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

Third (3rd) Report

Regarding the Consolidated *Mink and Bowman* Cases

Date of Report: March 16, 2026

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.

This report represents my third (3rd) as the *Mink/Bowman* Court Monitor, and the fourteenth (14th) overall report that I have produced in this case. This report is to inform the upcoming status hearing on 3/18/26 and will provide a basic overview of current data, a summary of my work since my last report dated 12/6/25, and comments with recommendations.

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 12/6/25 report, I have reviewed new relevant Court filings, including motions from Mr. Preston Berman to be considered as amicus, as well as motions filed by DRO and responses by the state pertaining to the fines exclusions. I also reviewed transcripts of

court hearings and a prior declaration of Derek Wehr and several additional sources to inform my conclusions.

Documents other than Court documents that I 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 monthly conditional release dashboard;
5. Data requests and reports, including the weekly dashboard that is reviewed with me that shows metrics on waiting times, census and admissions, NWRRC census, admissions and discharges, GEI patient progress, data on the Extended Care Management Unit and community forensic evaluations;
6. Data on a new “traffic report” dashboard sent Monday through Friday to show census management and patient movement at OSH;
7. Data projections related to extensions and misdemeanor admissions;
8. Case reviews by DRO regarding extensions;
9. Fines calculation reports;
10. Various clinical forensic evaluation reports;
11. *Mink & Bowman* Monthly Progress Reports from OHA from December 2025, February 2026, and March 2026;
12. Miscellaneous media reports;
13. Mink/Bowman Comprehensive Plan updates on progress;
14. E-mail correspondence with plaintiffs and defendants;
15. Various documents and data analyses reviewed for PCG report;
16. ECMU progress report for Lane, Multnomah and Washington Counties in 2025;
17. Community Navigator updated PowerPoint regarding data collection;

18. CMS restoration of deemed status letter to OSH leadership dated 1/21/26;
19. Governor's Behavioral Health Staff workplan for civil commitment legislative tracking;
20. Position description postings for OSH Deputy Chief Medical Officer/Chief of Psychiatry and Director of Forensic Services;
21. Realignment memorandum sent to OSH staff regarding leadership at OSH;
22. Notes and audio recording of Lane County hearing related to community restoration timelines as provided by DRO;
23. Modified draft expedited admissions protocol for civil commitment and voluntary by guardian/health care agent admissions.
24. Suggested use of fines communication from AOCMHP on 10/21/25; and
25. Status report draft by OHA and OSH filed for the 3/1826 status hearing.

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, Interim Chief Medical OfficerMr. 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; and
5. Meetings with Public Consulting Group, Inc. consultants who are working on the independent review.

I conducted site visits to OSH (12/9/25), Jackson House SRTF in Salem (12/9/25), Jackson House SRTF in Portland (12/10/25) and New Narrative in Portland (12/10/25).

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:

My work since the last status hearing has continued to involve 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 brief updates on data on a weekly basis.

The state has produced a dashboard for my review that helps me look at data in more real time and has helped organize our conversations and made them more efficient. Capacity management and trends with court orders are part of my review. Discussions and activity have also been centered around the implementation of HB2005.

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. Per my request, they produced an organized work plan to help review HB2005 and its impact and to work toward legislative fixes as needed based on that review. In their plan they identified some priority issues including establishing "permanent statutory timelines for OSH commitment and community restoration" and helping develop and putting in place "any statutory changes necessary to ensure the State's sustainable compliance with the Mink/Bowman order."

During the latest 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 eight fines reports and those fines have accrued to approximately $3.19 million.
I have been meeting regularly with PCG consultants and started to review draft sections of their report. They have worked closely with OHA, OSH and OJD to gather data to help in their analysis.

As noted previously, there have been no regular meetings with all the parties given the status of this litigation, so I have met with defendants and plaintiffs separately.

Data Summaries:

Background Data: Data show the state has started to move toward compliance with the 7-day admission time frame since my last report. Though they are still outside of the 7-day requirement, recent data started to show a bend in a positive direction, except for a recent uptick. **Figure 1** and **Table 1** show numbers of people waiting for admission. The average number of days people ordered for restoration are waiting is 9.2 days. Importantly, for individuals who were admitted the month prior (which is different from the snapshot average), defendants waited an average of 16.5 days as of the end of February, compared to 19.1 days I reported on reflecting time at the end of November, and the 22.7 days I noted at the beginning of December. Of note, the weekly dashboard I have been shown noted that the days individuals waited has also gone down further to 15 days.

The number of people ready to place (RTP) into the community also decreased, from 89 last November to 73 by 2/28/26. There were 36 people in GEI processes thought to no longer need hospital level of care at the end of November 2025 and at the end of February there were 41. This population continues to have long waits for discharge, which makes it difficult for the state to achieve compliance.

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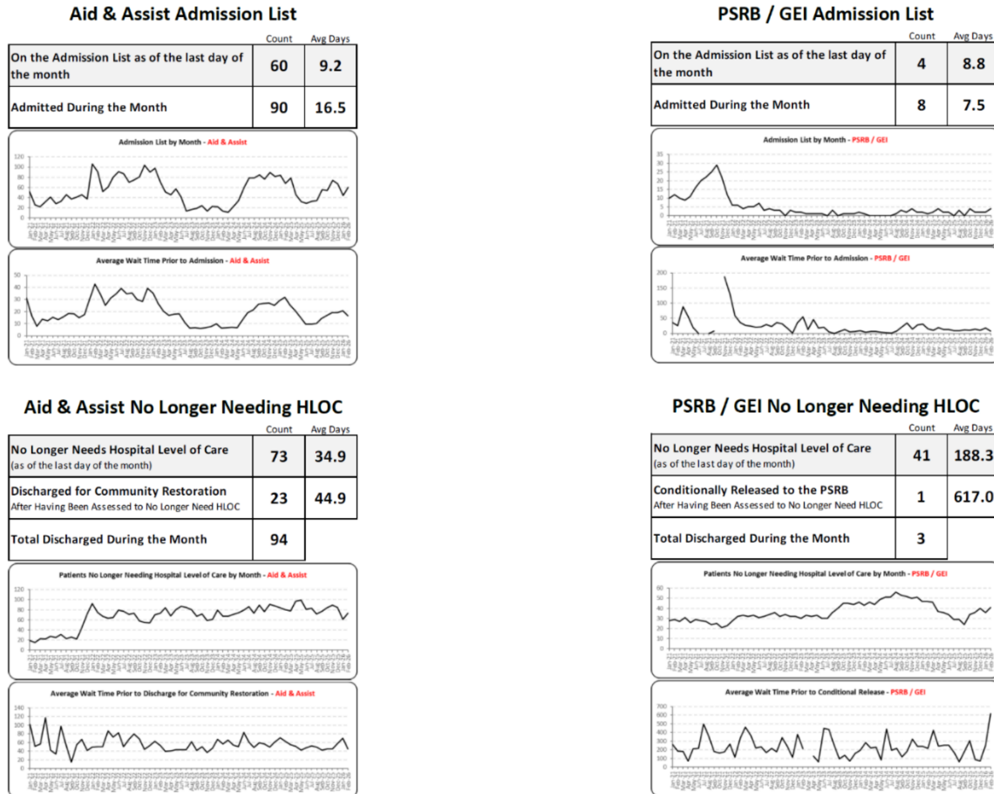
Figure 1. Data Dashboard Charts Reflecting Progress in *Mink/Bowman* as of February 28, 2026



