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

Fifth (5th) Report

Regarding the Consolidated *Mink and Bowman* Cases

Date of Report: September 13, 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. Hearings in the 9th Circuit are being scheduled for September 2026.

On 6/1/26, The Honorable Judge Adrienne Nelson issued her opinion regarding several pending matters before the Court. First, she clarified my role as Court Monitor, noting that I shall continue to "assure compliance with and implement the court's remedial directives," without the power to adjudicate or make rulings or take other legal actions.

In addition, the Court's 6/1/26 granted the plaintiffs' motion for a further remedial order to limit admissions by virtue of charges as follows:

> *Further Limitations on Admissions. Defendants are ordered to eliminate admission to the Oregon State Hospital of: a. All non-person level C felony charges that carry a sentence of ninety (90) days or less; and b. All non-person level C felony charges that carry a sentence of ninety (90) days or All pretrial detainees being held in jail on the following charges: (1) Criminal Mischief I; (2) Aggravated Harassment; (3) Unauthorized Use of a Vehicle, Criminal Possession of a Rented or Leased Motor Vehicle, and Possession of a Stolen Vehicle; (4) Resisting Arrest; (5) Burglary 2; (6) Theft I, Theft of Lost/Mislaid Property, Theft by Extortion, Theft by Deception, and Theft of Services; (7) Identity Theft, Computer Crime, Forgery I, Criminal Possession of Forged Instrument, Criminal*

Possession of Forgery Device, Credit Card Fraud, and Negotiating Bad Checks; (8) Mail Theft; (9) Failure to Appear I; and (10) Disorderly Conduct I.

The Court further ordered that all 30 day extensions for discharge planning are eliminated and Judge Nelson also eliminated the "safety valve" exceptions, other than a one-time per defendant 180-day extension involving Measure 11 crimes after a "judicial review of the criminal defendant's current symptoms that have rendered the criminal defendant incompetent based on a recent clinical opinion stating that the 180-extension of time has a substantial likelihood of restoring the defendant."

Finally, the 6/1/26 order included clarification regarding fines in that fines calculations will prospectively follow the 3/26/26 Order.

This report represents my fifth (5th) as the *Mink/Bowman* Court Monitor. This report is to inform the upcoming status hearing on 9/15/26 and will provide a basic overview of current data, a summary of my work since my last report dated 6/6/26, and my comments for the Court's consideration.

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:

Since my 6/6/26 report I have reviewed new relevant Court filings, including motions by both the defendants and the plaintiffs, as well as Judge Nelson's rulings.

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, recently revised for May 2026;
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. OSH "traffic report" dashboard sent Monday through Friday to show OSH active census;
7. Fines calculation reports;
8. *Mink & Bowman* Monthly Progress Reports from OHA from July, August, and September 2026;
9. Miscellaneous media reports;
10. Mink/Bowman Comprehensive Plan updates on progress;
11. E-mail correspondence with plaintiffs and defendants;
12. Various documents and data analyses reviewed for PCG report including a draft PCG report and clarifying comments and questions from defendants;
13. Information from 6/23/26 from Ms. Cherryl Ramirez related to a briefing packet to CMS about IMD exclusions and Oregon's approach regarding specific sites; and
14. Funding proposal from Ms. Cherryl Ramirez of AOCMHP from 7/15/26.

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. 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, Chief Medical Officer, Dr. Amit Bhavan, Mr. Dave Baden from OHA, as well as Dr. Andy Bustos Interim Director of the OSH Forensic Evaluation Services. I have also met with Medicaid leadership including Shawna McDermott at some of these meetings.
        ii. I also met with Dr. Sejal Hathi, OHA Director, during this reporting period prior to her departure in early July 2026.
        iii. I met once with Mr. Sean Murphy when he served as Superintendent of OSH.
    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
    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.
6. I spoke with Mr. Eric Neiman, legal counsel representing several private hospitals in an adjacent litigation.

I visited OSH on 6/10/26 following the last court hearing. I was able to speak with patients and staff during that visit.

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:

During this reporting period my work has continued to involve meeting with the defendants r approximately weekly basis as well as periodic updates with plaintiffs. The key themes have included monitoring of compliance metrics, progress on recommendations and discussions related to the PCG report. I note shortly after the Court's 6/1/26 remedial order and beginning on 6/13/26, the defendants began admitting the majority of patients within seven days except

for a handful of cases in which court orders were received late. I continue to discuss pathways to long-term sustained compliance even in the absence of Federal Court remedial orders.

