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Unresolved Issues in Right-to-Treatment: A Generative Workshop at the 2025 AAPL Conference

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Introduction

Twenty - Twenty-Five marked the 65th anniversary of the publication of Morton Birnbaum's seminal paper arguing that individuals civilly committed for severe mental illness possess a constitutional right to psychiatric treatment (1). Published in the American Bar Association Journal in 1960, Birnbaum's article, "The Right to Treatment," faced significant initial resistance and was rejected by fifty other academic and legal journals before finally finding a platform. (2) Morton Birnbaum's work contributed to a grassroots effort to bring relevant fact patterns to the court's attention, culminating in the landmark litigation of *Wyatt v. Stickney* in the early 1970s. (3, 4) The *Wyatt* court articulated three fundamental conditions required for adequate and effective treatment programs in public mental institutions: a humane psychological and physical environment, qualified staff in sufficient numbers, and individualized treatment plans. (4)

While the Wyatt standards remain relevant to state hospital care today, a rapidly changing medical and legal landscape frequently finds forensic psychiatrists in uncharted medicolegal situations that raise important questions of law. In such situations, with established precedents offering only limited guidance, clinicians may find themselves acting as real-time players in what may eventually become future landmark litigation. Such conflicts may arise in any setting but are particularly salient in forensic hospitals and in jails and prisons.

To catalog new dilemmas emerging from 65 years of medical and legal innovation, an interactive, generative workshop was convened at the 2025 AAPL Annual Meeting in Boston (5). This paper summarizes the findings of that session, identifying the most prominent themes generated by the work of the participants.

Methods

The workshop structure was developed utilizing the World Cafe methodology, an established method for facilitating collaborative dialogue and harvesting collective intelligence. (6, 7) In adherence to the core design principles of the World Cafe method, attendees were split into groups seated at round tables. A workshop facilitator

functioned as a scribe at each table to document the key points of the discussion in real-time.

Participants were asked to individually address, and later discuss in groups, a series of five progressive inquiries:

1. What situations unique to the institutional setting (e.g., jail, prison, or forensic hospital) have led to delays or limits in the provision of psychiatric care? Are there any challenges in timely identification of patients who need to be brought to psychiatric care or a higher level of psychiatric care? How do the availability of community treatment resources and institutional treatment resources impact each other?
2. When working with institutionalized patients (e.g., jail, prison, state hospital), what factors unique to those settings impact your clinical decision-making? What clinical scenarios most dramatically illustrate any differences in the *clinical assessment* of justice-involved patients compared to non-justice-involved patients?
3. What about in the *treatment* available to justice-involved patients compared to non-justice-involved patients? Are there paradoxical effects where the care provided in an institutional setting can be better than the care a patient was receiving outside?
4. From a constitutional and/or medicolegal perspective, are there different considerations when caring for justice-involved patients at different points of intercept, from initial arrest to post-conviction (if convicted)?
5. Synthesizing the above, what do forensic psychiatrists in 2025 think are the most pressing unresolved issues in right-to-treatment?

Data was captured at the individual level through digital polling software (Padlet), and group level discussions were documented by scribes at each table. Data were then analyzed qualitatively to identify key themes.

Results

Eighteen participants attended the workshop and provided input. Eight key themes were extracted from the individual and group data:

Systemic Delays in the Identification of Mentally Ill Inmates

A common theme from participant input was a pervasive lack of resources, including understaffing and limited mental health training among correctional officers. Behaviors stemming from severe mental illness were noted to sometimes be mischaracterized as

volitional behaviors, resulting in delayed psychiatric care and unrecognized psychiatric distress.

Participants in multiple groups discussed the Sandra Bland Act, passed in Texas in 2017 (8). This Texas legislation established a swath of intercept points to improve the early identification of justice-involved individuals suspected of having a mental illness, mandating magistrate notification within twelve hours and requiring telepsychiatry access (8). However, clinicians familiar with similar intercepts noted that the legal mechanism often generates generic "flags" without providing actionable clinical details. Furthermore, identification of those with mental illness was noted to be commonly hindered by patients actively denying symptoms in context of anosognosia and/or in a belief that denying symptoms would expedite their release from custody.

