D e b r a A. P i n a l s, M. D.

Board Certified in Psychiatry, Forensic Psychiatry, and Addiction Medicine

Court Monitor

Second (2nd) Report

Regarding the Consolidated *Mink and Bowman* Cases

Date of Report: December 6, 2025

Court Monitor: Debra A. Pinals, M.D.

Background and Context of this Report:

The *Mink/Bowman* consolidated case pertains to individuals in Oregon found unable to Aid and Assist in their own defense and individuals found Guilty Except for Insanity (GEI). Based on a longstanding permanent federal injunction against the Oregon Health Authority (OHA) and the Oregon State Hospital (OSH), OSH is ordered to admit detained Oregon criminal defendants within seven (7) days of a state court order to restore that defendant's abilities to Aid and Assist. There is no seven-day mandate for the GEI admissions, but because each of the two cases (*Mink*, pertaining to defendants unable to Aid and Assist and *Bowman*, pertaining to individuals found GEI) involved issues pertaining to timely admission of individuals who were waiting in Oregon jails for admission, the Federal Court agreed with my recommendations to merge the admission waitlists for both groups.

The original *Mink* litigation has spanned decades with several different judges. I was initially retained in December 2021 as a Neutral Expert in this case after the state was largely out of compliance in the wake of COVID-19 impacts on services. The state was moving toward

compliance in 2024 and was compliant with the order for several months and then fell out of compliance, leading plaintiffs DRO to file a motion for contempt, with MPD plaintiff also filing a motion for potential court ordered remedies. A hearing on the contempt motion was held in March 2025 before The Honorable Adrienne Nelson, who oversees this matter at present. Subsequently Judge Nelson did find the defendants in contempt and ordered remedies, including shifting my role from Neutral Expert to that of Court Monitor and issuing fines against the defendants. Specifically, the defendants are to pay fines of $500 for every day a defendant found unable to Aid and Assist wait in jail for admission beyond the 7-day mandate. The defendants have filed appeals on aspects of Judge Nelson's rulings. During the most recent status hearing, Judge Nelson ruled that if it's proven the defendants did not cause the delays, those days could be excluded from fines. Judge Nelson directed me to arbitrate those decisions, allowing plaintiffs to voice concerns. To date I have reviewed six fines reports and fines have accrued to approximately $1.4 million.

This report represents my second (2nd) as the *Mink/Bowman* Court Monitor, and the thirteenth (13th) overall report that I have produced in this case. Per the instructions of Judge Nelson, this report is to inform the upcoming status hearing on 12/8/25 and will provide a basic overview of current data, a summary of my work since my last report dated 9/5/25, and conclusions.

Qualifications to Perform this Work:

I have worked for over twenty-five years as a clinical and academic and forensic psychiatrist and have functioned for over twenty years in state and local level behavioral health administrative leadership, management, policy and legislative development, clinical treatment, forensic evaluation, and consultative roles across several U.S. jurisdictions. Other details are provided in my Neutral Expert First Report.

Sources:

In the interim since my 9/5/25 report, I have reviewed new relevant legal documents and several outside sources to inform my conclusions.

Documents reviewed include but are not limited to:

1. OSH Forensic Admission and Discharge Dashboard and Restoration Limit Report produced monthly and reporting date reflecting the month prior to report production;
2. OSH Forensic Admissions and Discharge Bi-Weekly reports;
3. Average Wait Time Prior to Admission Progress Metrics for Benchmark Goals, produced by OSH monthly;
4. OSH-PSRB conditional release dashboard;
5. Data requests and reports, including a new weekly dashboard that is reviewed with me that shows metrics on waiting times, census and admissions, NWRRC census, admissions and discharges, GEI patient progress, and data on the Extended Care Management Unit;
6. *Mink & Bowman* Monthly Progress Reports from OHA from October and November 2025;
7. Miscellaneous media reports;
8. Mink/Bowman Comprehensive Plan updates on progress;
9. E-mail correspondence with plaintiffs and defendants;
10. RFP proposal and RFP responses for outside consultant/audit selection;
11. Miscellaneous communications from CMS to OSH;
12. Deschutes County Health Services written testimony regarding HB2005 submitted by Evan Namkung, Program Manager, Forensic and Acute Services, Deschutes County Behavioral Health;
13. Fines exclusion calculations and supporting documentation;

14. Project tracker status updates for recommendations 14.2.3 (Training Non-Clinicians), 14.2.4 (Jurisdictional Treatment Plan), 16.1.4 (ODDS Workplan), and 7.2 (Flexible BH Housing Funds Resource);
15. Modified draft expedited admissions protocol for civil commitment and voluntary by guardian/health care agent admissions;
16. Suggested use of fines communication from AOCMHP on 10/21/25;
17. Status report by OHA and OSH filed for the 12/5/25 status hearing, along with a declaration from Ms. Ebony Clarke;
18. Information from Public Consulting Group including:
    a. E-mail correspondence;
    b. Community input matrix;
    c. Community interview guide;
    d. Regular project update reports;
    e. Data request spreadsheets; and
    f. CFAA fund source amounts previously shared with Optumas.

In the time since my prior report, meetings and discussions have included the following:

1. Periodic communications with The Honorable Adrienne Nelson;
2. Meetings with various OHA and OSH staff, including leadership from the hospital and FES;
3. Regular meetings and several ad hoc meetings and discussions with representatives of Governor Kotek, as well as OHA, OSH, DRO and MPD representatives. Specifically, I met with staff from these agencies at various points in this interval period.
    a. From the Governor's Office:
        i. Amy Baker, Behavioral Health Initiative Director
        ii. Constantin Severe, Deputy General Counsel
        iii. KC Ledell, Behavioral Health Senior Advisor

b. From OHA, OSH, the weekly/bi-weekly leadership meetings have included primarily:
    i. Current administrative leaders including Kristine Kautz, OHA Deputy Director, Ms. Ebony Sloan Clarke, Director of Behavioral Health, OHA, along with Samantha Byers and Dr. Christa Jones from OHA, OSH Interim Superintendent Mr. Jim Diegel, Mr. Dave Baden from OHA, as well as Dr. Morgyn Beckman and Dr. Andy Bustos of the OSH Forensic Evaluation Services. I have also met with Medicaid leadership including Shawna McDermott and Holly Heiberg.
c. From Oregon Department of Justice (DOJ):
    i. Carla Scott, DOJ Special Litigation Unit Counsel
    ii. Jill Conbere, Assistant Attorney General, DOJ
    iii. Kailana Piimauna, Sr. Assistant Attorney General, General Counsel Division
    iv. Melissa Chureau, General Counsel Division
d. From Disability Rights Oregon (DRO):
    i. Emily Cooper, Legal Director
    ii. Thomas Stenson, Deputy Legal Director
e. From MPD as plaintiff party, Jesse Merrithew of Levi Merrithew Horst PC

4. Meetings with Ms. Cherryl Ramirez, Director AOCMHP, and representatives of CMHPs across Oregon.

I continue to periodically consult with Kirsten Beronio, JD, a Medicaid expert, to help provide insights into potential strategies within Medicaid.