In my meetings with the defendants, significant issues have included the shift in leadership at OSH and the departure of Dr. Hathi as the OHA Director. I have met with DOJ Counsel, in particular Ms. Jill Conbere, to review items that have arisen and to review the progress tracker. Throughout this interim period, we have shifted largely to "focused meetings" to review particular themes, such as the work of FES, the update on community navigators, OSH updates and any other topics that have required specific discussion.

Another aspect of my effort this period has been to support the work of PCG and review and provide feedback on their draft report, as well as engage in several discussions with both the defendants and plaintiffs about the PCG efforts and data analyses. This will also be discussed further below.

Data Summaries:

Background Data: Data obtained from OSH demonstrate that the defendants have been able to admit almost all people within seven days of the court order. Of note, the number of Court orders significantly decreased from 90-120 admissions to less than 90 per month since the Court's remedial order on 6/1/26 limiting admissions and extensions. **Figure 1** and **Table 1** show numbers of people waiting for admission. The average number of days people ordered for restoration waited was 2.3 days on the last day in August. There were only six people waiting for admission by the end of August.

The number of people ready to place (RTP) into the community has shifted, from 89 last November to 73 by 2/28/26, 41 as of 5/31/26 and 71 by 8/31/26. There were 50 people in GEI processes thought to no longer need hospital level of care at the end of August 2026, up slightly from the 41 that were waiting at the end of May 2026. This back door silting up remains an

ongoing area of focus. This population continues to have long waits for discharge, which continues to put pressure on both hospital bed demand and community placements.

Figure 1. Data Dashboard Charts Reflecting Progress in *Mink/Bowman* as of August 31, 2026

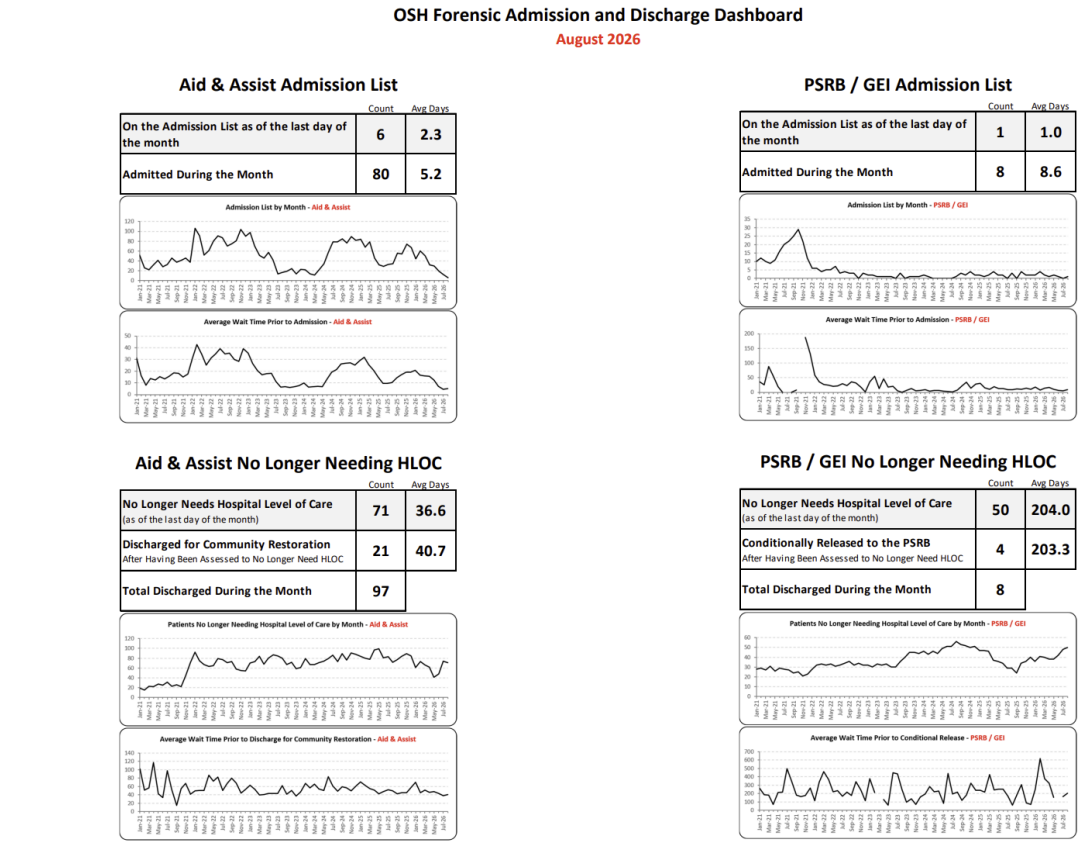


Table 1. Individuals Awaiting Admission

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***	***As of 6/1/26***	***As of 8/1/26***
Total Number of individuals	46	93*	67	70	104	51	42	24	11	76	79	33	54	60	30	12