OSH Forensic Admission and Discharge Dashboard
February 2026

Aid & Assist Admission List

	Count	Avg Days
On the Admission List as of the last day of the month	60	9.2
Admitted During the Month	90	16.5

PSRB / GEI Admission List

	Count	Avg Days
On the Admission List as of the last day of the month	4	8.8
Admitted During the Month	8	7.5

Aid & Assist No Longer Needing HLOC

	Count	Avg Days
No Longer Needs Hospital Level of Care (as of the last day of the month)	73	34.9
Discharged for Community Restoration After Having Been Assessed to No Longer Need HLOC	23	44.9
Total Discharged During the Month	94	

PSRB / GEI No Longer Needing HLOC

	Count	Avg Days
No Longer Needs Hospital Level of Care (as of the last day of the month)	41	188.3
Conditionally Released to the PSRB After Having Been Assessed to No Longer Need HLOC	1	617.0
Total Discharged During the Month	3	

Table 1. Individuals Awaiting Admission

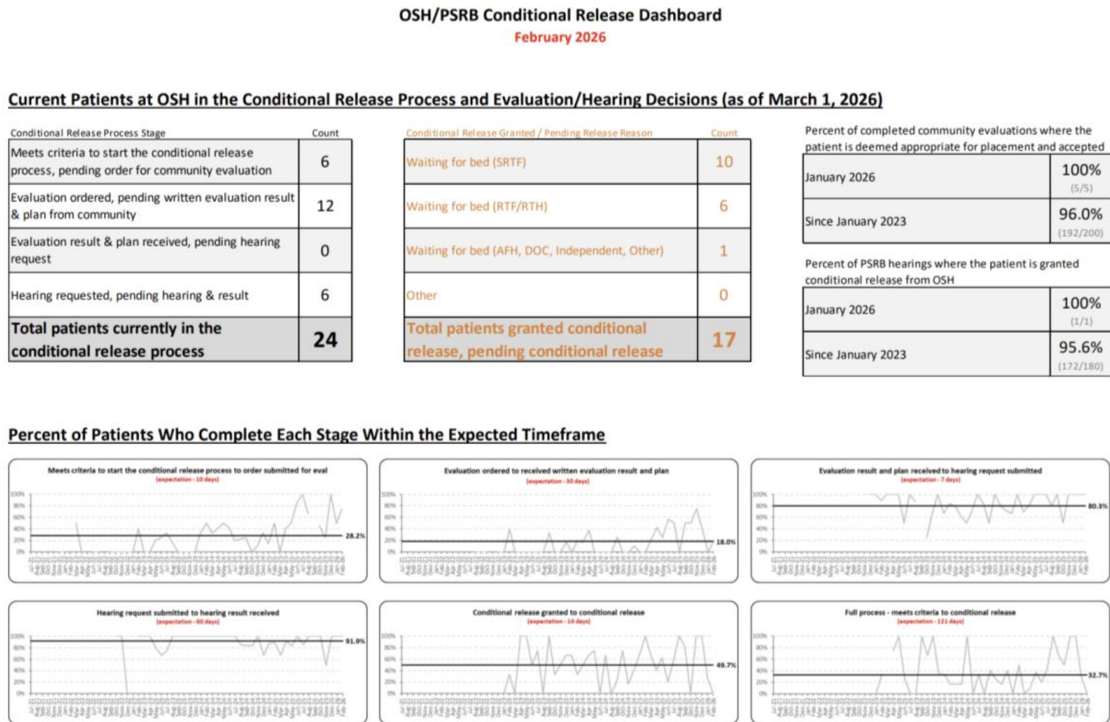
1. Regarding individuals on OSH admission list with signed and received A&A court order														
	As of 1/5/22	*As of 1/28/22*	*As of 5/1/22*	*As of 9/1/22*	*As of 12/1/22*	*As of 4/1/23*	*As of 7/1/23*	*As of 11/1/23*	*As of 4/1/24*	*As of 11/1/24*	*As of 4/1/25*	*As of 8/1/25*	*As of 11/1/25*	*As of 3/1/26*
Total Number of individuals	46	93*	67	70	104	51	42	24	11	76	79	33	54	60

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	9.2 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	2-20 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*	*As of 3/1/26*
Total number of individuals	15	4	3	4	0	1	1	1	0	2	2	0	4	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	8.8 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	2-18 days

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

The GEI conditional release dashboard showing each discharge process step (**Figure 2**), shows that at almost every step of the process for discharge, the timeline expectations are not met. There was some improvement in the evaluation result to hearing timeline, but other metrics did not improve. The step that involves the PSRB, to get the decisions from their hearings is still largely timely with over 91% meeting time expectations. I note in this review that some of the charts are difficult as timelines are better and will confer with the state regarding the depiction of this data.

Figure 2: GEI OSH Conditional Release Dashboard as of February 28, 2026



OSH/PSRB Conditional Release Dashboard
February 2026

Current Patients at OSH in the Conditional Release Process and Evaluation/Hearing Decisions (as of March 1, 2026)

Conditional Release Process Stage	Count
Meets criteria to start the conditional release process, pending order for community evaluation	6
Evaluation ordered, pending written evaluation result & plan from community	12
Evaluation result & plan received, pending hearing request	0
Hearing requested, pending hearing & result	6
Total patients currently in the conditional release process	**24**

Conditional Release Granted / Pending Release Reason	Count
Waiting for bed (SRTF)	10
Waiting for bed (RTF/RTH)	6
Waiting for bed (AFH, DOC, Independent, Other)	1
Other	0
Total patients granted conditional release, pending conditional release	**17**

Percent of completed community evaluations where the patient is deemed appropriate for placement and accepted	
January 2026	100% (5/5)
Since January 2023	96.0% (192/200)

Percent of PSRB hearings where the patient is granted conditional release from OSH	
January 2026	100% (1/1)
Since January 2023	95.6% (172/180)

Percent of Patients Who Complete Each Stage Within the Expected Timeframe

OSH Quality Management – Data and Analysis
'Informing the Pursuit of Excellence'

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Table 2 and **Table 3** show the capacity and census at OSH, which uses an operational active capacity metric. I was told that there are four medical beds that are no longer licensed and thus were removed from the licensed capacity count. The hospital leadership and I have been discussing the active capacity number of 704, and I have begun to receive newly produced daily 'traffic' reports on patient movement to understand bed utilization better. As of the data snapshot reported from 3/1/26, the number of patients was at 701, closer to the active capacity of 704. The defendants and I plan to have further conversation about the active capacity numbers and how they are set, to see whether there are opportunities for greater bed utilization without compromising patient safety.