Glossary of Acronyms and Terms Used in this and Prior Reports

A&A or AA: Aid and Assist
APD: Aging and People with Disabilities
CCOs: Coordinated Care Organizations

CCBHCs: Certified Community Behavioral Health Clinics
CFAA: County Financial Assistance Agreements
CMHPs: Community Mental Health Programs
CRR: Conditional Release Ready meaning approved by the hospital risk review and ready for review by the PSRB
DOJ: Department of Justice Oregon
DRO: Disability Rights Oregon
ECMU: Extended Care Management Unit
FES: Forensic Evaluation Services
GEI: Guilty Except for Insanity
HLOC: Hospital Level of Care
IMPACTS: Improving People's Access to Community-Based Treatment, Supports, and Services
ISU: Intensive Services Unit
MOOVRS: Multi-Occupancy OSH Vacancy Resource & System Improvement Team
MPD: Metropolitan Public Defender
NWRRC: Northwest Regional Reentry Center
OCBH: Oregon Council for Behavioral Health
OCDLA: Oregon Criminal Defense Lawyers Association
ODDS: Oregon Developmental Disability Services
ODHS: Oregon Department of Human Services
OHA: Oregon Health Authority
OPDS: Oregon Public Defenders Services
ORPA: Oregon Residential Provider Association
OSH: Oregon State Hospital
PDES: Program Design and Evaluation Services
PSRB: Psychiatric Security Review Board
RTP: Ready to Place
SHRP: State Hospital Review Panel
SRTF: Secure Residential Treatment Facility

Summary of Activities and Updates During this Reporting Period:

Since my last report (9/5/25) I have continued regular meetings with the defendants and periodic check-ins with the plaintiffs. I have had the opportunity to speak to Judge Nelson on several occasions. I continue to work with the state on aspects of tracking progress on prior recommendations.

Areas of focus in this reporting period have included review of NWRRC capacity management as

well as a focus on hospital operational bed capacity. Discussions and activity have also centered around the implementation of HB2005, which went into preliminary effect on 9/29/25. More changes are anticipated in January 2026.

The other leading activities have included discussions and clarifications with Medicaid leadership, in partnership with Kirsten Beronio, J.D., a consultant I retained who is a Medicaid expert. These meetings slowed some in the last part of this quarter and will resume following the status hearing. With Medicaid changes on the horizon federally, there are several initiatives that remain uncertain or have changed. For example, in October 2025 Oregon's Medicaid announced it would no longer pursue Medicaid expansion for people leaving carceral settings.[1] We have also discussed some of the challenges with CCO contracting. Other areas of discussion have included the challenges with the CFAA contracts with the counties.

I have continued to have regular communication with staff from the Governor's office including Amy Baker, KC Ledell, and Constantin Sever, who have spearheaded a workgroup to examine the impacts of HB2005. I was impressed with their commitment to continue these conversations with legislative staff. Although they have recently determined that changes to the bill would be better pursued in the long legislative session, they have provided persuasive remarks as to this strategy. Specifically, the delay will allow more time to examine how HB2005 is operationalized to help further the ability for legislators to react in accordance with those findings (see the State's own status report for this hearing).

I have also spent time helping to identify the contractor to conduct the "audit" reviewing expenditures over the last three years and projecting future needs for community expansion. Public Consulting Group was selected amongst the applicants. I collaborated with them to

[1] https://oregoncapitalchronicle.com/2025/10/11/oregon-abandons-medicaid-expansion-for-people-leaving-prison-months-after-delaying-launch/

support the initiation and execution of this comprehensive qualitative and quantitative study.

Because of the litigation posture, meetings with all parties have not occurred, except for one meeting where there was discussion about potential fines utilization.

Data Summaries

Background Data: Data show the state has returned to being out of compliance with the 7-day admission time frame since my last report. At that time the state was closer to compliance but still outside of the 7-day requirement. **Figure 1** and **Table 1** show numbers of people waiting for admission, a number which is increasing. The average numbers of days people ordered for restoration are waiting is 12.6 days. Importantly, for individuals who were admitted the month prior (which is different from the snapshot average), defendants waited an average of 19.1 days as of the end of November. This number continues to increase and on 12/3/25, the average time people are waiting was at 22.7 days. In November, OSH was able to discharge 88 patients under an Aid & Assist court order, admit 69 patients under an Aid & Assist court order, and received 89 new orders.

The number of people ready to place (RTP) into the community also decreased, but continues, at 89 people by 11/30/25. There were 36 people in GEI processes thought to no longer need hospital level of care at the end of November 2025.

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Figure 1. Data Dashboard Charts Reflecting Progress in *Mink/Bowman* as of December 1, 2025

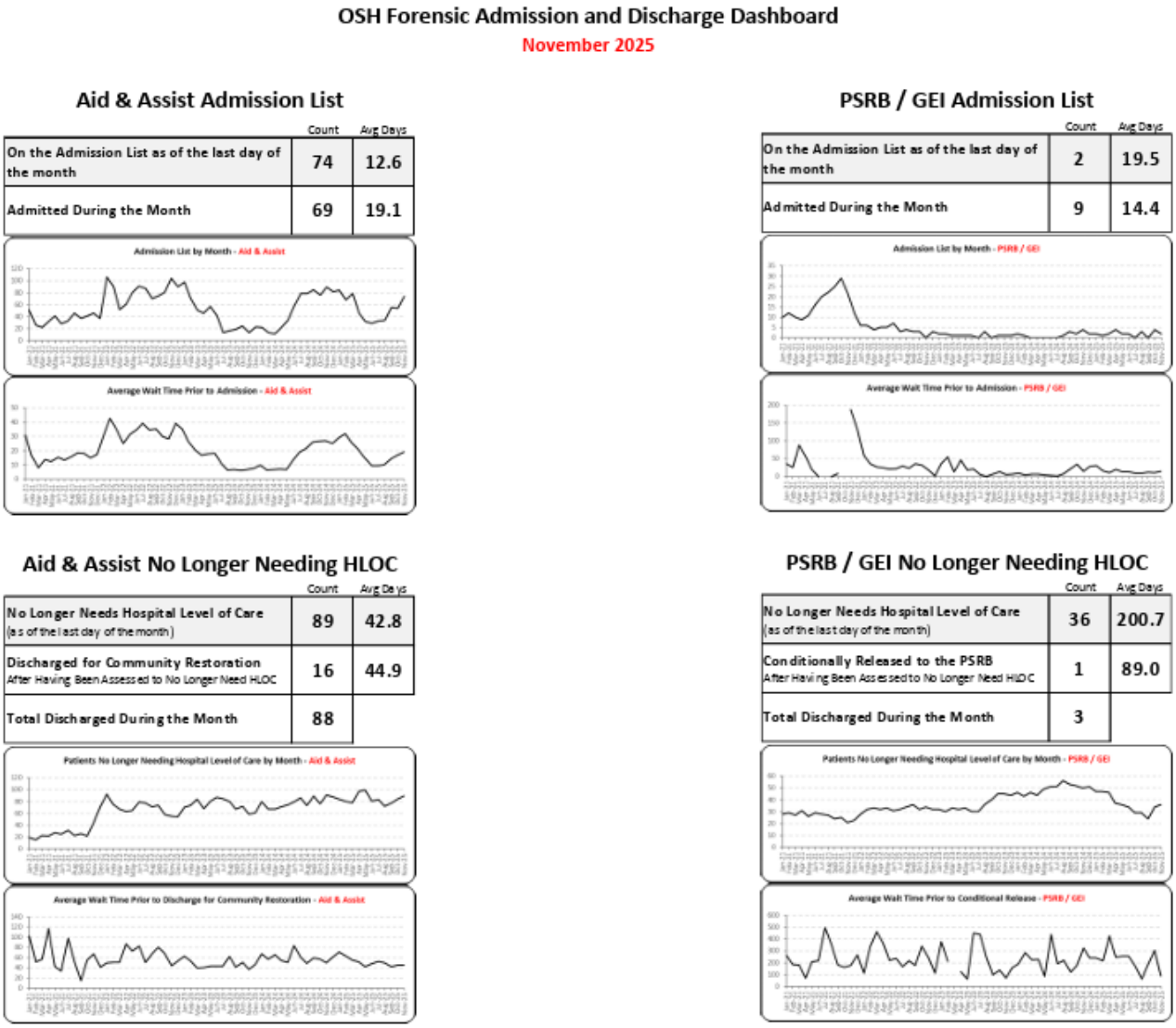


Table 1. Individuals Awaiting Admission as of November 1, 2025

1. Regarding individuals on OSH admission list with signed and received A&A court order													
	As of 1/5/22	***As of 1/28/22***	***As of 5/1/22***	***As of 9/1/22***	***As of 12/1/22***	***As of 4/1/23***	***As of 7/1/23***	***As of 11/1/23***	***As of 4/1/24***	***As of 11/1/24***	***As of 4/1/25***	***As of 8/1/25***	***As of 11/1/25***
Total Number of individuals	46	93*	67	70	104	51	42	24	11	76	79	33	54