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	7.6 days	4.8 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	4-13 days	1-28 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*	*As of 6/1/26*	*As of 8/1/26*
Total number of individuals	15	4	3	4	0	1	1	1	0	2	2	0	4	4	2	0
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	11.0 days	N/A
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	10-12 days	N/A

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

Table 2 and **Table 3** show the capacity and census at OSH. The hospital had identified that 704 beds were able to be utilized. Before the Court's order of 6/1/26, this was a major topic of discussion as the census typically ran closer to 698 or 700 when beds were in demand. After the Court limited admissions and orders for restoration at OSH decreased, the census dopped. For example, according to the traffic report on 9/11/26, the evening census was at 642, with 62 beds unused. This was a trend that I discussed with OHA and OSH leadership.

Table 2: OSH Bed Capacities as of 8/1/26

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 8/1/26**

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
6/1/2026	378	283	33	0	694
8/1/2026	344	296	33	0	673

The number of orders between April 2025 and October 2025 dropped after the 6/1/26 remedial order. This was to be expected to some degree, but orders have remained low. For example, by 8/26/26, according to the weekly dashboard OHA produces for my review, there were 54 orders that had been received in August 2026, a number close to what was seen since 2020. See **Table 4** and **Figure 2** for a more detailed depiction of the trends in orders for AA admissions**.** The lower numbers of orders have allowed OSH to catch up with admissions and reduce overall waitlists. GEI admissions do not show significant variability.

Table 4. Aid and Assist and GEI Orders

Number of Orders Received	Aid & Assist	GEI
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)
March 2026	99	7 (6 standard / 1 revocation)
April 2026	83	6 (6 standard / 0 revocation)
May 2026	99	5 (4 standard / 1 revocation)
June 2026	84	8 (7 standard / 1 revocation)
July 2026	76	8 (8 standard / 0 revocation)

