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16

The right to treatment

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Whereas the right to treatment was born in the early 1960s, its progenitor was the decades of parlous neglect of patients in America's public psychiatric institutions through the mid-twentieth century. Kenneth Appel, MD, chairperson of the mental hospitals committee of the Group for the Advancement of Psychiatry, proclaimed in 1947, 'Automobiles get better attention than most mental patients today. The grass surrounding the state hospitals receives more care and consideration than the patients inside.' (Deutsch 1948, p. 98) In his 1958 presidential address to the American Psychiatric Association, Harry Solomon indicated that 'the large mental hospital is antiquated, outmoded, and rapidly becoming obsolete. We can build them but we cannot staff them ... they are bankrupt beyond remedy.' (Solomon 1958, p. 7).

Much of the right-to-treatment litigation has focused on establishing standards of care and concomitant staffing patterns. In the 1940s, the American Psychiatric Association (APA) maintained that there should be no less than one psychiatrist for every 150 hospitalized patients, one graduate nurse for every forty patients, and one attendant for every eight patients, but no state hospital of the day met all the APA's standards (Deutsch 1948).

The history of the right to treatment is that of a moral position casting about for legal grounding. The right to treatment has been variously based on the Eighth Amendment (cruel and unusual punishment), the Fourteenth Amendment (both the due process clause and the equal protection clause), the quid pro quo rationale (treatment is due to civilly committed patients in exchange for enforced confinement), and the least restrictive alternative doctrine ('deprivations of liberty solely because of dangers to ill persons themselves should not go beyond what is necessary for their protection' (*Lake v. Cameron* 1966, p. 660). Further, courts have struggled with clearly defining *treatment*, differentiating between *treatment* and *habilitation*, and distinguishing between the rights and needs of persons with mental illness, and those with mental retardation.

INSTITUTIONAL TREATMENT

The early years: 1960–1974

The right to treatment was initially articulated by Morton Birnbaum, a lawyer and physician, who argued in 1960:

> If the right to treatment were to be recognized, our substantive constitutional law would then include the concepts that if a person is involuntarily institutionalized in a mental institution because he is sufficiently mentally ill to require institutionalization for care and treatment, he needs, and is entitled to, adequate medical treatment; that an institution that involuntarily institutionalizes the mentally ill without giving them adequate medical treatment for their mental illness is a mental prison; and that substantive due process of law does not allow a mentally ill person who has committed no crime to be deprived of his liberty by indefinitely institutionalizing him in a mental prison (Birnbaum 1960, p. 503).

The first tests of Birnbaum's theory were in criminal committees. In *Rouse v. Cameron* (1966), Judge Bazelon found that a District of Columbia statute mandated treatment for a patient committed after a finding of not guilty by reason of insanity. Judge Bazelon postulated, however, that there could be constitutional violations in confinement without treatment, noting the Eighth and Fourteenth amendments. He further remarked that the 'hospital need not show that the treatment will cure or improve him, but only that there is a bona fide effort to do so' (*Rouse v. Cameron* 1966, p. 456). In *Nason v. Superintendent of Bridgewater State Hospital* (1968), the Supreme Judicial Court of Massachusetts found a constitutional right to treatment for a patient found incompetent to stand trial and whose further court proceedings required his return to competency. This court grounded its decision in the due process clause of the Fourteenth Amendment.

The right to treatment was first applied to civilly committed patients in *Wyatt v. Stickney* (1971), a federal district court case, affirmed by the Court of Appeals, which challenged the deplorable conditions in the Alabama state hospitals. Judge Johnson adopted the theory articulated in *Rouse v. Cameron* in a series of far-reaching decisions. In the third Wyatt decision, Judge Johnson indicated he had found that Alabama failed to provide '(1) a humane psychological and physical environment; (2) qualified staff in numbers sufficient to administer adequate treatment; and (3) individualized treatment plans.' (*Wyatt v. Stickney* 1972, p. 375). The court delineated 'Minimum Constitutional Standards for Adequate Treatment of the Mentally Ill' for each of these three areas, outlining in great detail the minimal standards that the state would be required to meet. The staffing standards are of particular interest (see Table 16.1).