Environmental Constraints and Dual Agency

The physical layout of carceral settings as well as poor environmental temperature control was noted by many participants as a significant stressor. Also noted was the risk for re-traumatization that the correctional milieu posed for a population with high levels of traumatic exposure.

Noting that the primary focus of custodial staff in jails and prisons is safety and security may conflict with the psychiatry staff's goal to improve mental health, discussants emphasized the ethical challenge of dual agency, where forensic psychiatrists are under pressure from correctional and legal colleagues, even when their fiduciary duty is to the patient. They also observed that some clinicians working in jail or prison are less likely to diagnose primary psychiatric disorders in these environments than they may in the community due to concerns regarding malingering. Some participants linked these concerns to bias regarding the correctional patient population.

The Paradox of Institutional Care and Treatment Access

Notwithstanding the concerns described above, participants also acknowledged the existence of paradoxical benefits to carceral care. They emphasized that forensic hospital settings lack the length-of-stay pressures of civil hospitals, allowing for rapport building, a stable housing environment, and longitudinal observation with reduced opportunity for substance use to confound the clinical presentation.

In jails and prisons specifically, limitations on specific treatment modalities were noted to sometimes offset this benefit. Correctional institutional formularies were frequently reported to limit access to treatments that are more accessible in a non-correctional setting. For example, participants noted that in correctional settings where they worked, the availability of clozapine was highly variable, electroconvulsive therapy (ECT) was rarely available, and medications with diversion potential were heavily regulated, regardless of how therapeutically appropriate. Participants practiced in a wide variety of

jurisdictions and facility types (e.g., jails, prisons, state hospitals) and a recurring theme was that participants were surprised to hear about highly discrepant clinical practices across different locations and site types.

Additionally, participants discussed how differing legal standards govern treatment over objection for different types of forensic settings or jurisdictions (e.g., *Washington v. Harper* (9) for the convicted; *Sell v. United States* [10] for those pre-trial; *Rennie v. Klein* (11) and *Rogers v. Commissioner* (12) for the civilly committed). This was noted to create a fragmented landscape where pharmacological intervention was heavily influenced by setting and legal status.

Medicolegal Discrepancies Across the Intercept Spectrum

Discrepancies between optimal clinical practice and pragmatic realities of the justice system were repeatedly noted. Participants struggled with tradeoffs between facilitating a pre-arraignment detainee's right to immediate inpatient treatment and their constitutional liberty interest in an expedient arraignment.

It was noted by some participants that while *Ake v. Oklahoma,* interpreted at a broad level, constitutionally entitled an indigent defendant to psychiatric assistance for their medicolegal dilemma (13), pre-trial detainees routinely awaited competency restoration beds for months or longer.

Fragmented Continuity of Care Across Jurisdictions

Participants highlighted the absence of clear mechanisms to maintain the availability of specialized treatment regimens when individuals crossed jurisdictional (or even administrative) lines, for example between jails, prisons, state hospitals, and medical or civil psychiatric hospitals. This fragmentation was identified as a primary barrier to sustained psychiatric stability, with some participants arguing that the right to treatment must legally evolve to encompass a fundamental right to continuity of care across all settings.

The Inadequacy of the Deliberate Indifference Standard

Participants in multiple groups questioned the appropriateness of the "deliberate indifference" standard, established in *Farmer v. Brennan* (14), to mental illness. The deliberate indifference standard requires a prison official to subjectively identify and disregard an excessive risk to an incarcerated individual’s health. This legal standard was argued by many to be functionally unworkable for patients with anosognosia, who lack insight into their illness and cannot articulate their medical need, or may even deny it. For such patients, non-clinical staff may not perceive a "known medical risk.”

Conclusion

On the 65th anniversary of Birnbaum's proposal of a constitutional right to treatment for psychiatrically ill patients in state custody, this workshop generated a blueprint of contemporary "unresolved issues" in right-to-treatment for justice-involved individuals. The insights derived from the 18 participants revealed that the most pressing dilemmas affecting the real-world implementation of right-to-treatment included a complex web of jurisdictional fragmentation, restrictive formularies and policies, dual agency conflicts, and legal standards that do not align with the clinical reality of severe mental illness.

References

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Farmer v. Brenn