Figure 2. Aid & Assist Admissions/Orders Trends through July 2026

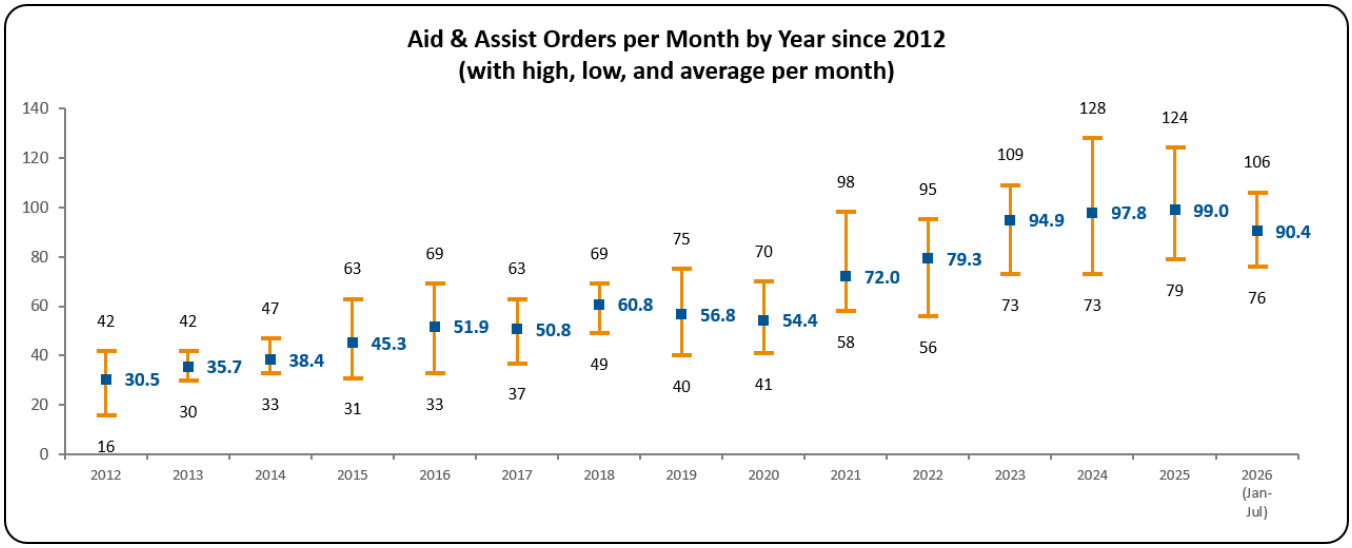
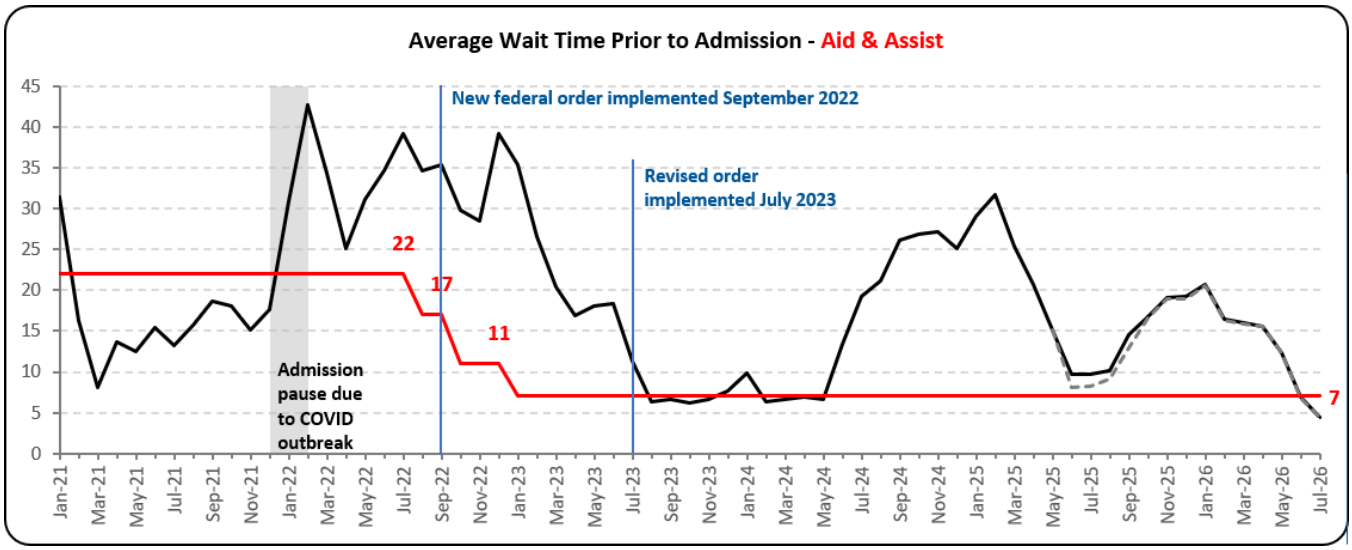


Figure 3 is a graphic depiction of the average wait times prior to admission. The state has admitted by far the majority of people within the seven-day requirement since 6/13/26, in the aftermath of Judge Nelson's further remedial order limiting admissions and reducing extensions. The long-term impact of the order remains to be seen.

Figure 3. Admission Wait Time Projections Compared to Benchmarks Set in Second Report based on data as of 8/1/26



Forensic evaluation data continues to show high numbers of evaluations conducted by FES staff, including requests for evaluations of individuals outside of OSH. **Table 5** shows recent data on active cases for which FES has been assigned to evaluate, 535 of which are not currently at OSH, which is up from the 361 reported in my June 2026 report. Waiting times for evaluations continue to be long but according to OSH FES is withing statutory limits for community cases for those individuals who fall under the HB2005 requirements. This may be an area to address legislatively.

Table 5. Number of Active FES Cases as of 8/27/26

Type of Evaluation and Location	Number
.370 Evaluations at OSH	325

.370 Evaluations not at OSH	420*
.365 Evaluations not at OSH	115**
.315 Evaluations not at OSH	38***
Total Cases	**898**

* FES currently has court orders for 420 community restoration cases. However, 39 of these cases are on active warrant status, absconded from their housing placement, or their location is otherwise unknown.

** FES currently has 115 active 161.365 orders. 61 of these orders are for individuals in custody. 54 of these orders are for individuals on their own recognizance (i.e., residing in the community on their own).

*** FES currently has 38 active criminal responsibility orders. 29 of these orders are for individuals in custody, 1 order is for someone currently lodged at OSH, and 9 orders are for individuals on their own recognizance (i.e., residing in the community on their own).

Table 6 shows that there are consistently about a third of people for whom a Ready to Place assessment was conducted who within 10 days are found ready to place. This continues to be an area of discussion though there are no specific mechanisms to rapidly discharge these individuals at this time. I have been told the ECMU is likely aware of these cases.