Average days current individuals have been waiting	15.8 days	22.5 days	16.2 days	19.8 days	20.7 days	11.1 days	9.3 days	3.5 days	5.4 days	12.6 days	14.3 days	4.7 days	9.0 days
Range of Days on waitlist	2-23 days	3-44 days	2-28 days	3-34 days	1-36 days	1-18 days	1-17 days	1-9 days	3-10 days	1-28 days	1-28 days	1-23 days	1-18 days
2. Regarding individuals found GEI and ordered to OSH													
	As of 1/5/22	***As of 1/28/22***	***As of 5/1/22***	***As of 9/1/22***	***As of 12/1/22***	***As of 4/1/23***	***As of 7/1/23***	***As of 11/1/23***	***As of 4/1/24***	***As of 11/1/24***	***As of 4/1/25***	***As of 8/1/25***	***As of 11/1/25***
Total number of individuals	15	4	3	4	0	1	1	1	0	2	2	0	4
Average days waiting	45.6 days	23 days	18 days	13.0 days	N/A	26.0 days	10.0 days	1.0 days	N/A	13.0 days	12.0 days	N/A	6.3 days
Range of Days on waitlist	1-110 days	17-28 days	12-26 days	3-20 days	N/A	26 days	10 days	1 day	N/A	9-17 days	12 days	N/A	2-9 days

*The marked increase in numbers awaiting admission was most likely a residual of the pauses in admissions due to COVID-19

Hospital discharges are also delayed for people found GEI. After a great deal of work to clarify language and map out discharge steps, there is a clearer picture of what is happening and where interventions may be useful.

The GEI conditional release dashboard showing each discharge process step (**Figure 2**), shows that at every step of the process for discharge, the timeline expectations are not met. Some involve PSRB, but the step of getting hearing decisions that largely falls to the PSRB for responsibility is in the highest degree of alignment with the expectations, with over 91% of decisions being delivered timely.

Figure 2: GEI OSH Conditional Release Dashboard

OSH/PSRB Conditional Release Dashboard
November 2025

Current Patients at OSH in the Conditional Release Process and Evaluation/Hearing Decisions (as of December 1, 2025)

Conditional Release Process Stage	Count
Meets criteria to start the conditional release process, pending order for community evaluation	3
Evaluation ordered, pending written evaluation result & plan from community	10
Evaluation result & plan received, pending hearing request	1
Hearing requested, pending hearing & result	6
Total patients currently in the conditional release process	**20**

Conditional Release Granted / Pending Release Reason	Count
Waiting for bed (SRTF)	5
Waiting for bed (RTF/RTH)	10
Waiting for bed (AFH, DOC, Independent, Other)	1
Other	0
Total patients granted conditional release, pending conditional release	16

Percent of completed community evaluations where the patient is deemed appropriate for placement and accepted

October 2025	100% (4/4)
Since January 2023	95.8% (181/189)

Percent of PSRB hearings where the patient is granted conditional release from OSH

October 2025	100% (2/2)
Since January 2023	95.8% (161/168)

Percent of Patients Who Complete Each Stage Within the Expected Timeframe

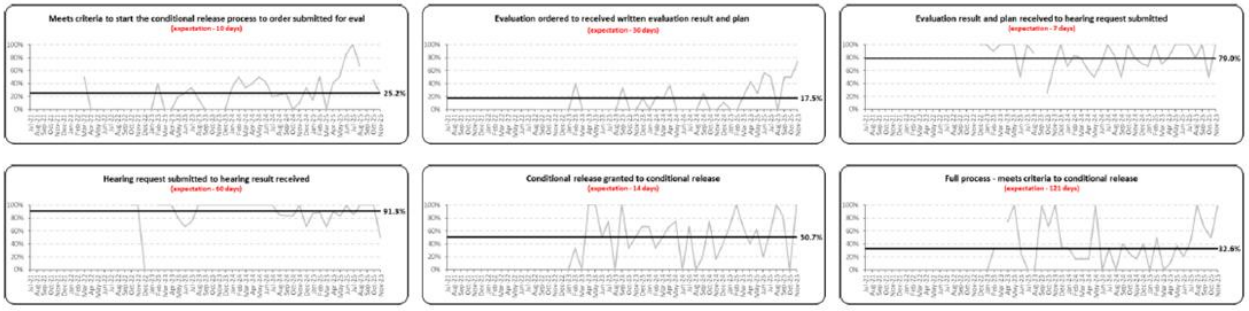


Table 2 and **Table 3** show the capacity and census at OSH, which uses an operational active capacity metric and has not shown any significant changes since my prior report. Although it appears on 11/1/25 that the hospital was at closer to active capacity, on 12/3/25 it was reported that the census of the facility was 694. Although the census went higher with the ability to admit next individuals on the waitlist when sheriffs delayed transport, it continues to be below active capacity. This is something that I have been discussing and will continue to discuss with the defendants. Of note, four medical beds were removed from licensed capacity that had been previously reported, but this did not change active capacity.

Table 2: OSH Bed Capacities as of 11/1/25

Site	Licensed Capacity	Active Capacity
Salem Main Campus HLOC	498	474
Salem Main Campus SRTF	90	87
Salem Main Campus Total	**588**	**561**
Junction City HLOC	75	72
Junction City SRTF	75	72
Junction City Total	150	144
OSH Total	**738**	**705**

Table 3. OSH Census as of 11/1/25

Date	Aid & Assist	PSRB	Civil Commitment	Other	Total
9/1/2022	410	275	14	1	700
12/1/2022	396	279	13	0	688
4/1/2023	400	279	11	1	691
7/1/2023	389	281	13	1	684
11/1/2023	366	291	17	1	675
4/1/2024	360	288	30	0	678
11/1/2024	375	270	27	8	680
4/1/2025	383	269	28	3	683
8/1/2025	394	262	37	3	696
11/1/2025	396	265	37	5	703

The ongoing high numbers of new orders for restoration continue to be notable. Record numbers of evaluations came in during four consecutive months of June to September 2025, of over 100 orders per month (See **Table 4** and **Figure 3**). This has had a significant impact on the waitlist numbers as the defendants are challenged to keep up with court order demand. Of note, GEI revocations and admissions appear to also be increased though the numbers are low and as such variations are difficult to discern.