Other courts took up Judge Bazelon's analysis, applying it to institutions for the mentally retarded. In *New York State Association for Retarded Children v. Rockefeller* (1973), the so-called Willowbrook case, the court found that institutionalized mentally retarded persons had a right to protection from harm but no clear right to treatment. To this point, no case had been heard by the United States Supreme Court.

U.S. Supreme Court: 1975–1982

During this time period the Supreme Court had three major opportunities to find a right to treatment, but did not do so. In *O'Connor v. Donaldson* (1975), Justice Stewart, writing for the majority of the Supreme Court, indicated that:

> There is no reason now to decide whether mentally ill persons dangerous to themselves or to others have a right to treatment … this case raises a single, relatively simple but nonetheless important question concerning every man's constitutional right to liberty. (*O'Connor v. Donaldson* 1975, 573).

Rather, the Court found:

> A state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of

Table 16.1 *A comparison of state hospital staffing pattern per 250 patients as required by* Wyatt v. Stickney *(1972),* U.S. v. Indiana *(1984),* U.S. v. Hawaii *(1991), and* U.S. v. Virginia *(1999)*

Staff member	*Wyatt v. Stickney* (1972)	*U.S. v. Indiana* (1984)[1]	*U.S. v. Hawaii* (1991)[2]	*U.S. v. Virginia* (1999)[3]
Psychiatrist	2	8.3	16	18.25 + 3 in administrative positions independent of census
Physician	4		Not discussed	2.5 MDs + 1.5 NPs
Psychologist (PhD & MA)	3	5.4	12.5	16 + 1 Director
Social worker (MSW & BA)	7	7.5	16.7	1 per treatment team of 15–25 patients (size dependent on type of patient population)
Rehabilitation staff (O.T. & R.T.)	12	Not discussed	27.8	Specified by functions not numbers
Registered nurse	12	13.8 excluding nights	272 Of these, must be: at least one RN per ward per shift; RNs must be 30% of each ward's staff; any 1:1 or other special assignments are in addition	5.0–5.5 HPPD[4] Of these, must be: at least one RN per ward per shift; RNs must make up 25–35% of HPPD depending on type of patient population; any 1:1 staffing is in addition
Licensed practical nurse	6	Not discussed		
Aides	92	153		

[1] Based on assumption of 50% acute patients (as defined by consent decree) and 50% continuing care patients; also based on 1.7 FTE nursing staff to have 1 FTE on duty every day.
[2] Based on assumption of 18% acute patients, 32% long-term care patients and 50% forensic patients; also based on 1.7 FTE nursing staff to have 1 FTE on duty every day.
[3] Central State Hospital. Based on assumption of 34% civil patients and 66% forensic patients.
[4] HPPD is nursing care hours per patient day. It is used to calculate staff as follows: required number of nurses and direct care staff = (1.8 × average no. of patients × HPPD)/8.

willing and responsible family members or friends.' (*O'Connor v. Donaldson* 1975, 576).

To emphasize the absence of a finding of a right to treatment, in a concurring opinion Chief Justice Burger found:

> ... no other basis for equating an involuntarily committed mental patient's unquestioned constitutional right not to be confined without due process of law with a constitutional right to *treatment*. (*O'Connor v. Donaldson* 1975, p. 587–588, emphasis in original).

However, while Chief Justice Burger's opinion appears to reject the right to treatment, the majority opinion, while failing to find such a right, does not explicitly reject it either. In fact, the use of the phrase 'without more' has been interpreted by some to mean that non-dangerous individuals cannot be involuntarily hospitalized *without treatment*. Hence lower courts could, and have, considered the right in subsequent litigation.

Having failed explicitly to find a right to treatment for the mentally ill, the Supreme Court turned its attention to the mentally retarded. In *Halderman v. Pennhurst State School & Hospital* (1977), the Federal District Court found:

> ... that when a state involuntarily commits retarded persons, it must provide them a reasonable opportunity to acquire and maintain those life skills necessary to cope as effectively as their capacities permit.

The Supreme Court again did not reach the issue of a constitutional basis for a right to treatment or habilitation, but rather found in this case that the Developmental Disabilities Assistance and Bill of Rights Act (an act establishing a federal-state grant program) did not guarantee to institutionalized mentally retarded persons any such rights (*Pennhurst State School & Hospital v. Halderman* 1981).