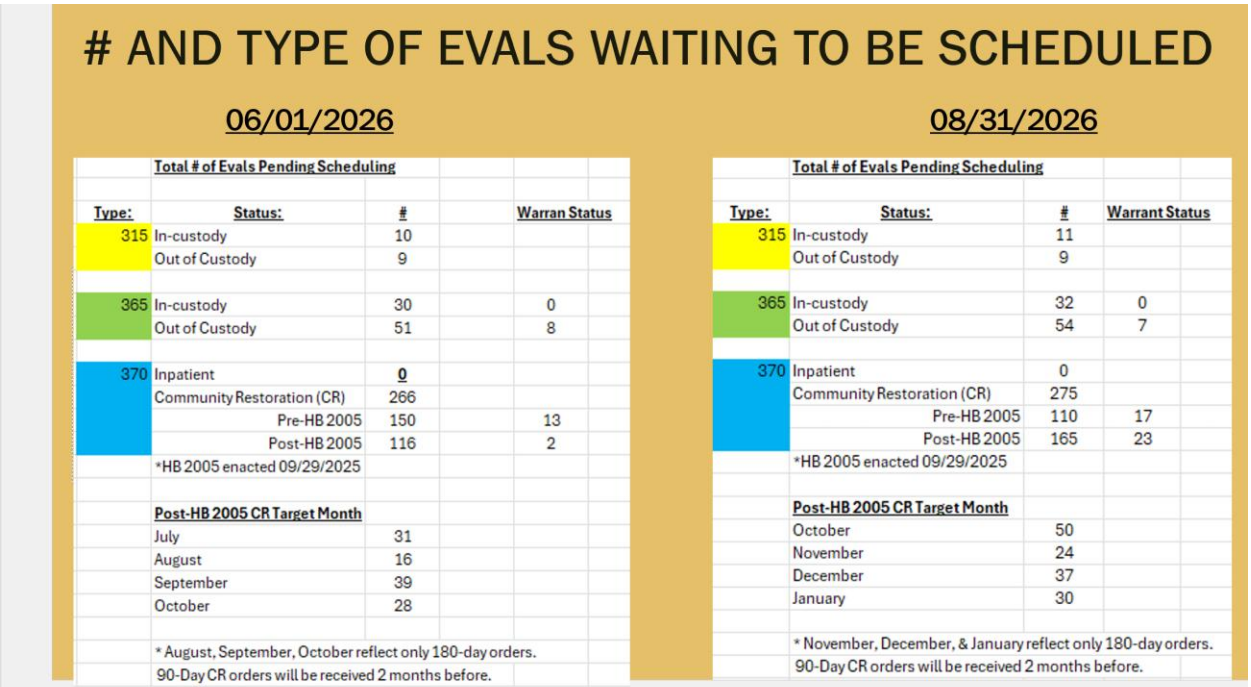
Table 6. 10-Day RTP Assessment Outcomes (August 2022 through July 2026)

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-Jul)	343	111	32.4%
Total	**2,447**	**828**	**33.8%**

Figure 4 shows 266 individuals were waiting to be scheduled for community restoration evaluations at the beginning of June and 275 were waiting by the end of August. It is also noteworthy that the number of cases that are considered “Pre-HB2005” where there is no

statutory time frame has gone down from 150 to 110 and it is anticipated that these cases will attrit to zero. The number of cases waiting for a scheduled evaluation that related to post-HB2005 orders, however, has gone up to 165 individuals.

Figure 4. Number and Type of Evaluations Waiting to be Scheduled



AND TYPE OF EVALS WAITING TO BE SCHEDULED

06/01/2026

Total # of Evals Pending Scheduling			
Type:	Status:	#	Warran Status
315	In-custody	10	
	Out of Custody	9	
365	In-custody	30	0
	Out of Custody	51	8
370	Inpatient	0	
	Community Restoration (CR)	266	
	Pre-HB 2005	150	13
	Post-HB 2005	116	2
	*HB 2005 enacted 09/29/2025		
	Post-HB 2005 CR Target Month		
	July	31	
	August	16	
	September	39	
	October	28	
	* August, September, October reflect only 180-day orders.		
	90-Day CR orders will be received 2 months before.		