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

Site	Licensed Capacity	Active Capacity
Salem Main Campus HLOC	498	473
Salem Main Campus SRTF	90	87
Salem Main Campus Total	**588**	**560**
Junction City HLOC	75	72
Junction City SRTF	75	72
Junction City Total	150	144
OSH Total	**738**	**704**

Table 3. OSH Census as of 3/1/26

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
3/1/2026	386	280	35	0	701

The numbers of orders for restoration continue to be over 100 in some months, most recently December and February. The GEI revocation orders remained fairly constant, though in February there were 10. This is more than in any month in the past two years. (See **Table 4** and **Figure 3**). As noted in prior reports, when the AA restoration orders are over 100, OSH sees impact within a few months as that number tends to overwhelm system capacity.

Table 4. Aid and Assist and GEI Orders Since January 2025

Number of Orders Received	Aid & Assist	GEI
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	100	7 (5 standard / 2 revocation)
November 2025	89	6 (4 standard / 2 revocation)
December 2025	101	6 (3 standard / 3 revocation)
January 2026	86	3 (2 standard / 1 revocation)
February 2026	106	10 (6 standard / 4 revocation)

Figure 3. Aid & Assist Admissions/Orders Trends through February 2026

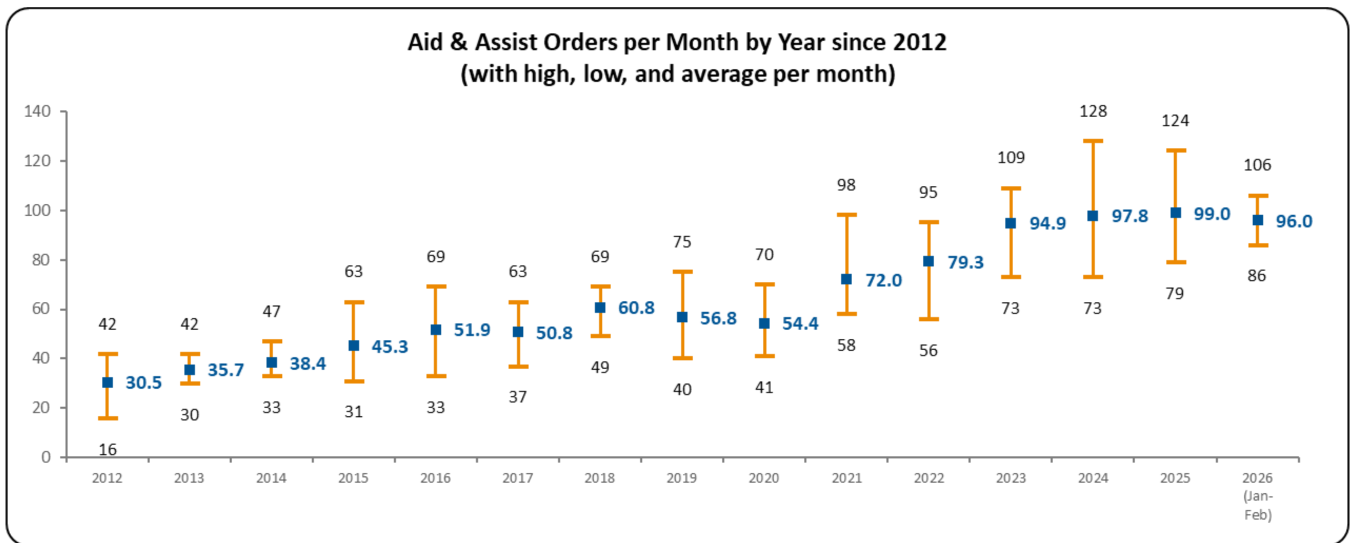


Figure 4 is a graphic depiction of the waitlist trends, which have been decreasing overall from the last few months. Some of the downward trend may be related to fewer orders received in February as opposed to more discharges or expanded system capacity.

Figure 4. Admission Wait Time Projections Compared to Benchmarks Set in Second Report based on data as of 3/1/26

