4573, 4581, 4582, 4591 to 4593 (1970).
14. Figures are based on unpublished data from the National Institute of Mental Health. National Association of Social Worker, *Encyclopedia of Social Work*, p. 886.
15. *Ibid.*
16. National Association of Social Workers, *Encyclopedia of Social Work* (Washington: 1977), p. 240.
17. Title XIV covers aid to the "totally and permanently disabled".
18. 29 U.S.C.A. secs. 31 to 35, 37, 38, 41 to 41d, 42 (1965).
19. 29 U.S.C.A. secs. 31 to 35, 37, 41 to 41b, 42-1 to 42b (1968).
20. 29 U.S.C.A. secs. 701 to 709, 720 to 724, 730 to 732, 740, 741, 750, 760 to 764, 770 to 776, 780 to 787, 790 to 794 (1973).
21. *Hawaii Rev. Stat.*, sec. 333-21.
22. *Hawaii Rev. Stat.*, sec. 333-22.
23. H. David Sokoloff, *The Role of the Hawaiian State Developmental Disabilities Planning and Advisory Council in the Development of the Service System* (San Francisco: 1974).
24. *Hawaii Rev. Stat.*, sec. 333E-1.
25. 42 U.S.C.A. secs. 295 to 295e, 2661a, 2678 to 2678d, 6001 to 6012, 6031 to 6033, 6041 to 6043, 6061 to 6068, 6081 (1975).
26. *Hawaii Rev. Stat.*, sec. 333E-2.
27. Senate Concurrent Resolution No. 132-77, Ninth Legislature, 1977, State of Hawaii.
28. *Hawaii Rev. Stat.*, sec. 334-3.
29. Hawaii, Department of Health, *Annual Report, 1975-76* (Honolulu: 1977).
30. Hawaii, Department of Budget and Finance, *The Multi-Year Program and Financial Plan and Executive Budget for the Period 1977-1983 (Budget Period: 1977-79)*, Vol. IV (Honolulu: 1976), p. 2092.
31. *Hawaii Rev. Stat.*, sec. 348-1.
32. *Hawaii Rev. Stat.*, sec. 348-2.
33. Hawaii, Department of Social Services and Housing, *Annual Report*, (Honolulu: 1977).

Chapter 3

1. The term "handicapped" is used as an all inclusive term. Therefore, discussion in this chapter will be directed specifically to 3 main areas: mental retardation, mental illness, and physically handicapped.
2. National Association of Social Workers, *Encyclopedia of Social Work* (Washington: 1976), p. 871.
3. *Ibid.*, p. 876.
4. President's Committee on Mental Retardation was established in 1966 as an ongoing advisory group to the President.
5. President's Panel on Mental Retardation, *Report of the Task Force on Law* (Washington: U.S. Government Printing Office, 1963).
6. The President's Committee on Mental Retardation, *The Mentally Retarded Citizen and the Law* (New York: 1976).
7. 29 U.S.C.A. secs. 31-41 (1943).
8. 42 U.S.C.A. secs. 201, 209, 210, 215, 218, 219, 232, 241, 242a, 244, 246 (1946).
9. Pub. L. No. 89-97, 79 Stat. 286, Pt. IV, sec. 231.
10. 42 U.S.C.A. secs. 2681, 2682, 2687 to 2688a, 2688c, 2688d, 2688f to 2688h, 2688j-1 to 2688l, 2688o, 2688r to 2688v, 2691, 2693, 2697b (1973).
11. 42 U.S.C.A. sec. 246 (1973).
12. 18 U.S.C.A. secs. 4251 to 4255; 28 U.S.C.A. secs. 2901 to 2906; 42 U.S.C.A. secs. 3411 to 3426, 3441, 3442 (1966).
13. 42 U.S.C.A. secs. 218, 246, 2688h, 2688j-2, 2688t, 4551, 4552, 4561, 4571 to 4573, 4581, 4582, 4591 to 4593 (1970).
14. Figures are based on unpublished data from the National Institute of Mental Health. National Association of Social Worker, *Encyclopedia of Social Work*, p. 886.
15. *Ibid.*
16. National Association of Social Workers, *Encyclopedia of Social Work* (Washington: 1977), p. 240.
17. Title XIV covers aid to the "totally and permanently disabled".
18. 29 U.S.C.A. secs. 31 to 35, 37, 38, 41 to 41d, 42 (1965).
19. 29 U.S.C.A. secs. 31 to 35, 37, 41 to 41b, 42-1 to 42b (1968).
20. 29 U.S.C.A. secs. 701 to 709, 720 to 724, 730 to 732, 740, 741, 750, 760 to 764, 770 to 776, 780 to 787, 790 to 794 (1973).
21. *Hawaii Rev. Stat.*, sec. 333-21.
22. *Hawaii Rev. Stat.*, sec. 333-22.
23. H. David Sokoloff, *The Role of the Hawaiian State Developmental Disabilities Planning and Advisory Council in the Development of the Service System* (San Francisco: 1974).
24. *Hawaii Rev. Stat.*, sec. 333E-1.
25. 42 U.S.C.A. secs. 295 to 295e, 2661a, 2678 to 2678d, 6001 to 6012, 6031 to 6033, 6041 to 6043, 6061 to 6068, 6081 (1975).
26. *Hawaii Rev. Stat.*, sec. 333E-2.
27. Senate Concurrent Resolution No. 132-77, Ninth Legislature, 1977, State of Hawaii.
28. *Hawaii Rev. Stat.*, sec. 334-3.
29. Hawaii, Department of Health, *Annual Report, 1975-76* (Honolulu: 1977).
30. Hawaii, Department of Budget and Finance, *The Multi-Year Program and Financial Plan and Executive Budget for the Period 1977-1983 (Budget Period: 1977-79)*, Vol. IV (Honolulu: 1976), p. 2092.
31. *Hawaii Rev. Stat.*, sec. 348-1.
32. *Hawaii Rev. Stat.*, sec. 348-2.
33. Hawaii, Department of Social Services and Housing, *Annual Report*, (Honolulu: 1977).