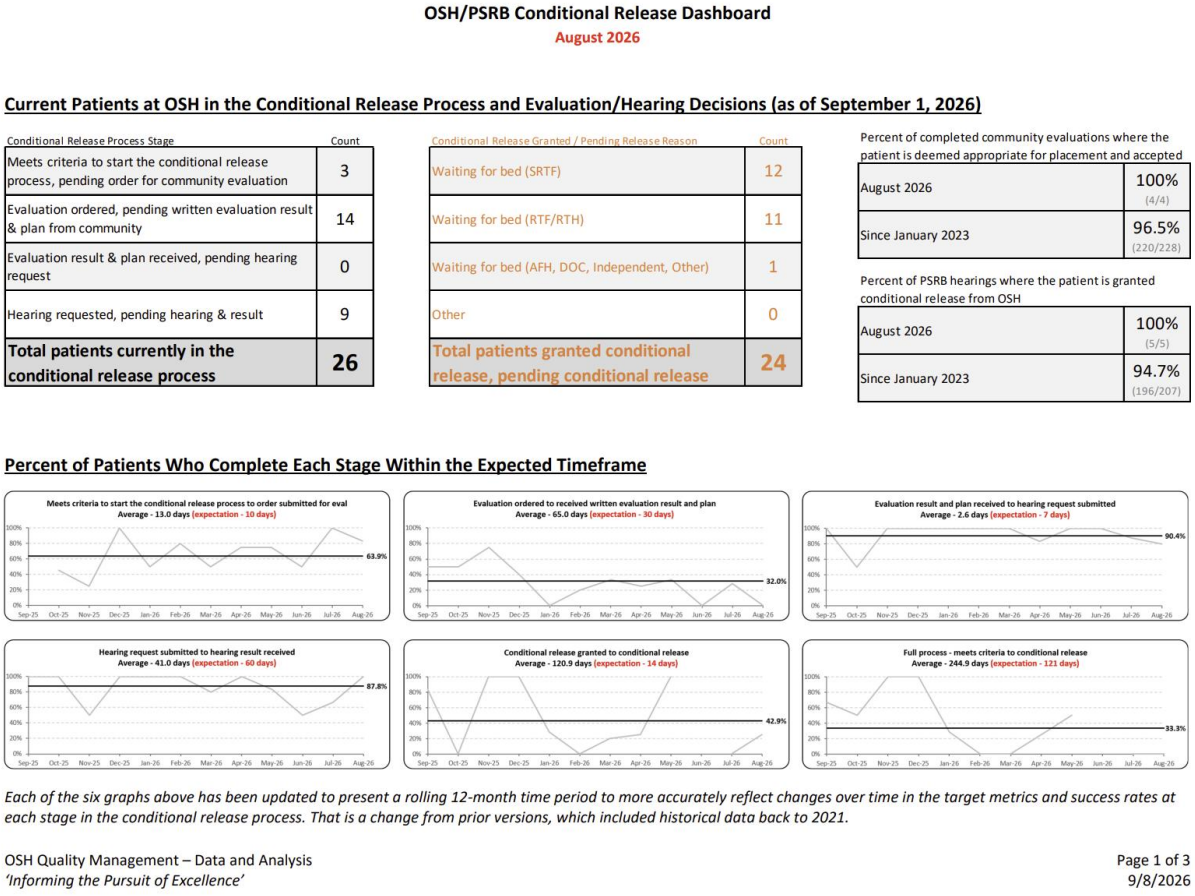
08/31/2026

Total # of Evals Pending Scheduling			
Type:	Status:	#	Warrant Status
315	In-custody	11	
	Out of Custody	9	
365	In-custody	32	0
	Out of Custody	54	7
370	Inpatient	0	
	Community Restoration (CR)	275	
	Pre-HB 2005	110	17
	Post-HB 2005	165	23
	*HB 2005 enacted 09/29/2025		
	Post-HB 2005 CR Target Month		
	October	50	
	November	24	
	December	37	
	January	30	
	* November, December, & January reflect only 180-day orders.		
	90-Day CR orders will be received 2 months before.		

In-patient 370 defendants are all assigned to evaluators' caseloads.

The GEI conditional release dashboard showing each discharge process step is shown in **Figure 5**) was updated during this reporting period. As with prior reports and despite the shift in how the data is depicted, it is clear that the longest delays relate to finding community placement.

Figure 5: GEI OSH Conditional Release Dashboard as of 8/31/26



OSH/PSRB Conditional Release Dashboard
August 2026

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

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	14
Evaluation result & plan received, pending hearing request	0
Hearing requested, pending hearing & result	9
Total patients currently in the conditional release process	**26**

Conditional Release Granted / Pending Release Reason	Count
Waiting for bed (SRTF)	12
Waiting for bed (RTF/RTH)	11
Waiting for bed (AFH, DOC, Independent, Other)	1
Other	0
Total patients granted conditional release, pending conditional release	24

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

August 2026	100% (4/4)
Since January 2023	96.5% (220/228)

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

August 2026	100% (5/5)
Since January 2023	94.7% (196/207)

Percent of Patients Who Complete Each Stage Within the Expected Timeframe

Each of the six graphs above has been updated to present a rolling 12-month time period to more accurately reflect changes over time in the target metrics and success rates at each stage in the conditional release process. That is a change from prior versions, which included historical data back to 2021.