Table 4. Aid and Assist and GEI Orders

Number of Orders Received	Aid & Assist	GEI
April 2022	79	7 (4 standard / 3 revocation)
May 2022	76	7 (4 standard / 3 revocation)
June 2022	73	6 (4 standard / 2 revocation)
July 2022	72	5 (3 standard / 2 revocation)
August 2022	81	7 (4 standard / 3 revocation)

September 2022	84	6 (5 standard / 1 revocation)
October 2022	95	3 (3 standard / 0 revocation)
November 2022	89	6 (2 standard / 4 revocation)
December 2022	74	4 (4 standard / 0 revocation)
January 2023	107	3 (3 standard / 0 revocation)
February 2023	78	5 (3 standard / 2 revocation)
March 2023	109	7 (2 standard / 5 revocation)
April 2023	103	5 (2 standard / 3 revocation)
May 2023	94	7 (3 standard / 4 revocation)
June 2023	86	1 (1 standard / 0 revocation)
July 2023	73	3 (0 standard / 3 revocation)
August 2023	109	5 (3 standard / 2 revocation)
September 2023	93	7 (6 standard / 1 revocation)
October 2023	97	3 (2 standard / 1 revocation)
November 2023	98	3 (2 standard / 1 revocation)
December 2023	92	3 (2 standard / 1 revocation)
January 2024	83	4 (4 standard / 0 revocation)
February 2024	73	9 (3 standard / 6 revocation)
March 2024	87	2 (2 standard / 0 revocation)
April 2024	99	1 (1 standard / 0 revocation)
May 2024	127	7 (3 standard / 4 revocation)
June 2024	90	2 (0 standard / 2 revocation)
July 2024	128	3 (0 standard / 3 revocation)
August 2024	99	4 (3 standard / 1 revocation)
September 2024	92	6 (6 standard / 0 revocation)
October 2024	102	6 (3 standard / 3 revocation)
November 2024	89	5 (3 standard / 2 revocation)
December 2024	105	3 (3 standard / 0 revocation)
January 2025	89	2 (2 standard / 0 revocation)
February 2025	79	4 (3 standard / 1 revocation)
March 2025	96	8 (4 standard / 4 revocation)
April 2025	101	9 (8 standard / 1 revocation)
May 2025	82	7 (5 standard / 2 revocation)
June 2025	105	5 (4 standard / 1 revocation)
July 2025	111	7 (4 standard / 3 revocation)
August 2025	111	8 (5 standard / 3 revocation)
September 2025	124	6 (4 standard / 2 revocation)
October 2025	99	7 (5 standard / 2 revocation)

Figure 3. Aid & Assist Admissions/Orders Trends through October 2025

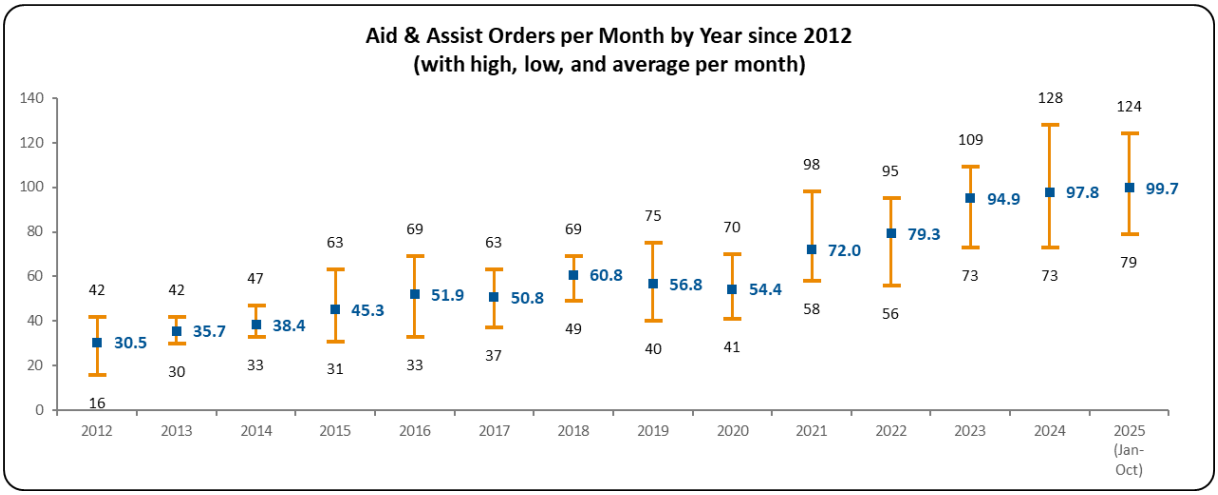


Figure 4 is a graphic depiction of the waitlist trends, which are clearly increasing again.

In November 2025, OSH admitted 69 A&A patients with an average wait time of 19.1 days (19.0 days when the days from late orders and/or transportation delays are omitted – the dotted line that is now noted on the figure below). There may be a slight decrease in waitlist trends over the winter as the order numbers decreased after September 2025. Generally that would be reflected in December and January. However, that will also depend on admissions keeping apace.

Figure 4. Admission Wait Time Projections Compared to Benchmarks Set in Second Report based on data as of 11/1/25

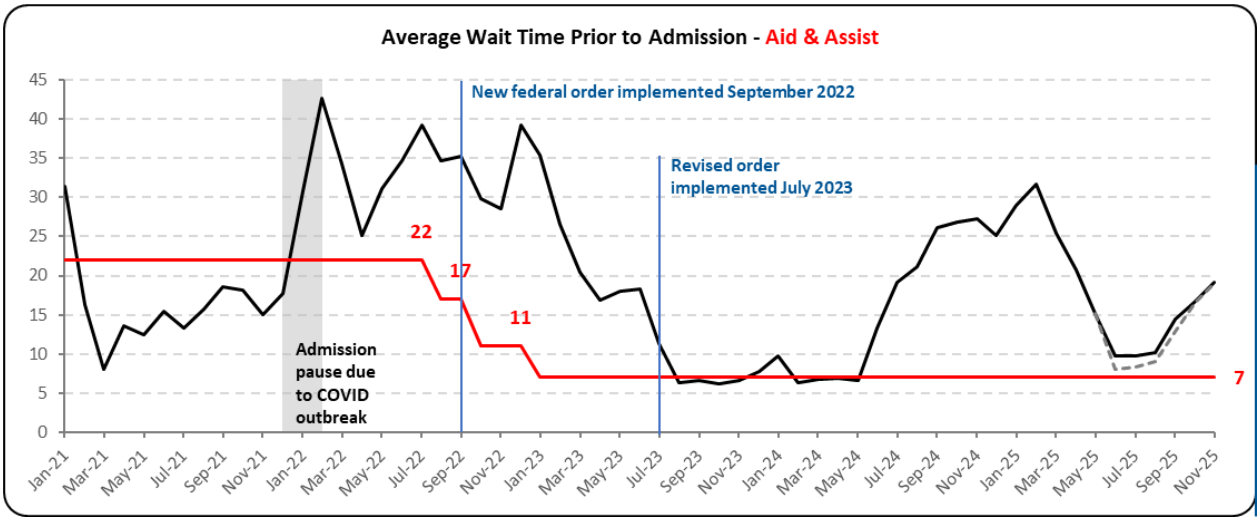


Table 5 below is an abbreviated depiction of numbers and outcomes, according to OSH data, of cases that went to OSH before and after the 9/1/22 Federal Court order limiting times for restoration at the hospital. **Figure 5** shows that the percentage of discharges that occur simply because they "timed out" on the Federal Court Order restoration time limits, has decreased from 27% to 15%, with no change since last quarter's report. Thus, although many stakeholders report that the new time limits are creating more discharges just due to the clock running out, this appears to be leveling out. As noted in my last report, a higher percentage are being discharged into community restoration (See **Figure 6**). As I have noted in multiple prior reports, it is likely that many of these individuals would ultimately be found unrestorable (whether in the hospital or not), though the impact of HB 2005 remains to be seen.