34. *Ibid.*, p. 14.
35. *Hawaii Rev. Stat.*, sec. 347-20.
36. *Hawaii Rev. Stat.*, ch. 348E.
37. National Association of Attorneys General, Committee on the Office of the Attorney General, *Right to Treatment in Mental Health Law* (North Carolina: 1976), p. 1.
38. *Ibid.*
39. *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966).
40. *Wyatt v. Stickney*, 344 F. Supp. 373, 344 F. Supp. 387 (M.D. Ala. 1972), *enforcing*, 325 F. Supp. 781, 344 F. Supp. 1341 (M.D. Ala. 1971), *aff'd in part remanded in part, decision reserved in part sub nom. Wyatt v. Alerholt*, 503 F.2d 1305 (5th Cir. 1974).
41. National Association of Attorneys General, Committee on the Office of the Attorney General, p. 18.
42. *Ibid.*
43. *Ibid.*, p. 19.
44. *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971).
45. *Wyatt v. Stickney*, 344 F. Supp. 1341, 1342-2 (M.D. Ala. 1971).
46. 422 U.S. 563 (1975).
47. *Ibid.*, p. 576.
48. *Ibid.*, p. 575.
49. *Shelton v. Tucker*, 364 U.S. 479, 488 (1960).
50. *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966). The case involved a Catherine Lake who had been involuntarily committed to St. Elizabeth's Hospital in Washington, D.C., and *Lake v. Cameron* was an appeal from a denial of release.
51. *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).
52. *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis., 1972), *vacated and remanded on other grounds*, 94 S. Ct. 713 (1974).
53. *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D.C. Haw. 1976).
54. *Ibid.*
55. *Ibid.*, p. 1127.
56. *Suzuki v. Yuen*, 46 LW 2181 (D.C. Haw. 1977).
57. *Ibid.*
58. *Ibid.*
59. *Hawaii Rev. Stat.*, sec. 333-25.
60. *Hawaii Rev. Stat.*, sec. 333-27.
61. *Hawaii Rev. Stat.*, sec. 333-4.
62. *Hawaii Rev. Stat.*, sec. 333-34.
63. The President's Committee on Mental Retardation, *The Mentally Retarded Citizen and the Law* (New York: 1976), p. 462.
64. The National Association of Attorneys General, Committee on the Office of Attorney General, p. 63.
65. Discussion on the right to health as a "claim" found in article by Thomas Szasz in the 57 *Georgetown L.J.* 734, (1969).
66. 29 U.S.C.A. sec. 794 (1973).
67. *Arizona Const.* art. XXII, sec. 15. Other states which have similar provisions include Colorado, Idaho, Indiana, Kansas, Mississippi, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Utah, Washington, West Virginia, and Wyoming.
68. *California Const.* art. XVI, sec. 4.
69. *Michigan Const.* art. VII.
70. *Missouri Const.* art. IV, sec. 37(a).
71. *Montana Const.* art. XII, sec. 3.
72. *New York Const.* art. XVII, sec. 4.