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Figure 6 represents community navigator sites and timelines for expansion. This is the outgrowth of one of the earlier recommendations I made as a Neutral Expert. The caseload size reflects those individuals who agreed to participate in the services. The state spends approximately $1M to $1.2M per site. Although this seems like a large expense, on a per person basis the range of costs are approximately $20K to $50K, which is far less than OSH level of care. In addition, there may be ways to ultimately leverage Medicaid dollars in care coordination services. The major question, however, is also whether the outcomes are achieving their targeted goals of supporting individuals and preventing further arrests and re-hospitalizations to reduce the reliance upon OSH for restoration services. This could help

achieve compliance. I have asked for updated data from OHA to track more details on these services.

Figure 6. Community Navigator Sites and Timelines for Expansion

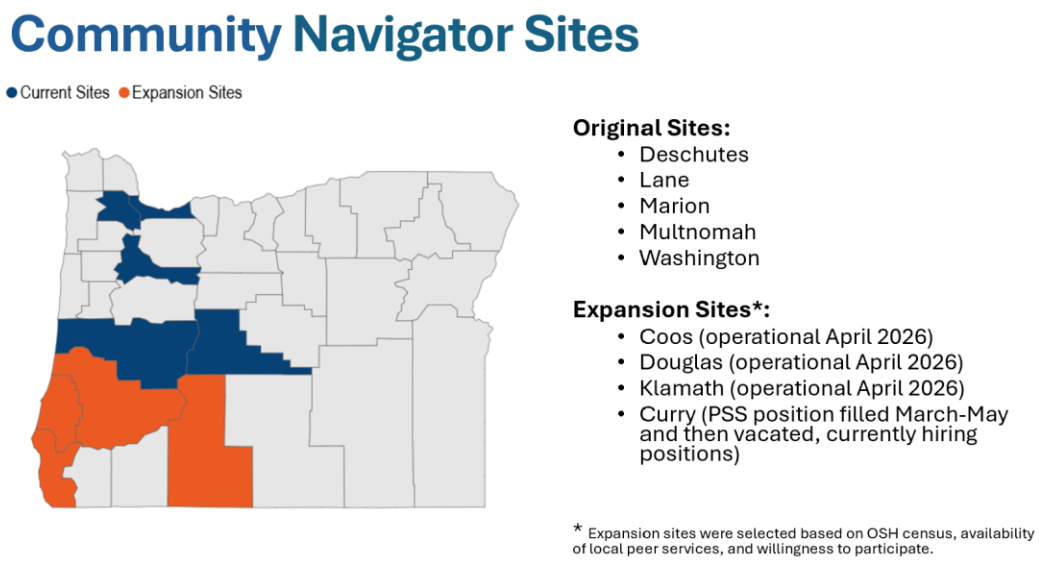


Table 7. Caseloads of the Community Navigator Original Sites

Caseloads: Five Pilot Sites

County	Number of Episodes	Number of Persons	Number of Persons w/ 2+ Episodes
Deschutes	29	28	1
Lane	40	39	1
Marion	60	55	3
Multnomah	59	59	0
Washington	32	24	3
Total	**220**	**205**	**8**

Select Updates from OHA:

Since my last report, OHA has had some leadership change, with Dr. Sejal Hathi resigning in early July. Governor Kotek appointed Fariborz Pakseresht, prior Director of Oregon Department of Human Services, to serve as Interim Director of OHA. I have not yet met with Interim Director Pakseresht.

Budget cuts are expected throughout the agency related to HR1 at the federal level, and work is being done to examine where such cuts can be made. I have been told that this will be a difficult year for funding overall. Oregon is one of the states involved in litigating against some of the impacts related to HR1.

I received a report on the Community Navigator program with a preliminary discussion of the data as shown above. The anecdotal reports are that the Community Navigator program has been helpful for individuals leaving OSH. In addition, Community Navigators have also begun to work with individuals in the jails to help as a strategy to avoid utilization of OSH when appropriate. I have asked the state to gather more data related to the Community Navigator service. I had also had many prior discussions with Medicaid about the potential overlap or even the potential to leverage Medicaid funding for care coordination that could be structured like the Community Navigator program.