Table 5. Discharge Data Related to the 9/1/22 Order by the Federal Court

Reason	2021	2022 (Jan-Aug)	2022 (Sep-Dec)	2023	2024	2025 (Jan-Oct)
Restoration Limit			**8**	**285**	**254**	**148**
Community Restoration			**12**	**215**	**244**	**317**
Dischargable Finding	**620**	**386**	**58**	**514**	**535**	**451**
Able	*518*	*332*	*51*	*442*	*466*	*397*
Never Able	*71*	*34*	*3*	*40*	*46*	*41*
Med Never	*31*	*20*	*4*	*32*	*23*	*13*
Other	137	166	4	55	73	73
Grand Total	757	552	82	1069	1106	989

Figure 5. Outcomes of Aid and Assist Discharges through October 2025

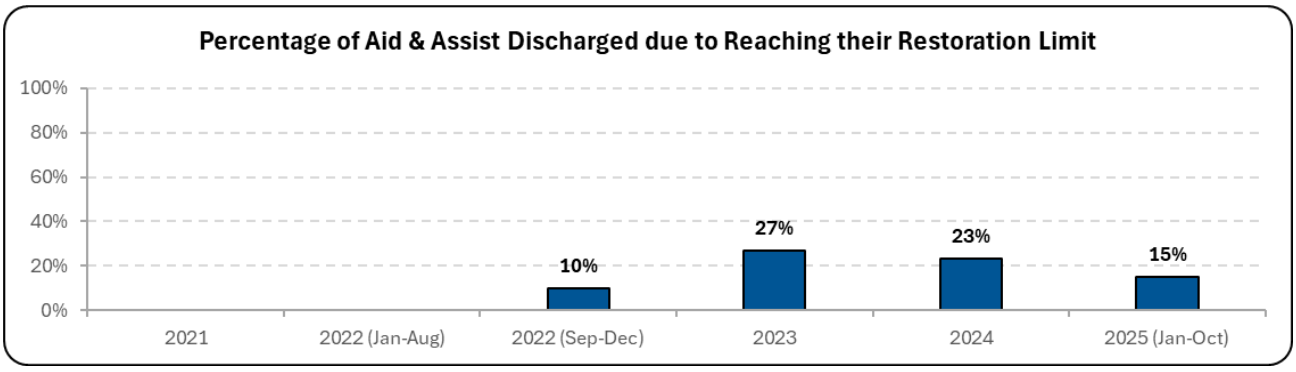


Figure 6: Percentage of Aid and Assist Discharged into Community Restoration

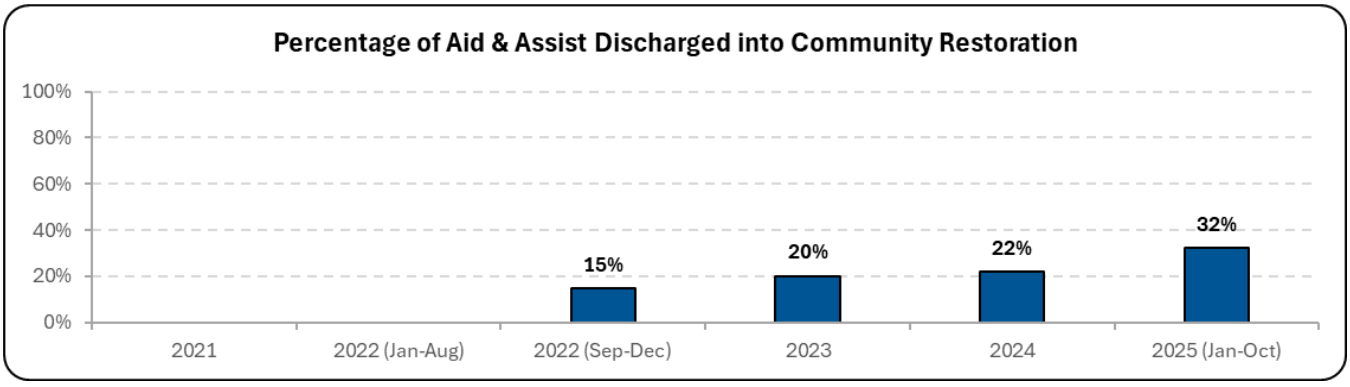


Figure 7 examines data that looks at type of dischargeable finding among those discharged from OSH after receiving a dischargeable finding, and as recommended by evaluators. The data shows that overall, proportions of discharges of individuals found Able remains between 85-88% range in the last two years, Never Able has hovered around 9%, and Med Never findings since 2021 have decreased from about 5.5% to about 3%.

Figure 7. Percentage of Dischargeable Finding by Type

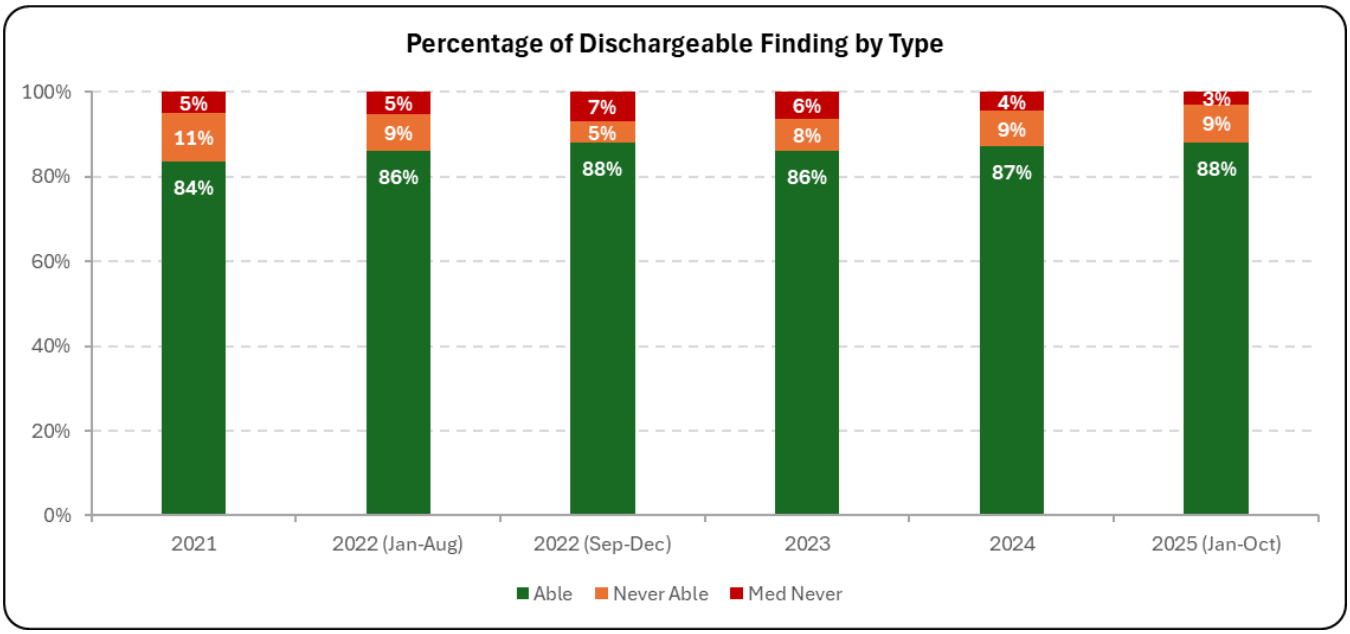


Table 6 depicts the types of findings for the month of October, with most people being discharged with a dischargeable finding (although this was down from the July 2025 data I presented which showed 48% with a dischargeable finding). Monitoring these trends will help determine if other hospital interventions are needed for restoration itself.