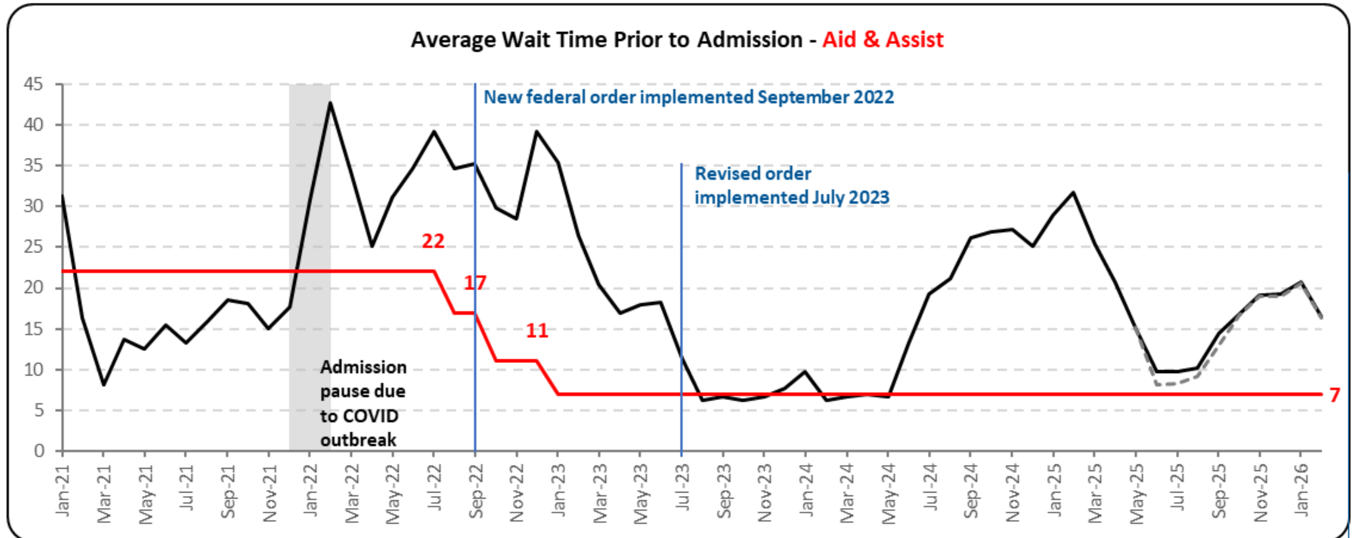


Table 5 shows the number of people discharged with a dischargeable finding (Able, Never Able), as compared to those reaching their restoration limit or discharged to a less restrictive community placement. There appears to be fewer people reaching their restoration limit. Figure 5 depicts this in graphic form showing that fewer (approximately 15%) people are discharged by meeting their restoration limit. This is further depicted in **Figures 5** and **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	2026 (Jan-Feb)
Restoration Limit			**8**	**285**	**254**	**176**	**28**
Community Restoration			**12**	**215**	**244**	**374**	**49**
Dischargable Finding	**620**	**386**	**58**	**514**	**535**	**532**	**103**
Able	*518*	*332*	*51*	*442*	*466*	*471*	*94*
Never Able	*71*	*34*	*3*	*40*	*46*	*16*	*1*
Med Never	*31*	*20*	*4*	*32*	*23*	*45*	*8*
Other	137	166	4	55	73	91	11
Grand Total	757	552	82	1069	1106	1173	191

Figure 5. Outcomes of Aid and Assist Discharges through February 2026

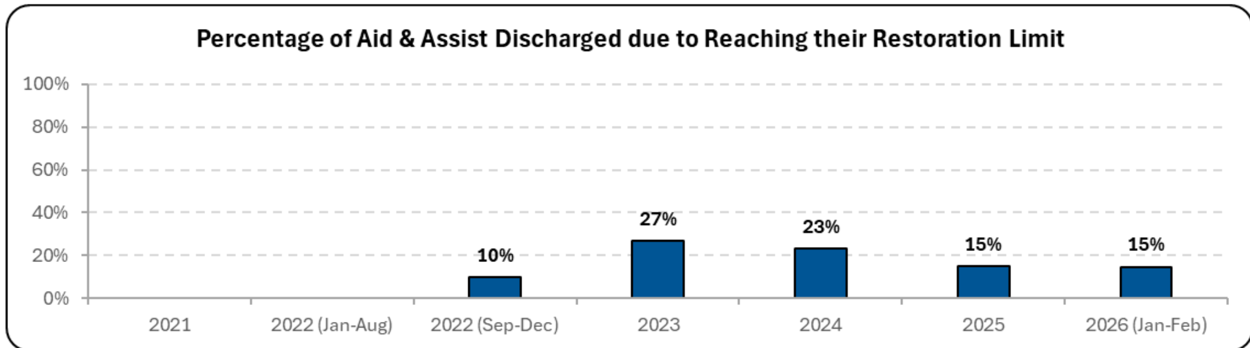


Figure 6: Percentage of Aid and Assist Discharged into Community Restoration

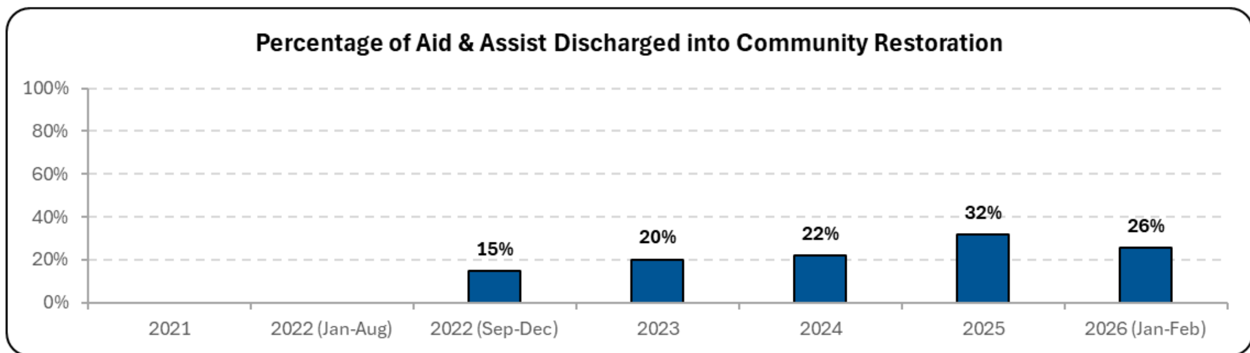


Figure 7 examines data that looks at type of dischargeable finding among those discharged from OSH after receiving a dischargeable finding, and as recommended by evaluators. The data shows that overall, proportions of discharges of individuals found Able remains between 87-91% range in the last two years, Never Able findings seem to have decreased, while Med Never findings have hovered at about 8%.