In *Youngberg v. Romeo* (1982), the Supreme Court did finally address the substantive due process rights of mentally retarded persons involuntarily committed to institutions. The Court specifically addressed whether such persons had rights under the Fourteenth Amendment to '(i) safe conditions of confinement; (ii) freedom from bodily restraint; and (iii) training or "habilitation"' (*Youngberg v. Romeo* 1982, 309). The Court held:

> Respondent has constitutionally protected liberty interests under the Due Process Clause of the Fourteenth Amendment to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, and such minimally adequate training as reasonably may be required by their interests.... And in determining what is 'reasonable', courts must show deference to the judgment exercised by a qualified professional, whose decision is presumptively valid. (*Youngberg v. Romeo* 1982, p. 307).

The 'training' aspect of this case appeared to particularly interest members of the Court. Justice Blackmun, in a concurring opinion, articulated that the level of training should be 'that habilitation or training necessary to *preserve* those basic self-care skills he possessed when he first entered Pennhurst.' (*Youngberg v. Romeo* 1982, p. 327, emphasis in original). On the other hand, in his concurring opinion Chief Justice Burger opined:

> I would hold flatly that respondent has no constitutional right to training, or 'habitation', *per se*.... I agree with the court that some amount of self-care instruction may be necessary to avoid unreasonable infringement of a mentally retarded person's interests in safety and freedom from restraint, but it seems clear to me that the Constitution does not otherwise place an affirmative duty on the state to provide any particular kind of training or habilitation – even such as might be encompassed under the essentially standardless rubric 'minimally adequate training' to which the Court refers. (*Youngberg v. Romeo* 1982, p. 329–330).

Subsequent to Youngberg: 1983–1990

The Supreme Court did much less than those who championed the cause of the right to treatment would have hoped. Even before the Supreme Court completed its way through these cases, psychiatrists with particular expertise in these matters were doubtful of the usefulness of the judicial process for this right. Stone (1975) argued, 'The right to treatment cannot come from complicated judicial discourse about civil rights and about civil liberties.' Roth (1977) lamented, 'I do not believe that the so-called right-to-treatment laws will ever provide the help that physicians hoped they would in ensuring that patients receive needed and effective treatment.'

The right to treatment continued to struggle throughout this period. Litigation in federal court attempting to broaden *Youngberg* is best exemplified by the long struggle between Morton Birnbaum and New York State, started as *Woe v. Matthews* (1976) and ending as *Foe v. Cuomo* (1989). The major advances in the right to treatment in the 1980s occurred pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA) of 1980. This act authorizes the U.S. government to institute a civil action against any state whose officials, employees, or those acting on their behalf are 'subjecting persons residing in or confined to an institution to egregious or flagrant conditions which deprive such persons of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States causing such persons to suffer grievous harm.' Under this authority, the Civil Rights Division of the U.S. Justice Department has been able to substantially bring the right to treatment closer to a reality for thousands of persons in state psychiatric hospitals

and in developmental disabilities/mental retardation facilities. It has done so by applying the standards of *Youngberg*, and it has accomplished its end largely through the vehicle of consent decrees. Just how far this process has come can be ascertained by comparing the staffing parameters of the *Wyatt* case, the first consent decree in 1984 (*United States v. Indiana* 1984), and a consent decree initiated in the late 1980s (*United States v. Hawaii* 1991) (see Table 16.1).

ADA and Wyatt: 1990–2000

The Americans with Disabilities Act (ADA), passed on July 26, 1990, is an act 'to establish a clear and comprehensive prohibition of discrimination on the basis of disability.' The Act has four major components: Title I applies to employment; Title II to public services; Title III to accommodations required of private entities; and Title IV to telecommunication services. Enforcement varies by Title. Title I is enforced by the Equal Employment Opportunity Commission (EEOC); Titles II–IV are enforced by specific government agencies, such as Department of Housing and Urban Development enforcing housing; and the United States Department of Justice (USDOJ) enforces all areas of Titles II–IV not enforced by any other federal agency (Wylonis 1999). Title II is of greatest interest in the area of right to treatment in that this title covers state and local government services and so includes state and county hospitals.