Table 6. Legal Status of AA Discharges in October 2025 based on Hospital Data

October 2025 A&A Discharges

Reason	Count	Percent
Restoration Limit	17	18%
Community Restoration	27	29%
Dischargable Finding	36	39%
Able	*33*	*35%*
Never Able	*3*	*3%*
Med Never	*0*	*0%*
Other	13	14%
Total	**93**	**100%**

Data from community restoration services is presented in **Table 7** below. Of note, this is drawn from the previously existing data collection method, and per my earlier recommendations there continues to be work done to help improve community restoration data. Nonetheless, this data in comparison to my last report shows that for community restoration through 4/1/25 to 9/30/25, an additional 534 episodes of community restoration were recorded (3633 – 3099). Maximum days decreased from 1726 to 1661, and mean days also decreased from 208 to 202. According to the current information, 569 episodes have lasted more than one year (3616-3047) for all community restoration, and 231 episodes have lasted more than a year in Quarters 1-3 in 2025 (**Table 8**). This is more than were reported at the last data report, with 497 episodes occurring for more than one year. With HB2005, it will be critical to track whether the intended limits of restoration times will be effective, or whether extensions will allow for many more exceptions that will effectively swallow the recommendation for finite and ultimately shorter community restoration time periods.

Table 7. CMHP Reported Completed Community Restoration Data 1/1/2019 - 9/30/2025

CMHP Reported Community Restoration Data 1/1/2019-9/30/2025

# of Community Restoration Episodes	3633
# of Days Minimum	1
# of Days Maximum	1661
# of Days Mean	202
# of Days Median	144

Days in Community Restoration	# of Community Restoration Episodes	% of Total Community Restoration Episodes
0-90	1282	35.3%
0-180	2113	58.2%
0-365	3047	83.9%
0-730	3544	97.6%
0-1095	3616	99.5%

- This table includes all community restoration cases, completed and ongoing.
- The reported numbers may change in the near future as counties are being asked to review and clean their data as necessary.

Table 8. CMHP Reported Year by Year Data 1/1/19 to 9/30/25

CMHP Reported Community Restoration Data 1/1/2019-9/30/2025

	2019		2020		2021		2022		2023		2024		2025 Q1-Q3	
# of Community Restoration Episodes	337		383		454		641		1021		1244		1270	
# of Days Minimum	2		1		1		1		1		1		1	
# of Days Maximum	1661		1661		1661		1661		1661		1485		1485	
# of Days Mean	278		304		285		285		291		285		213	
# of Days Median	200		223		196		196		218		242		142	
Days in Community Restoration	# of Community Restoration Episodes	% of Total Community Restoration Episodes	# of Community Restoration Episodes	% of Total Community Restoration Episodes	# of Community Restoration Episodes	% of Total Community Restoration Episodes	# of Community Restoration Episodes	% of Total Community Restoration Episodes	# of Community Restoration Episodes	% of Total Community Restoration Episodes	# of Community Restoration Episodes	% of Total Community Restoration Episodes	# of Community Restoration Episodes	% of Total Community Restoration Episodes
0-90	74	22.0%	63	16.4%	99	21.8%	131	20.4%	214	21.0%	281	22.6%	507	39.9%
0-180	156	46.3%	156	40.7%	202	44.5%	288	44.9%	441	43.2%	481	38.7%	716	56.4%
0-365	248	73.6%	269	70.2%	333	73.3%	482	75.2%	723	70.8%	869	69.9%	1028	80.9%
0-730	319	94.7%	357	93.2%	428	94.3%	599	93.4%	951	93.1%	1184	95.2%	1217	95.8%
0-1095	332	98.5%	377	98.4%	447	98.5%	624	97.3%	1008	98.7%	1233	99.1%	1259	99.1%

- This table includes all community restoration cases, completed and ongoing.
- The reported numbers may change in the near future as counties are being asked to review and clean the reported data as necessary.

According to information provided by OSH (see **Table 9**), evaluations conducted by FES continue to be high, with an increasing number of all types of evaluations ordered for individuals not currently at OSH (431+89+37=557) compared to 498 (394+79+25=498) reported in my last quarterly report.

Table 9. Number of Active FES Cases as of 11/18/25

Type of Evaluation and Location	Number
.370 Evaluations at OSH	391
.370 Evaluations not at OSH	431

.365 Evaluations not at OSH	89
.315 Evaluations not at OSH	37
Total Cases	**948**

As depicted in **Table 10**, approximately 32.4% of the 577 individuals eligible for RTP assessments admitted to OSH are ready to place in the community by day 10. Yet these individuals go on the RTP list and wait along with others for much longer.

Table 10. RTP 10-Day RTP Assessment Outcomes (August 2022 through October 2025)

Year	10-Day RTP Assessments	Patients Found RTP	Percent Found RTP
2022 (Aug-Dec)	205	87	42.4%
2023	648	250	38.6%
2024	596	170	28.5%
2025 (Jan-Oct)	577	187	32.4%
Total	**2,026**	**694**	**34.3%**

The mediation that resulted in the Second Amended order from 7/3/23 offered exceptions to the original restoration duration limits. In 2025 between January and October there were 74 30-day extension requests and 41 180-day extension requests, accounting for 2,220 and 7,380 bed days respectively. If admission length of stay average is 90 days, then 106 additional admissions could have been managed, or 53 if the length of stay was 180 days. These extensions were negotiated with an intention to review their impact, and while the state is significantly out of compliance, their impact is felt more significantly.

Table 11. **Number of 30-day and 180-day Requests to Extend Restoration Duration**

	30-Day Extension Requests				**180-Day Extension Requests**				
Period	**Initial**	**2nd**	**3rd**	**Total**	**Initial**	**2nd**	**3rd**	**4th**	**Total**
Jul 2023 – Dec 2023	17			**17**	17	5			**22**
2024	74	5	1	**80**	42	11	4		**57**
2025 YTD (Jan-Oct)	72	2		**74**	24	11	5	1	**41**
Total	**163**	**7**	**1**	**171**	**83**	**27**	**9**	**1**	**120**

According to OSH tracking, currently all competency restoration extension requests are being granted, whether they meet criteria or not.

In addition, civil expedited admission requests and admissions were also examined. The data produced by OSH indicated is in **Table 12**. An updated civil expedited admission protocol was recently sent to me for review and I returned my feedback. It will essentially narrow the number of individuals who need biological therapies such as ECT that can more easily be obtained in medical hospital settings than through OSH.