Chapter 4

1. All of these philosopher/writers of the 18th and 19th century represented a point of view generally defined as liberalism.
2. 394 U.S. 618 (1969).
3. 392 U.S. 309 (1968).
4. 397 U.S. 280 (1969).
5. 397 U.S. 254 (1970).
6. 397 U.S. 471 (1970).
7. 406 U.S. 535 (1972).
8. 397 U.S. 397 (1970).
9. 421 U.S. 707 (1975).
10. 420 U.S. 575 (1975).
11. In 1940, a total of \$1,020,100,000 was spent in money payments for major social welfare programs. By 1960, the amount had risen to \$3,262,800,000. In 1975, the total amount was \$10,568,000,000 a year. National Association of Social Workers, *Encyclopedia of Social Workers* (Washington: 1976), p. 896.
12. U.S., Department of Health Education and Welfare, Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement 1975* (Washington: 1976), p. 186.

13. Poverty level is set at \$418/month for a female headed family of 4.
14. Pub. L. No. 92-603, 86 Stat. 1329.
15. U.S., Department of Health, Education and Welfare, Social Security Administration, Social Security Bulletin, p. 181.
16. Hawaii, Department of Social Services and Housing, *Annual Report*, (Honolulu: 1976), p. 3.
17. *Ibid.*, p. 6.
18. *Ibid.*, p. 7.
19. Hawaii, Department of Social Services and Housing, *Hawaii Income Maintenance, 1987-76* (Honolulu: 1976), p. 1.
20. *Ibid.*, pp. 5,6. The Board of Public Welfare was established under 1949 Haw. Sess. Laws, Act 346. Among the basic rules the board set up for public assistance were: (1) the board would not run a financial deficit in its income maintenance despite escalating caseload; (2) cut back in payments would be made only in the general assistance category. No reduction in aged, blind, disabled, or needy children in AFDC; and (3) reinstate cut-backs as soon as practical when funds become available, due to savings generated from policy cutbacks.
21. *Ibid.*, p. 8.
22. *Ibid.*, p. 10.
23. *Ibid.*, p. 16.
24. The items included food, household supplies, personal essentials, education, and community activity, transportation allowance, and laundry.
25. *Hawaii Rev. Stat.*, sec. 346-53.
26. Hawaii, Department of Social Services and Housing, *Annual Report*, (Honolulu: 1976), p. 4.
27. Work Incentive Program provides direct job placement for persons under the AFDC program. The groups that are exempted from WIN are families with children under 6 years of age, families with disabilities, and other specific exemptions.
28. Target population for the TLF program are the General Assistance able-bodied individuals who are required to register with TLF and then be placed on public service projects to "earn" the money received from public welfare.
29. Eligibility for determining medically needy involves a disregard of liquid assets of \$1,500 for a single person and \$2,250 for a couple with an additional \$250 for each additional person included on the application.
30. The purchase of services program was begun in response to the consolidation of Titles IV-A and VI of the Social Security Act under a new title identified as Title XX. Title XX provided matching grants requiring the state to match funds on 75 per cent to 25 per cent ratio for social services. To fully utilize these funds the state established a program of public/private partnership to encourage private funding participation to expand public social services.
31. *Georgia Const.* art. VII, sec. 2.
32. *North Carolina Const.* art. V, sec. 2.
33. *Oklahoma Const.* art. XXIV.
34. *New York State Const.* art. XVIII, sec. 1.
35. *California Const.* art. XVI, sec. 11.
36. *Missouri Const.* art. III, sec. 36.
37. *Missouri Const.* art. IV, sec. 37.
38. *Alaska Const.* art. VII, sec. 5.
39. Ruth A. Whiteside, *The Impact of the Texas Constitution on Public Welfare*, for Southwest Center for Urban Research, Institute for Urban Studies (Houston: 1973), p. 31.
40. *Ibid.*
41. Entitlement provisions found in Title I, sec. 6(a); Title IV, sec. 406(a); Title X, sec. 1006; Title XIV, sec. 1405; Title XVI, sec. 1605(a); and Title XIX, sec. 1905 of the Social Security Act.
42. 42 U.S.C.A. sec. 602(a)(9) (1972).
43. 394 U.S. 618 (1969).
44. Note: "Durational Residence Requirements from Shapiro through Sosna--The Right to Travel Takes a New Turn." 50 *N.Y.U.L. Rev.* 3 (1975).
45. In *Vlandis v. Kline*, the court indicated that a "reasonable durational residence requirement could be imposed as a condition for resident tuition for educational purposes." 412 U.S. 441, 454 (1972).
46. 360 F. Supp. 1182 (N.D. Iowa 1973), *aff'd* 419 U.S. 383 (1975).
47. Hawaii, Department of Budget and Finance, *Hawaii Analysis in Government, Growth Management Issues in Hawaii* (Honolulu: 1977), p. 146.
48. *Ibid.*

Chapter 5

1. U.S., Department of Housing and Urban Development, *Housing in the Seventies*, A Report of the National Housing Policy Review (Washington: 1974), p. 5.
2. Authorized by the Emergency Relief and Construction Act of 1932.
3. Authorized by the Federal Home Loan Bank of 1932.
4. Authorized by the Federal Home Loan Bank of 1932.
5. Authorized by the Federal Banking Act of 1933.
6. Authorized by the Homeowners Loan Act of 1933.
7. Authorized by the National Industrial Recovery Act of 1933.