Figure 7. Percentage of Dischargeable Finding by Type

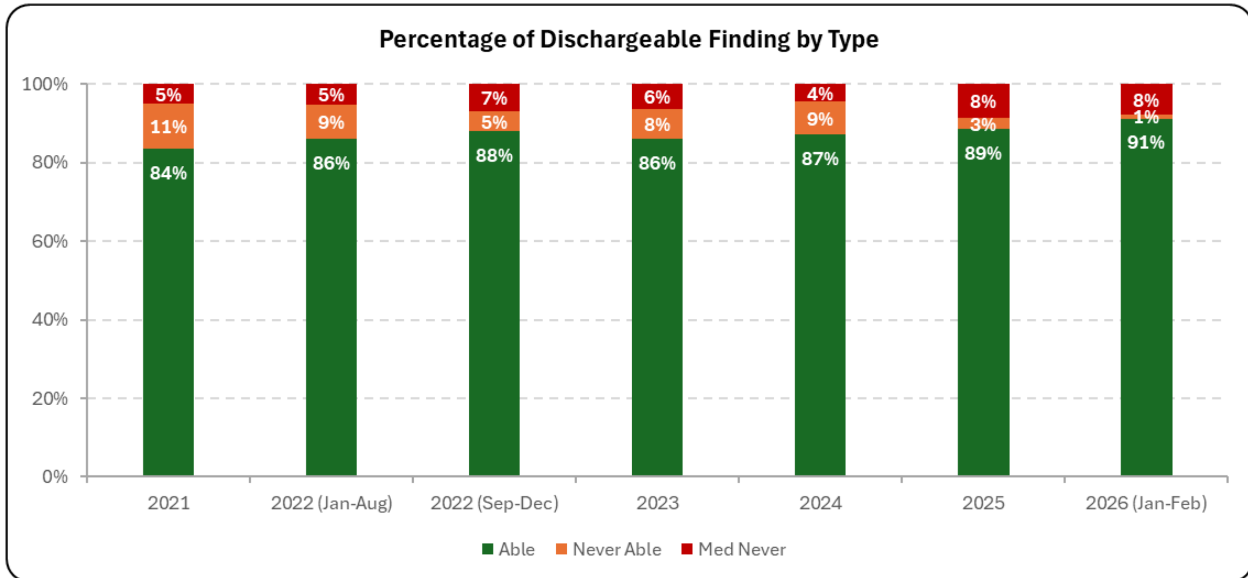


Table 6 depicts the types of findings for the month of February, with most people getting a dischargeable finding.

Table 6. Legal Status of AA Discharges in February 2026 based on Hospital Data

February 2026 A&A Discharges

Reason	Count	Percent
Restoration Limit	9	10%
Community Restoration	29	31%
Dischargable Finding	51	54%
Able	*47*	*50%*
Never Able	*4*	*4%*
Med Never	*0*	*0%*
Other	5	5%
Total	**94**	**100%**

Data from community restoration services is presented in **Table 7** below. As noted in prior reports this continues to be drawn from existing OHA data that is collected from the CMHPs. It is hoped that data wil be expanded and more available through the new data collected on community restoration as implemented with HB2005. For this reporting period, however, the

data covers the timeframe from 1/1/19 to 12/31/25 and shows a difference in the number of community restoration episodes (3355 vs 3633 reported in my last report). Data on community restoration is still lacking and should be improved with the required forms. As noted previously, HB2005 will likely place additional strain on the community system and data to understand its impact is critical.

Table 7. CMHP Reported Completed Community Restoration Data 1/1/2019 - 12/31/2025

CMHP Reported Community Restoration Data 1/1/2019-12/31/2025

# of Community Restoration Episodes	3355	
# of Days Minimum	1	
# of Days Maximum	1661	
# of Days Mean	193	
# of Days Median	140	
Days in Community Restoration	# of Community Restoration Episodes	% of Total Community Restoration Episodes
0-90	1202	35.8%
0-180	1995	59.5%
0-365	2855	85.1%
0-730	3298	98.3%
0-1095	3348	99.8%

- 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.

According to information provided by OSH (see **Table 8**), evaluations conducted by FES continue to be high, with evaluations ordered for individuals who are not at OSH outnumbering the demand for evaluations for individuals who are at OSH.

Table 8. Number of Active FES Cases as of 3/3/26

Type of Evaluation and Location	Number
.370 Evaluations at OSH	381
.370 Evaluations not at OSH	378
.365 Evaluations not at OSH	104
.315 Evaluations not at OSH	31
Total Cases	**894**

As has been reported previously, almost a third (32.6%) of individuals assessed at 10-days for being ready to place are identified as no longer needing a hospital level of care, and these individuals are then put on the Ready to Place (RTP) list (**Table 9**). Not all patients undergo these assessments, as they are only conducted on individuals with lower-level charges.

Table 9. 10-Day RTP Assessment Outcomes (August 2022 through February 2026)

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	655	210	32.1%
2026 (Jan-Feb)	89	29	32.6%
Total	**2,193**	**746**	**34.0%**

The mediation that resulted in the Second Amended order from 7/3/23 offered exceptions to the original restoration duration limits. In the mediation agreement it was noted that the data on the use of these exceptions would be reviewed to determine their impact on compliance. Data is shown in **Table 10** regarding the currently permissible extension orders and their impact on compliance.

Table 10. **Number of 30-day and 180-day Orders to Extend Restoration Duration and Total Hospital Days Used for Extensions**

A&A Restoration Limit (LOR) Extension Days in 2025 for 30-Day Extension Orders	
Number of patients with 30-day extensions	85
Number of patients who used 30-day extensions	73
Number of patients with 30-day extensions who did not use them	12
Number of patients with 30-day extensions who used 1-10 days	18
Number of patients with 30-day extensions who used 11-20 days	16
Number of patients with 30-day extensions who used 21-30 days	36
Number of patients with 30-day extensions who used more than 30 days	3
Average Extension Days beyond initial LOR for 30-day extensions	**20.0**
Total Extension Days beyond initial LOR for 30-day extensions	**1462**

A&A Restoration Limit (LOR) Extension Days in 2025 for 180-Day Extension Orders	
Number of patients with 180-day extensions	50
Number of patients who used 180-day extensions	47
Number of patients with 180-day extensions who did not use them	3
Number of patients with 180-day extensions who used 1-10 days	8
Number of patients with 180-day extensions who used 11-180 days	29
Number of patients with 180-day extensions who used 181-360 days	8
Number of patients with 180-day extensions who used more than 360 days	2
Average Extension Days beyond initial LOR for 180-day extensions	**119.1**
Total Extension Days beyond initial LOR for 180-day extensions	**5597**
Total Extension Days beyond initial LOR for 30-day extensions	1462
Total Extension Days beyond initial LOR for 180-day extensions	5597
Total Extension Days in 2025	**7059**
Avg. Length of Stay for A&A Patients in 2025	116.5
Potential Patient Stays Prevented by Extensions in 2025	**60.6**

The data below in **Table 11** provides the counts of 30-day extensions being granted since July 1, 2023. Despite the mediation not contemplating more than one 30-day extension, 9 individuals were ordered for two such extensions and one individual was ordered to a third. According to data provided by OHA, of the 195 patients who received 30-day extensions, 95 (49%) of those extension requests met the Federal Court Order's criteria for such an extension. In addition, all 30-day extension requests are being granted, whether they meet criteria or not. Of note, information on cases provided by DRO supports that extensions often do not follow the terms set forth in the mediation and court order.

Table 11. 30-day extensions granted since July 1, 2023

30-Day Extensions	Count
1st 30-day extension	185
2nd 30-day extension	9
3rd 30-day extension	1

The data below in **Table 12** examines and depicts the effectiveness of 180-day extensions for patients under both Measure 11 and Non-Measure 11 violent felony charges since 2024. OHA also provided the following analyses:

<u>Measure 11 Charges</u>

Of the 42 patients under Measure 11 charges, 17 (40%) received a final determination (able or never able) while at OSH during the initial 180-day extension period.