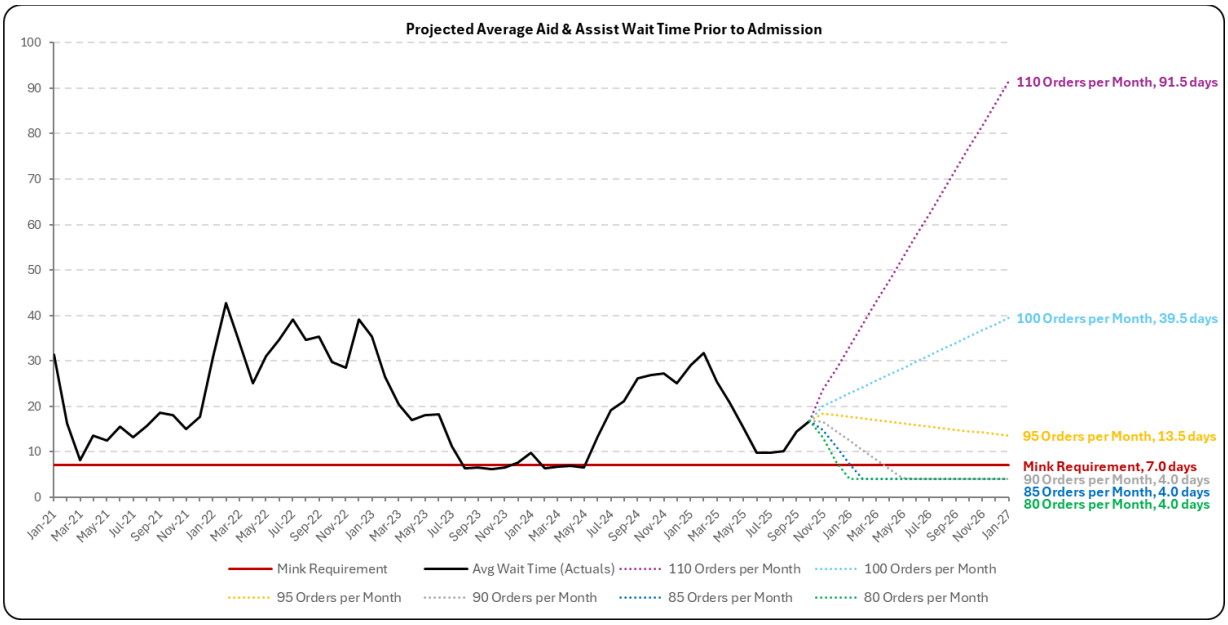
Table 12. Civil Expedited Admission Requests

Period	Requests	Accepted	Denied	Under Review
Sep 2022 – Dec 2023	22	14	8	
2024	58	34	24	
2025 YTD (Jan-Oct)	84	49	31	4
Total	**164**	**97**	**63**	**4**

To prepare this report I met and conferred with Mr. Scott Hillier, the OSH data analyst, and asked for projections of compliance with hypothetical scenarios of varying numbers of court orders coming forward in the future. This is depicted in **Figure 8**. The following assumptions and historical data are included for the analysis:

> *Since September 2022, OSH has been able to average roughly 96 total discharges and admissions per month - with current bed capacity (both inside and outside of OSH) and with the current federally enforced restoration limits in place.*
>
> *Whenever OSH receives more than 96 orders per month, it usually adds people to the admission list and increases the waiting time. When OSH receives fewer than 96 orders per month, it usually decreases the number of people on the admission list and the waiting time for admission.*
>
> *Below is a chart projecting the impact on the average waiting time based on the average numbers of orders received over the foreseeable future (ranging from 110 new orders per month to only 80 new orders per month).*

Figure 8. Hypothetical Projected New Orders Impact on Compliance



With all else being constant, if OSH received an average of 110 or 100 new orders per month, it would push the hospital further away from compliance, potentially reaching an average wait time of 91.5 days (110 orders per month). Averaging 95 new orders per month would inch the hospital towards compliance, but not until 2029.

If OSH only received 80-90 new orders per month, compliance could potentially be reached as early as February 2026 (80 orders per month) or July 2026 (90 orders per month).

These projections do not take into consideration any new bed capacity that is slated to come online during this period (which could increase the number of discharges per month and speed up compliance). Nor does it take into consideration any aspects of HB 2005, which could slow down the rate of discharges and compliance.

Select Updates from OHA

The OHA leadership has been focused on responding to areas of uncertainty related to federal funding. Discussions with CCOs have included postponing the full procurement and adjusting

the payment into the CCO contracts for their renewal, given reports of increased expenses, including increases for behavioral health expenditures.[2] Similarly, with rule changes to the County Financial Assistance Agreements (CFAAs), there is ongoing discussion of funding needs to ensure that the communities are adequately funded for both forensic and civil commitment mandated and non-mandated populations. There is a great deal of discussion taking place about these issues among the OHA leadership and partner organizations.

OHA has also been working on the implementation of HB 2005. I reviewed the community restoration draft manual, and we determined that it needs updates in accordance with the new legislation.

OHA has been much more actively managing the contract at NWRRC and maintaining the census at 35 individuals. In addition, in response to the recent increase in numbers of people waiting for admission to OSH, Dr. Jones at OHA has responded by working with NWRRC leadership to accommodate up to 41 individuals when they are able. OHA leadership has also worked to help facilitate discharges of individuals who had been at NWRRC for more than a year. These are positive steps forward.

The ECMU is focused on 46 individuals on the Ready to Place list and continues to work with Multnomah, Washington, Lane, Coos, Curry, and Douglas counties. A report on ECMU impact is being reviewed by OHA and then will be sent to me for review. Preliminary reports of its effectiveness are promising.

OHA is also working on data regarding the community navigators and their impact, and I am looking forward to receiving this information to determine if further expansion or refinement is warranted.

[2] https://www.opb.org/article/2025/09/10/oregon-health-care-plan-kotek-plan-medicaid-ccos-insurance/

OHA has also been developing a capacity to provide forensic evaluations in the community and coordinate community restoration. They have just reported in time for this Status hearing report that they will be funding a community-based forensic evaluation service in accordance with my earlier recommendations.

There are plans in place for community expansion that will require further review. There are meetings set up for this month with me to discuss the community services and planning. I refer the Court to the Declaration of Ms. Ebony Clarke for the defendant's current report on community expansion, submitted for the 12/8/25 Status hearing.

OSH Updates

Mr. Jim Diegel has facilitated many transitions at OSH. He has re-invigorated medical leadership, and after the departure of Dr. Bell, Dr. Bhavan has taken on the interim role in earnest. I had the opportunity to meet with Mr. Diegel and Dr. Bhavan during this interim period, and they are working on several fronts to ensure maximum safety and well-being for patients and ability to admit people timely. They have addressed Joint Commission issues and are working on CMS remedies.

Of note, I have recently pressed hard on the safe use of all available beds within their active capacity, as they have not maintained a census of 704 in any consistent manner and are generally operating at 10 beds less than this stated capacity. I met with OSH leadership to discuss unit utilization and will meet with them again during my site visit on 12/9/25. In addition, Mr. Diegel has asked for daily admission and discharge reports to help improve clarity of and planning for open beds.

Leadership at OSH remains largely filled with interim positions. It is concerning that the plan is to name permanent members of the leadership team (CNO, Chief of Psychiatry, CMO) prior to the identification of a permanent Superintendent.

To effectuate more efficient admissions and reduce fines, the OSH leadership and others have improved communication to Sheriffs and the Courts for timely transport and orders. There are still efforts underway to help systematically reduce those operational lags.

Administrative delays with GEI discharges have not improved with any consistency, and this will again be a focus of the next interim period.

Forensic Evaluation Services

OSH reported on 12/3/25 that there were 153 people waiting for community restoration evaluations. FES continues to work to address the increasing community restoration evaluation orders in the meantime. They report being able to conduct evaluations within the six-month statutory timelines but there are also concerns that referral numbers will increase after January due to the provisions of HB 2005 There have been additional staff hires, but there have also been some resignations and contractor onboarding. For example, the OHSU fellowship in forensic psychiatry no longer is doing evaluations at OSH. This may benefit the community where they may be more able to work with the contracted evaluation service. This remains to be seen.

Summary of AOCMHP Discussions and Activities:

I continue to meet with CMHP representatives approximately once per month and this has proven to be very productive. The topic areas include concerns about the CFAAs, ideas about how to use Fines money, and the impact of HB 2005. The reports I am hearing is that there are

county differences regarding restoration timelines in whether the bill is being made retroactive to all people on community restoration or only those ordered to restoration after 9/29/25 when the bill went into effect. There seems to be uniform concern about the administrative burden, the lack of adequate funding, the practical and due process impacts on defendants of the HB2005 provisions, most especially around the potential "pauses" in restoration, the administrative burdens of frequent reporting to the court, the responsibility of tracking time in restoration, the way the judicial authority over discharges from OSH will work, and the impact of the civil commitment language expansion, when more of the legislation goes into effect in January.