The part of Title II most pertinent to the right to treatment is at section 12132, which indicates: 'no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subject to discrimination by any such entity.' Regulations that were required to be promulgated to operationalize this Act, state at one section, referred to as the 'integration regulation,' that 'A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities' (28 Code of Federal Regulations 1998, at 35.130(d)). In the 'reasonable-modifications regulation,' it states that public entities must make 'reasonable modifications' in order not to discriminate 'on the basis of disability,' but these pubic entities are not required to 'fundamentally alter' the nature of the public entity's programs (28 Code of Federal Regulations 1998, at 35.130(b)(7)).

While the ADA addresses public institutions, it was seen not so much as a way to improve services within state and county hospitals, but rather as a way to force states to move patients out of these institutions. The ADA could become a vehicle to further the now four-decade-old movement of patients from institutional to non-institutional settings, generally referred to as 'in the community' (Geller 2000a).

After 30 years, it appears that the *Wyatt* case may be coming to an end. On January 20, 2000 all parties reached a settlement agreement; a fairness hearing was held on May 4 and a decision was reached July 13. The Settlement Agreement endorsed by the court includes the following components:

1. Accreditation: all mental illness facilities must maintain Joint Commission on Accreditation of Health-Care Organizations (JCAHO) accreditation.
2. Advocacy programs: maintain an advocacy staff to educate about rights, investigate complaints of rights violations, monitor conditions of facilities and certified community programs.
3. Census reduction: specific target census reductions set, but no facility closures required.
4. Community placement: develop a plan and implement 'out-placements' and concurrently increase community-based placements and services.
5. Public education: institute a comprehensive, state-wide plan to enhance the public's appreciation for abilities, needs and rights of persons with mental illness.
6. Quality improvement: maintain adherence to current policy and procedures and continue Continuous Quality Improvement Systems.
7. Safety and protection: allegations of abuse and neglect require timely responses by trained employees using standard procedures.
8. Treatment and habilitation: Alabama Disabilities Advocacy Program can have input into individualized treatment plans, and consultants will be hired to address special needs populations (dually diagnosed mental illness/mental retardation, organic brain injured, physically handicapped, HIV/AIDS, self-injurious, others) and to review and make recommendations concerning the use of seclusion and restraint (*Wyatt v. Sawyer* 2000).

While the most recent *Wyatt* decision addresses conditions in the state facilities of Alabama, it equally addresses institutional downsizing, expansion of community services, and the monitoring of some community services. The projected ending date of this Settlement Agreement is September 30, 2003 or before. The Agreement ends when all parties agree that Alabama has completed 'certain obligation undertaken in the agreement.' (*Wyatt v. Sawyer* 2000). It will be of great interest to see how Alabama proceeds, and to monitor how treatment for those with serious mental illness is actually advanced through these efforts.

As a footnote to this era, it is worth noting that CRIPA is still active in the states, although new wrinkles have appeared. States are continuing to write Settlement Agreements with Plans for Continuous Improvement. Newer agreements advance somewhat different requirements from early Consent Decrees (see *United States v. Commonwealth of Virginia* in Table 16.1). Hawaii recently modified its direction in improving Hawaii State Hospital

by announcing its intent to alter the nature of the hospital by modifying it into a 'secure rehabilitation facility' (Act 119, 1999 State of Hawaii Legislature). Florida announced in 2000, amidst litigation (*Johnson v. Murphy* 1987), that it would close the state hospital that was the subject of the suit (Krueger 2000).

COMMUNITY TREATMENT

The right to treatment in the community was initially based on the right to treatment in the least restrictive alternative (LRA), a doctrine first articulated in mental health cases by Judge David Bazelon in *Lake v. Cameron* (1966). That landmark case prohibited commitment if less 'restrictive' treatment alternatives were possible. Although LRA is a convoluted concept at best (Hoffman and Foust 1977; Gutheil, Appelbaum, and Wexler 1983; Munetz and Geller 1993; Fisher *et al.* 1995), it has provided the basis for extending the right to treatment through both state statutes and the federal court.