Of the 17 patients under Measure 11 charges who received a 2nd 180-day extension, 6 (35%) received a final determination (able or never able) while at OSH during the additional 180-day extension period.

Of the 7 patients under Measure 11 charges who received a 3rd 180-day extension, 3 (43%) received a final determination (able or never able) while at OSH during the additional 180-day extension period.

Of the 4 patients under Measure 11 charges who have received a 4th or 5th 180-day extension, none (0%) have received a final determination (able or never able) while at OSH during the 4th or 5th 180-day extension periods.

<u>Non-Measure 11 Charges</u>

Of the 29 patients under Non-Measure 11 charges, 7 (24%) received a final determination (Able or Never Able) while at OSH during the initial 180-day extension period.

Of the 3 patients under Non-Measure 11 charges who received a 2nd 180-day extension, 1 (33%) received a final determination (Able or Never Able) while at OSH during the additional 180-day extension period.

Table 12: Outcomes of 180-Day Extensions since 2024

	Measure 11 Violent Felony					Non-Measure 11 Violent Felony	
180-Day Extension Outcome	**1st Extension**	**2nd Extension**	**3rd Extension**	**4th Extension**	**5th Extension**	**1st Extension**	**2nd Extension**
Number of extensions	42	17	7	3	1	29	3
Found Able	12	5	2	0	0	6	1
Found Never Able	5	1	1	0	0	1	0
Moved into CR	4	0	0	0	0	12	1
Discharged back to jail	0	0	0	0	0	2	0
Termination of commitment	0	0	0	0	0	0	1
Still at OSH within extension period	4	4	1	2	1	5	0
Received another extension	17	7	3	1	0	3	0

Civil expedited admission data produced by OSH is depicted in **Table 13.** It is noteworthy that 10 of 10 requests were approved to date in 2026. The census as noted above of civil admissions was 35 as of 3/1/26, and it has been in the mid 30's since August 2025.

Table 13. Civil Expedited Admission Requests

Period	Requests	Accepted	Denied	Under Review
Sep 2022 – Dec 2023	22	14	8	
2024	58	34	24	
2025	99	59	36	4
2026 YTD (Jan-Feb)	10	10		
Total	**189**	**117**	**68**	**4**

In my Second Court monitor report, I included a figure that demonstrated how the number of orders would dramatically slow progress toward compliance if they were above 100 ordered admissions per month. Based on numerous conversations with plaintiffs and defendants, I have asked the state to produce projected bed days used and potentially saved if both extensions toward discharge and various combinations of admissions would be further curtailed pursuant to the Federal Court. The following data was produced by the state and is depicted in **Table 15** and **Table 16**.

In **Table 15**, the state has produced estimated projections based on past use of extensions. OHA noted that the three projections together would result in potentially admitting 3.6 more people per month, which would have some, but less immediate impact on compliance.

Table 15. Projections Related to Changes to the Extension Process

No more 30-day extensions	
30-day extension days per year	1,462
A&A Avg LOS	116.5
Additional A&A served per year	12.5
Additional A&A admits per month	**1.0**
Starting Admit List count	60
Months to get down to 15 on Admit List	**43.0**
Est. compliance date	**Dec of 2029**

No more 180-day extensions for non-BM11 Felonies

180-day extension days per year for non-BM11 felonies	1,015
A&A Avg LOS	116.5
Additional A&A served per year	8.7
Additional A&A admits per month	**0.7**
Starting Admit List count	60
Months to get down to 15 on Admit List	**62.0**
Est. compliance date	**May of 2031**

Only a one-time 180-day extension for BM11 Felonies

180-day extension days per year for additional extensions	2,491
A&A Avg LOS	116.5
Additional A&A served per year	21.4
Additional A&A admits per month	**1.8**
Starting Admit List count	60
Months to get down to 15 on Admit List	**25.3**
Est. compliance date	**May of 2028**

Information regarding admissions and potential limits to types of admissions is depicted in **Table 16**. I also asked for information on how many bed days were used in 2025 for misdemeanor defendants charged only with resisting arrest, an A-level misdemeanor that is often associated with persons with mental illness who encounter police. There were 7,175 additional days used by individuals charged with resisting arrest, which would account for approximately 62 more admissions that could have been brought into the hospital in 2025 if those individuals had not been admitted for restoration.

Table 16. Projected Hospital Bed Days Saved and Time to Achieve Compliance with No Misdemeanor Admissions, No low-level Felony Admissions

No Misdemeanor admissions

Misd patient days in 2025	35,161
A&A Avg LOS	116.5
Additional A&A served per year	301.8
Additional A&A admits per month	**25.2**
Starting Admit List count	60
Months to get down to 15 on Admit List	**1.8**
Est. compliance date	**May of 2026**

No low-level Felony admissions	
Low-level felony patient days in 2025	19,961
A&A Avg LOS	116.5
Additional A&A served per year	171.3
Additional A&A admits per month	**14.3**
Starting Admit List count	60
Months to get down to 15 on Admit List	**3.2**
Est. compliance date	**Jun of 2026**

Of note, no Low-Level Felony admissions plus no resisting arrest admissions would result in 27,136 bed days saved, which translates to 232.93 additional individuals ordered for restoration that could have been admitted. This means that each month, 19 more people could have been admitted. As a rough estimate at the current pace of orders, this could result in compliance within two and a half months, or by the end May 2026 if started in sometime in March. If combined with bed days saved for limits on extensions, compliance would likely be achieved even sooner.

These projections only take into account the hospital utilization data, and do not incorporate flow that may result when new community placements become available, or reductions if crisis services with clinical supports result in fewer arrests, for example. As noted in my previous reports as well, the impacts of any future budget cuts and HB2005 remain unknown at this time, though there is ongoing concern about how much more this will strain the community behavioral health system. It also remains unclear that it will result in improved restoration outcomes.

Select Updates from OHA:

Since my last report, the contracts with the counties have been signed. OHA has indicated that these new CFAA contracts will give them greater ability to monitor how funds are being allocated and expended. New forms have been issued to the CMHPs that require the input of data that will allow information about services to be tracked better. In addition, the forms have

been set up to collect information related to HB2005 and related to information recommended for improved Mink/Bowman compliance.

In addition to the forms, the state is involved in discussions pertaining to HB2005 along with the Governor's Office.

Budget cuts to OHA have also been presented considering HR1 through Congress. In addition, there have been some hiring freezes that the state has been facing.