Summary of Legislative Efforts Regarding the Mink Restoration Time Limits and Behavioral Health Funding:

As noted previously OHA, OSH, and the Governor's office strongly advocated for legislation that would implement competency restoration times in line with my Second Report recommendations. Governor Kotek signed the resultant legislation with a signing letter expressing concerns about the bill's potential costly and impractical impact on the system. The Governor's office immediately stood up a workgroup to continue to discuss the legislation and to work with partners to help identify potential areas for improvement. This is ongoing and will likely allow for more discussion during the long session. Although I had expressed my thoughts that efforts should be made in the short session to modify the bill toward the original intended restoration limits without the numerous "pauses", the Governor's office and OHA have determined that it will be important to gather data and then determine where fixes may be useful and politically feasible. This approach does have some merit given the controversial nature of the bill at its inception.

Federal Court Order for an External Study led by the Court Monitor

In Judge Nelson's contempt order dated 6/6/25 she articulated the following remedial measure:

> *Defendants are ordered to hire an independent auditor, to be chosen and overseen by Dr. Pinals, to review how the State has spent funding dedicated to increasing the supply of behavioral health services in the community; identify what levels of care are still lacking and where; and provide this information in a public report to the Court, to be completed within ninety days of the date of this Opinion and Order. Defendants shall be responsible for the costs associated with implementing this remedial measure.*

To that end, a procurement for contractors was conducted and Public Consulting Group was selected to conduct this study. Their contract work began 10/17/25. The data collection and community information interviews have begun. A timeline was reviewed and revised, assuming all data is collected timely. The timeline is delineated in **Table 13**.

Table 13. PCG Project Timeline with Milestones

Project Phase	Major Milestones	Timeline
Project Initiation and Project Management	• Project Kickoff with Dr. Pinals (10/16) • Official Project Kickoff with OHA Team (10/23) • Workplan • Weekly Meetings and Bi-weekly Status Report	October 16, 2025 – Contract End
Community Partners Identified	• List of priority community partners identified by OHA and Dr. Pinals	October 31, 2025
Data Received from OHA	• OHA submission of requested data to PCG	December 5, 2025
Funding Analysis	• Analysis of 2022–2025 funding and current Aid & Assist and GEI expenditures • Summary of current fiscal year funding sources and allocations	January 16, 2026
Gap Analysis & Needs Assessment	• Evaluation of existing Aid and Assist and GEI services • Identification of service gaps and unmet needs	January 16, 2026
Community Input	• Key Informant Interviews • Focus Groups • Community Input Key Summary Report	December 5, 2025* Additional community input to be collected as needed beyond these dates
Cost Estimations and Projections	• Estimated current fiscal year costs to close service gaps, plus 3-year projections based on trends.	January 30, 2026
Final Report and Presentations	• Public report and presentation of findings for Mink/Bowman Court Monitor, OHA, Plaintiffs in Mink/Bowman and the relevant Federal Court	Draft Report: February 23, 2026 Final Report: March 16, 2026 Presentations: March 16, 2026 – April 1, 2026

Fines Updates

The state has issued six fines reports to Judge Nelson, and initial reports have been reduced to judgment. The total fine dollar amount currently is approximately 1.4 million dollars. With the increased waiting times, these amounts will increase. Of note, each month for the last three months I have reviewed any exclusions of days for fines and have received supporting documentation from courts that have delayed in sending orders and from counties who delay transport. The defendants are attempting to communicate with these other parties about the serious problems of these administrative delays when the constitutional rights of defendants waiting in jail are at stake. More work is needed with regard to encouraging outside entities to do their part to help this statewide problem of delays. The Governor's office appears engaged in facilitating some of this work.

Regarding the accumulating funds, there have been several suggestions that have been presented to me for the use of the fines money that I am reviewing. I have also spoken with the defendants and the plaintiffs regarding the fines money.

Conclusions and Comments

At the status hearing in September 2025, I was more optimistic about improvements in compliance, but with the waiting times up to 22.7 days, the metrics are going in the wrong direction. There were four months of record increases in the orders received by the hospital, as well as the community shifts and attention to HB 2005 and attention to fiscal cuts from federal funds that in my opinion, raise serious concerns about timelines to return to compliance. That said, even though more is needed, I do believe OHA is working in earnest to address my prior recommendations and advance system changes to help remedy the situation. This will take time, and likely more time than I had anticipated previously given current factors. As noted in the data projections above, if all is maintained at current status quo, increased orders will continue to greatly impact compliance. If the community expansion does not keep a pace, this will bode negatively. If federal cuts and the state budget curtail community expansion, this will also have a negative impact on compliance. The fines dollars are also complicated as they pull from

other areas of services and should be utilized for something that OHA is not already required to fund by its mandate, or the logic behind the fines will become circular.

As of this status report, I am recommending that a return to the 11th report and the recommendations of the plaintiffs be considered, especially the potential to eliminate admissions for restoration of specific defendants including specific misdemeanor crimes and possibly certain felony crimes where risk issues are not overt. Even holding those admissions for short periods when waitlist numbers are high would help the situation. This may require further analysis, and I am engaging with plaintiffs and defendants about this potential remedy yet again.

Also, regarding OSH operations, I recommend that the recruitment of a permanent superintendent begin immediately, to allow this individual to then recruit their own leadership team, rather than recruit in reverse. Mr. Diegel seems to be doing a fine job in his role, but he plans to leave at the end of June, which in administrative time, is right around the corner. I also recommend that OSH continue to explore every opportunity to use available bed space and maintain capacity at its stated active capacity of 704 and develop contingency plans for when waitlist numbers are higher. I plan to continue to explore this further with OSH leadership during my upcoming site visit and will consider any additional options for assistance with this after that visit as I review hospital operational capacity issues with the staff at OSH and Dr. Bhavan and Mr. Diegel.

Regarding fines, I will review specific proposals that have come to my attention but also recommend that a work group be formed for up to four meetings to develop a list of priorities for the use of the fines money. I hope to establish such a workgroup in the next interim period, and I plan to include the voice of an individual with lived experience to help weigh in on what may be helpful for individuals to maximize positive community tenure. At the same time, I am awaiting information from the forthcoming Optumas study as well as the PCG study to help inform where system expansion is most needed that could take advantage of fines money.

As per my prior reports, ongoing work with OSH and OHA will include reviewing prior workplan progress. I will continue to work with the defendants to make refinements as tasks are completed and new milestones need to be established. I especially appreciate the help of Deloitte Staff and Ms. Jill Conbere from DOJ in tracking the recommendations and progress.

In conclusion, in my opinion, the increased wait time is highly problematic and requires both front door and back door remedies at all levels of care throughout the behavioral health system to reduce reliance on OSH and jails, and increase flow through the system and help people establish permanent housing, even when supported, to reduce recycling through the behavioral health and criminal system and reduce time waiting in jails in violation of their constitutional rights.

On the positive side, the defendants appear to be working cooperatively with me to address remedies I have suggested and the court has ordered, and the leadership appears committed to the work ahead. As I have noted before, Oregon has many positive yet disparate behavioral health, fiscal, and legislative initiatives that are occurring at the same time, and it will be important to remain cognizant of how each initiative can impact the other and can impact compliance. I appreciate the efforts of the defendants, their counsel, the plaintiffs and other interested partners in helping improve the waiting times at issue in this matter.

Respectfully Submitted,

Debra A. Pinals, M.D.
Court Monitor, *Mink/Bowman*