Most states have statutes conferring a right to appropriate treatment and services, and many states have statutes that explicitly address a right to treatment in the LRA (Beis 1984; Brakel, Parry, and Weiner 1985). In *Dixon v. Weinberger* (1975), a case involving the patients of Saint Elizabeths Hospital in the District of Columbia, the court, in basing its decision on statutory grounds (the District of Columbia Hospitalization of the Mentally Ill Act), found that patients were guaranteed a right to treatment and that this right was no less than a right to treatment in the LRA. Unfortunately, the *Dixon* case has resulted, throughout most of its existence, in considerably more process than outcome (Armstrong 1979; *Dixon v. Sullivan* 1989; Advocates welcome agreement... 2000). Through a Consent Order in late winter of 2000, however, it was hoped that returning the mental health system to the District (by ending the receivership) would hasten compliance with the twenty-five-year-old court decision (*Dixon v. Miller* 2000; Miller 2000).

In Arizona, the Superior Court of Arizona ruled in *Arnold v. Sarn* (1985, p. 40) that the Arizona Department of Health Services, the Arizona State Hospital, and the Maricopa County Board of Supervisors were obligated to provide, pursuant to state statute, 'a continuum of care' through a 'unified and cohesive system of community mental health care that is well integrated.' This continuum was defined by the court as including case management, residential services, day treatment, outreach, medications, outpatient counseling, crisis stabilization, mobile crisis services, socialization, recreation, work adjustment, and transportation. This process in Arizona through the mid 1980s has been cogently summarized by Santiago (Santiago *et al.* 1986; Santiago 1987).

The *Arnold* case remains alive and active in 2000. The plaintiff class and the state of Arizona and Maricopa County entered into a Supplemental Agreement in December, 1998. Included in what the Defendants are required to complete is a needs assessment on a sample of class members; determine the services necessary to meet these needs and the methodology to create these services; develop interim and long-term plans for the operation of clinical teams; and create standards and conduct performance reviews (*Arnold v. ADHS* 1998). By August, 1999 a study of the mental health services needs of class members had been completed by the Human Services Research Institute of Cambridge, Massachusetts (Personal communication, H. Stephen Leff to Ronald Smith, August 6, 1999). Progress remains slow. The 2000 Independent Audit Report of the Office of the Monitor states that 'only modest substantive progress has been made in the areas of assessment, service planning, service provision or adequate monitoring by the clinical teams' (*Arnold v. Sarn* 2000, I) and refers to these results as 'disheartening.'

One of the most far-reaching cases to date, in terms of its outcome, has been *Brewster v. Dukakis* (1976). Plaintiffs brought action against the Commonwealth of Massachusetts claiming violations of state statutes and federal entitlements focused on their right to be treated in the LRA. Two years later, a consent decree was signed (*Brewster v. Dukakis* 1978) that mandated a 'comprehensive community mental health and retardation system to include no less than residential environments; nonresidential treatment, training, and support programs; and management services to coordinate and monitor the network of environments and programs.' The consent decree focused on those persons of western Massachusetts who had been, were, or could be patients at the Northampton State Hospital. While the outcome has been mixed (Geller *et al.* 1990a, 1990b; Geller 1991a), some achievements have been remarkable. A decade after the consent decree was signed, every patient in the hospital on the day of the signing had been discharged at least once (Geller *et al.* 1990a). The Commonwealth of Massachusetts managed to establish in the area covered by the consent decree the best-funded community residential system in the United States (Geller and Fisher 1991). And the lawyer who brought the suit concluded ten years after the decree took effect, 'By most accounts, few persons are still institutionalized in western Massachusetts or are at risk of hospitalization as a result of a lack of an appropriate, less restrictive alternative' (Schwartz and Costanzo 1987, p. 1400).

Currently, the major changes in community-based treatment are being fuelled by courts' applications of the ADA to persons in psychiatric institutions. Prior to the first case heard by the U.S. Supreme Court, there were a series of cases in lower federal courts that basically found that persons with mental illnesses must receive care and treatment in community settings where professional judgment finds such treatment to be appropriate (Petrila 1999). An interesting example of such cases is *Kathleen S. v. Department of Public Welfare* (1998 and

1999), a Pennsylvania case which focused on the closing of Haverford State Hospital. The thrust of the case was which, if any, patients could be transferred to Norristown State Hospital (another Pennsylvania state hospital). The court divided the patients into three subclasses and found the following:

- Those identified by the state as appropriate for community placement now – placement immediately.
- Those identified by the state as placeable during the next three years – place all within one and one half years.
- Those identified by the state as not placeable and requiring hospital level of care – transfer to Norristown State Hospital, but conduct independent evaluations by a psychologist or psychiatrist within six months to determine appropriateness for community treatment.