8. Authorized by Title IV of the National Housing Act of 1934.
9. Authorized by the National Housing Act of 1934.
10. U.S., Department of Housing and Urban Development, *Housing in the Seventies, National Housing Policy Review* (Washington: 1974), p. 14. The section authorizing this program is section 221(d)(3) of the Housing Act of 1961.
11. *Ibid.*, p. 14.
12. Pub. L. No. 90-448, 82 Stat. 476 sec. 1601.
13. *Hawaii Rev. Stat.*, sec. 359-1.
14. *Hawaii Rev. Stat.*, sec. 359-31.
15. *Hawaii Rev. Stat.*, sec. 359G-1.
16. Hawaii, Department of Social Services and Housing, *Annual Report* (Honolulu: 1977), p. 18.
17. 1974 Haw. Sess. Laws, Act 171.
18. Marshall Kaplan, Gans, Kahn and Yamamoto, *Housing in Hawaii: Problems, Needs and Plans* (Honolulu: 1971), prepared for the State of Hawaii, Department of Planning and Economic Development.
19. Hawaii, Department of Social Services and Housing, *Annual Report* (Honolulu: 1977), p. 18.
20. 1975 Haw. Sess. Laws, Act 185.
21. Hawaii, Commission on Revenues and Expenditures, *CORE Report to the Governor* (Honolulu: 1974), p. B-30; hereinafter *CORE Report*.
22. *Ibid.*, p. B-30.
23. *Ibid.*, p. 1.
24. In 1975, the per capita personal income in Hawaii was \$6,658. Assuming the figures were doubled to accommodate 2 per capital incomes per family, the total would be \$13,000 a year, \$2,000 less than what is needed to qualify for a mortgage loan.
25. *California Const.* art. XXXIV, sec. 1.
26. *New York Const.* art. XVIII.
27. New York, Special Legislative Committee on the Revision and Simplification of the Constitution, Inter-law School Committee, *Report on the Problem of Simplification of the Constitution*, Staff Report No. 1 (New York: 1958), p. 210.
28. *New York Const.* art. XVIII, sec. 10.
29. New York, Special Legislative Committee on Revision and Simplification of the Constitution, p. 208.
30. *Rhode Island Const.* art. XXXIII. *New Jersey Constitution* is similar in wording, art. VIII, sec. 3.
31. U.S., Department of Housing and Urban Development, *Housing in the Seventies, Working Papers 2, National Housing Policy Review* (Washington: 1976), p. 1299.

32. *Hawaii Rev. Stat.*, sec. 359G-1.

Chapter 6

1. Hawaii, Constitutional Convention, 1950, *Proceedings*, Vol. I, Standing Committee Report No. 16, p. 160.
2. Richard J. Richardson, *Article VIII: Public Health and Welfare*, Hawaii Constitutional Convention Studies (Honolulu: University of Hawaii, Legislative Reference Bureau, 1968), p. 19.
3. Hawaii, Constitutional Convention, 1968, *Proceedings*, Vol. I, Standing Committee Report No. 30, p. 187.
4. *Ibid.*
5. *Ibid.*
6. Specific proposals included air and water pollution, noise abatement, preservation of land and natural resources, social and cultural welfare, animal, fish and wildlife control.
7. Hawaii, Constitutional Convention, 1968, *Proceedings*, Vol. I, p. 188.
8. *State v. Diamond Motors, Inc.*, 50 Haw. 33, 36, 429 P.2d 825 (1967).
9. Hawaii, Department of Land and Natural Resources, Division of State Parks, *Historic Preservation Annual Report 1976* (Honolulu: 1976), Appendix, p. 1.
10. *Ibid.*, p. 5.
11. *Hawaii Rev. Stat.*, ch. 341.
12. *Hawaii Rev. Stat.*, sec. 344-1.
13. *Hawaii Rev. Stat.*, sec. 344-3.
14. A. E. Howard, "State Constitutions and the Environment", 58 *Va. L. Rev.* 229 (February 1972).
15. States include Florida, Illinois, Massachusetts, Michigan, Montana, New Mexico, New York, North Carolina, Pennsylvania, Rhode Island, and New Jersey.
16. Sixth Illinois Constitutional Convention, *General Government Committee Proposal No. 16*.
17. *Massachusetts Const.* art. 97.
18. *New Mexico Const.* art. XX, sec. 21.