Since the time of the last status hearing in December, NWRRC has had a census largely at or above 35 until this last month, when the census dipped below 35. I have discussed this with OHA leadership, and they appear to be aware of this issue and are addressing it with NWRRC leadership. In addition, construction is underway for the additional 20 bed capacity slated for approximately a year from now.

OHA produced a report to demonstrate the impact of the ECMU, which started at the end of 2024. The ECMU preliminary report showed promise in its impact for Lane, Multnomah and Washington Counties. According to the report,

> *Since ECMU implementation, discharges to Community Restoration (CR) from these counties have increased from 35% (pre-ECMU) to 70% (post ECMU) suggesting improved discharge outcomes. Additionally, patients from these counties who transitioned to CR experienced a reduction in the number of days spent on the RTP list prior to discharge. The average days decreased by 7.6% (from 57.3 to 52.9), and the median days decreased by 10.7% (from 56.0 to 50.0).*

Although the counties that had ECMU efforts showed improved discharges, the impact for these improvements system-wide was not evident. The findings did demonstrate that a greater statewide effort may be beneficial in more effectively impacting the RTP list.

OHA has also been developing a capacity to provide forensic evaluations in the community and coordinate community restoration evaluations. 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. It is projected that this will take a year before evaluations through this new service, the Community Restoration Evaluation Unit (CREU) will be available. In the interim period, the OSH FES will continue to work on community evaluations.

Data collection for community navigators was reviewed in October 2025, and updated data elements will now be incorporated based on feedback I gave at that review. In mid-January 2026 I received an updated presentation regarding the data collection plans. I look forward to seeing data on the community navigator efforts.

There are plans in place for community expansion that will require ongoing further review. Some of this will also be examined by PCG.

OSH Updates:

Mr. Jim Diegel continues as the Superintendent of OSH in an interim capacity. A posting for a new Superintendent was issued at the end of January, and there are several applicants currently under consideration. The Deputy Chief Medical Officer and Chief of Psychiatry position was filled. The Chief Medical Officer and the Chief Nursing Officer are still both in interim roles.

CMS has provided OSH with a positive review and restored the hospital deemed status as of 1/21/26.

Mr. Diegel and Dr. Bhavan have continued to explore opportunities for greater patient flow and have been reorganizing unit patient populations to help with this. There have been ongoing discussions about the operational capacity of 704 and I plan to continue those. In the interim, I have begun to receive reports that were created through Mr. Diegel that are referred to as "OSH Traffic Reports" to show patient flow and active census information on each unit.

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. Mr. Diegel met with the Jackson County Deputy leadership with apparently positive rapport established.

Administrative delays with GEI discharges have not improved with any consistency, and this will again be a focus of the next interim period. It should be noted that Mr. Preston Berman filed for amicus status related to restoring the REACH program, which was an incentive-based program from approximately 2011. This has not been considered a priority for the staff at this time, though I plan to continue dialogue with the clinical staff regarding engagement strategies to motivate especially long-term patients.

Forensic Evaluation Services:

The Director of FES, Dr. Morgyn Beckman, gave notice in early March that she would be leaving to take another position. The media noticed this resignation and noted that one of the reasons stated was the scrutiny that concerned the *Mink/Bowman* case and increasing pressures on the system. OSH leadership has been working with OHA leadership to replace her position, and the Director position was posted for backfill last week. I appreciate the tireless efforts of Dr. Beckman and Dr. Bustos (the Deputy Director) and their clinical acumen that has helped in many cases. They have faced tremendous pressures, and the services have been an area of ongoing review, which is no doubt difficult for management. I am hopeful that the planned Community Forensic Evaluation Unit (CREU), and additional contract staff to help with the

increased number of orders related to HB2005, will help decrease the burden on the hospital service.

According to the 3/11/26 dashboard, there were 41 individuals on the community restoration waitlist. FES continues to work to address the increasing community restoration evaluation orders in the meantime.

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 discussions during this interim period continue to center around HB2005. In addition, there has been a great deal of discussion about the intake forms that OHA has issued that the CMHPs have been concerned about as being unwieldy for their staff. There has been productive feedback to OHA to help reduce redundancies and minimize administrative burden. Ultimately it appears the form will continue to be modified, but it incorporates needed information for multiple purposes.

There seems to be ongoing 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 especially since more of the statute went 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. The Governor’s Office has built a plan to address the HB2005 bill with workgroups and discussions and milestones. Part of the plan is also to collect data to help

advocate in front of the legislature about the true impact of the bill. I appreciate the work of Amy Baker and KC Ledell from the Governor's Office for their thoughtful efforts regarding this legislation.

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.*

I have been working closely with Public Consulting Group as they have been gathering data for their analysis. During the months since the last Federal Court status hearing, the primary task has been to collect data, conduct community partner interviews, and draft aspects of the report for preliminary review. The analysis is underway. Some of the analyses have required decisions as to best data sources and best ways to depict data so that it can help yield specific recommendations. I am appreciative of the efforts of the state and of the consultants in their collaborative approach to this task. The timeline and milestones are delineated in **Table 17**. Some timeframes have been extended given variables and the complexity of getting the clearest data available.

Table 17. PCG Project Timeline with Milestones

Project Milestone	Owner	Due Date	Status
Data Received from OHA	OHA	January 28, 2026	Complete
Funding Analysis	PCG	Draft: February 25, 2026	Draft Deliverable Submitted on 2/25/26 for review.
Gap Analysis & Needs Assessment	PCG	Draft: February 25, 2026	Draft Deliverable Submitted on 2/25/26 for review.
Community Input	PCG	December 19, 2025* *Additional community engagement to be completed as needed beyond this date	Complete
Cost Estimations & Projections	PCG	March 31, 2026	Pending
Final Report and Presentations	PCG	Draft Report: April 24, 2026 Final Report: June 8, 2026 Presentations: Through June 30, 2026.	Pending

Fines Updates:

The defendants sent me the fines reports with their requests for exclusion from fines cases where courts delayed sending orders and when sheriffs transports were delayed per the sheriff. The eighth fine report was presented to me and included four jail transport delays from Jackson County for which exclusions were sought. I denied those exclusions. My rationale was that I had asked on 12/11 for follow-up documentation to address questions that would be conveyed by the jail staff. For example, in some of the documentation the jail staff would ask if it "would be ok" or if it is "possible" to delay the transport. Although the defendants had strengthened the language in their letters to the sheriff in accordance with my recommendations and what came up during the Court's status hearing, I did not see communication to the jail to indicate a more direct communication response to the sheriff's staff inquiries as to whether a delay would be acceptable. I asked for documentation showing such effort. Later, on 12/31 I also communicated to OHA that I had been waiting to see "a list of efforts made with Jackson County for transport delays." A call was scheduled after some time for the end of January

around the time my opinion on the fines was to be rendered. These efforts and responses appeared insufficient to me to be able to allow the fines exclusions per my understanding of the arguments and expectations in the Court. The plaintiffs noted that they agreed, but OHA indicated that they did not agree with my decision as they believed my expectations went beyond the parameters set out by Judge Nelson in her order for what standard I should use for my review. In later discussions OHA and OSH indicated that they would continue to look into what other options might be available to remedy the delays, but that there were also a number of practical considerations that made it difficult for the sheriffs to transport and also difficult for OHA, given their lack of authority over the sheriffs and their ongoing efforts to maintain good working relationships with sheriffs across the state.