The state appealed; the ultimate outcome was a Settlement Agreement between the two parties that made no changes for the first subclass, extended the date for the second subclass by three months, and indicated that all members of the third subclass identified as appropriate for community services would receive them no later than six months after the determination of appropriateness deadline. This case not only supported the right to community-based care and treatment, but established quite narrow time frames for the state to accomplish this objective for all of a state hospital's patients determined by professional judgment to be appropriate for community-based services.

The case of *Olmstead v. L.C.* (1999) is the hallmark U.S. Supreme Court decision to date on the application of the ADA to persons in state hospitals. The case involved two women with mental retardation – one of whom also had schizophrenia and the other of whom carried a personality disorder diagnosis – who were being maintained in a Georgia state hospital despite the fact that treatment professionals had concluded each could be appropriately treated in community-based programs. The Supreme Court, by a 6-3 majority opinion found that, for any person with a mental disability, community-based treatment rather than institutional placement is required of the states when '(1) the state's treatment professionals have determined that community placement is appropriate; (2) the transfer from institutional care to a less restrictive setting is not opposed by the affected individual; and (3) the community placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities' (*Olmstead v. L.C.* 1999, p. 607). The majority found that the 'unjustified isolation ... [of persons with mental disabilities] is properly regarded as discrimination based on disability' (*Olmstead v. L.C.* 1999, p. 597). This finding is rooted in the majority's opinion that 'institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life' (*Olmstead v. L.C.* 1999, p. 600) and that institutional confinement 'severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment' (*Olmstead v. L.C.* 1999, p. 601).

The implications of the Olmstead case for the right to treatment remain unclear. Commentators have noted that the decision is 'vague,' 'weak,' and 'fractured' (Herbert and Young 1999). Others have remarked 'that the decision is unlikely to precipitate the widespread creation of community-based services for persons with mental disabilities' (Appelbaum 1999).

CONCLUSION

Where is the right to treatment now? Perhaps best described as in the eye of the hurricane, where so much is swirling around it that one can't get to it. The federal government is jumping into the fray with legislation passed in the fall of 2000 (Children's Health Act of 2000 (H.R. 4365)) incorporating parts of the Mental Health Early Intervention, Treatment and Prevention Act (5.2639/H.R. 5091) to fund jail diversion programs, integrated programs for persons with co-occurring mental illness and substance abuse disorders, suicide prevention programs targeted to children and adolescents, and other programs. To whatever degree services in community settings are improved, the scope of those who are in institutions but would be appropriate for care and treatment outside of institutions, continues to expand. A recent court decision stirs the winds of change by finding that an individual can make claims simultaneously under the ADA and under Social Security Disability Insurance (Broadman 2000). And meanwhile, Alberta Lessard, the named plaintiff in the case of *Lessard v. Schmidt* (1972) – a case that addresses the bases for and procedures of civil commitment – has failed several times over the years to obtain care and treatment from the public psychiatric system in Milwaukee. This because, in a system of downsized acute inpatient treatment, 'they said I wasn't sick enough,' said Ms. Lessard (Mental-illness ruling hinders patients 2000).

While the activity level around the right to treatment is high, clarity is far from evident. The concept 'least restrictive alternative' was never adequately defined (Munetz and Geller 1993); the concept 'most integrated setting' uses new language, but is equally inadequately defined. If an individual has a right to 'community-based services,' do we not need to define 'services,' and do we not need to define 'community' (Geller 1991b; Geller 2000b)? Until such definitions are clear, and until such services are uniformly a reality, the right to treatment remains what in current parlance could be referred to as an 'unfunded mandate,' though for persons who would

be the beneficiaries of this, 'right' remains simply an unfulfilled promise.

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