On a positive note, many of these delays have decreased and for this last fine calculation there were no delays in receipt of court orders, and the sheriff transport delays seem to be slowing down.

Regarding the spending of the fines money, there has been ongoing discussion as to whether it should accumulate to an amount that would be helpful in a broader way, and discussion about the appeal on the fines that was sent to the 9th Circuit. Some of the fines have not yet been reduced to judgment. In my last report I suggested putting together a work group regarding the fines expenditures, but based on discussions I have had, it seems the time is not yet ripe for such a workgroup.

Conclusions and Comments:

As of this reporting period, the defendants have been able to reverse course and shown that days to admission have reduced from 22.7 as reported in December 2025 to 15 days as noted at the end of February. There were two out of the last four months when orders numbered over 100, yet overall, the orders have shown a slight downward trend. This is likely temporary. The

state continues to face some potential barriers to compliance including the fiscal cuts that are looming and the impacts of HB2005. There are plans for community expansion, but this takes time and may not keep pace with demand. In addition, maximum utilization of all available spaces and places that serve this forensic population is critical. To that end, discussions about getting the census at OSH at least to 704 will be important, and there may be ways that need to be explored to stretch this capacity without compromising safety. NWRRC also should be operating as it had been at a capacity of 35, and I appreciate that OHA is having active conversations with the facility to achieve this goal.

Despite the lack of compliance with the 7-day admission requirement, in my opinion, at this time OHA is working reasonably and appropriately to address the needs that this Court has required. The problems that the behavioral health system is facing are not fixable overnight, but there are many steps that have been taken to help. More capacity and is undoubtedly still needed and I look forward to seeing the results of the PCG report reviewing allocations and expenditures to learn more about potential solutions.

In my last status report, I indicated that I would be reviewing the impact of limiting admissions and particular extensions of restoration commitment times. I have done that work with the help of the defendants and the plaintiffs. Based on that review, and with potential demand that will continue to increase, status quo does not appear to be an option at this point. If the seven days to admission requirement remains a constitutional priority, then despite the ongoing work of the state on remedies outlined in my prior reports, a return to compliance would not be in the immediately foreseeable time. In addition, it would not be likely sustainable given future projections. As has been seen repeatedly, one to two months of over 100 orders can set the state back for almost three to six months.

Based on the information available to me at this time, I am recommending the following more immediate solutions for sustained compliance:

1. Reduce admissions and extensions of length of commitment:
   A. Reduce pressure and backlog on the back door of OSH:
      i. Eliminate thirty-day extensions (over half are ordered without following agreed-upon terms, and some are ordered more than once). These take up relatively few beds, but many do not meet the agreed-upon criteria. These extensions are often unnecessary and unjustifiable.
      ii. Only permit one extension of up to 180 additional days for M11 crimes. This should only be permitted with a judicial review of the defendant's current symptoms that render them incompetent and should be accompanied prior to a decision to include a recent clinical opinion that the extended time has a substantial likelihood of restoring the defendant.
      iii. Eliminate extensions of non-BM11 crimes- the rate of return on investment is small, and there are cases where no clinical opinion informs whether the additional time would be likely to improve the individual's mental state.
   B. Reduce pressure on the front door by two remedies:
      i. Eliminate from admission all non-person level Felony C charges that carry a sentence of 90 days or less; and
      ii. Eliminate from admission the Class A misdemeanors that are all too often seen as the result of an interaction with officers that are not indicative of larger public safety threats (specifically as an example, resisting arrest).

As for the extensions, these were agreed upon during a mediation process, and the plan was to review their impact. That review has now occurred. Too many of them are ordered outside the bounds of the Court’s order, and often they do not yield the impact of restoring an individual. For the more serious crimes, given the statutory time frame of three years, it may be difficult

for the system to adjust to shorter time frames for some cases, and there may be legitimacy in utilization of hospital bed days-a precious resource for Oregon- to see if restoration is feasible. However, any extension of M11 cases should have available a forensic opinion as to whether the extension is clinically reasonable, as noted in the Court order.

As for the admissions, although many people charged with non-person crimes may have serious illness and symptoms, there are several issues to consider. The duration of hospitalization may exceed the time an individual would have served if convicted, particularly when sentences are less than 90 days, with the average length of stay for restoration reaching 116.5 days. Additionally, by day 10 at OSH, approximately 30% of individuals charged with lower-level offenses are determined not to require hospital-level care. Thus, the state is encouraged to continue to foster crisis services, as they have been, that help eliminate any unnecessary interactions with law enforcement to avoid arrests when treatment and supportive services would be indicated as a better route to enhance public safety. In addition, community systems are already accessing acute hospitalization for individuals in community restoration when needed. With broader civil commitment criteria, persons with serious illness charged with lower-level offenses are better served in the civil system than cycling through jails.

2. OHA and OSH should work with the Court Monitor to continue to review utilization of beds.

A. Continue to review the NWRRC bed capacity utilization to ensure it remains at 35 beds and identify barriers to achieving this.
B. OSH leadership should ensure full utilization of its active capacity of 704 beds, and this number should be reviewed with the Court Monitor to help determine whether that number is the best number for operational capacity given safety, treatment and bed demand pressures.
C. Examine the GEI processes to increase GEI discharges and review reasons for the recent increase in revocations.

3. Prioritize hiring leadership positions at OSH

OSH currently has several key vacancies in its leadership, and the hiring of those positions should be a priority in the next interim period.

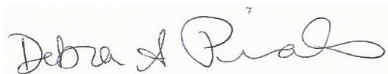
4. OHA and OSH should continue to participate as needed to provide PCG information as requested to assist with its analysis of spending to date and capacity needed.

5. OHA and OSH should continue to work on completion of the items delineated in my prior recommendations and re-articulated in the tracker.

I have discussed the above recommendations with the defendants and the plaintiffs. I am available to the Court as needed to answer any questions about them.

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*