OHA has been working on the development of community services and overseeing planning for expansion, as noted in Ms. Clarke's prior declarations. In addition, there have been ongoing questions about rules related to residential services and HB 2015 sought for an independent review of what might be done to help provide services for individuals including those that are within the so-called mandated populations. At the behest of the legislature, a report was commissioned by OHA for Myers and Stauffer, a private consulting firm, to conduct and analyze the residential services. This report was just released, and a preliminary review shows that

there are areas of recommended refinement in rules. One of them pertains to the rule change in which OHA prioritized the AA and GEI individuals for residential placement. This was something raised by the report as a concern as other individuals who needed higher levels of care were thought to have difficulty accessing the higher levels of residential support. This and other recommendations in the HB 2015 report are under review by OHA.

OHA also recently presented to me the latest information about the establishment of the Community Restoration Evaluation Unit (CREU). The plan is for the CREU services to begin in March 2027. I was told that there will be eight OHA staff including a manager, fiscal analysts, administrative support and day-to-day operational staff. This service will be managed by Ms. Lisa Nichols who works under Ms. Clarke. There will also be forensic evaluators under contractual arrangement. OHA estimates that they will contract with 13 evaluators, and these positions have been posted as of 8/5. There will also be a clinical supervisor for the evaluators. OHA leadership is building out policies, procedures, technical elements, a secure file system, a Teams site and a data tracking system. They are also socializing the plan with stakeholders like AOCMHP and the Behavioral Health Advisory Committee and the OJD attorneys. Dr. Andy Bustos and some of his colleagues from FES have provided consultation on the development of CREU.

NWRRC has maintained a census of about 35 people for most of this reporting period, and it is clear it is being managed more closely. In addition, the construction is well underway for the expansion of the service. This site is due to take individuals by the end of this year. OHA has worked with NWRRC leadership with this initiative, and it may be that there will need to be further discussion about how to fill those new beds to help decrease the OSH RTP list as well as decrease the number of people on the GEI discharge ready list.

OSH Updates:

During this interim period, Mr. Sean Murphy was announced as the new Superintendent of OSH. He started on 7/13/26 and was terminated as of 8/12/26. Media reports with his quotes indicated there were disagreements with how to manage the hospital particularly related to staffing levels as well as other reports that indicated some performance concerns. OHA leadership was able to persuade Mr. Jim Diegel to return to the hospital to remain the Acting Superintendent for the foreseeable future while a new plan is crafted for permanent leadership. In addition, a new Chief Nursing Officer began on 7/20/26. Brandy Eurto, who has been a very strong asset and has helped immeasurably manage bed flow as the Director of Admissions, resigned her position as of 9/11/26. Her work has been very much appreciated, and it is important that her position is filled as soon as possible.

As noted above, shortly after the Court's remedial order of 6/1/26, orders for OSH restoration decreased and the census dropped, leaving empty beds (at times over 60). This represents an issue for Oregon to solve. First, it is not clear what happened to the individuals who did not get ordered into the hospital, and one of my early concerns with limiting admissions was that individuals who were sick would not access a hospital bed elsewhere, even though many people ordered for restoration would not need a hospital level of care (as noted above approximately 30% of admissions screened are ready for the RTP list within 10 days of admission). Correspondence from community members and a recent review indicated that some people may instead be held in custody rather than released, despite having lower-level charges. There is work being done to attempt to learn from OJD what has happened to the individuals who previously would have been ordered to OSH. Second, there are individuals who might need hospital level of care who currently have limited admissions access due to the expedited admissions protocols- and even patients who could meet civil commitment criteria following restoration are not subject to commitment unless they meet expedited admission or fall under the category of violent crimes that makes them fall under the provisions for conditional release monitoring. Third, the staffing for OSH remains as if the hospital is full, and therefore the shift in patient numbers can change morale and expectations of management and

staff. It is important that flow be kept pace with staffing and ensure that staffing would not be reduced with temporary census dips, as a decrease in staffing could put the hospital at risk of being unable to manage any surge in admissions.

In addition to the low census, the ready-to-place list is not shrinking. As of 9/9/26, 63 people were awaiting community placement for restoration services, with an average of 60.5 days of waiting to be discharged. As of the same date, 26 people who had been granted conditional release were awaiting placement in the community. Discharge coordination and efficiencies remain an ongoing matter of concern. Improvement in flow and capacity for community-based support services is critical. It is hoped that the PCG report will shed some light on what barriers may have existed and what can be done moving forward.

There has also been a Grand Jury investigation being conducted by the Marion County District Attorney's Office- as an outgrowth of a statutory allowance. Individual staff have been questioned about this, and it remains to be seen what the report will cover. This has created some tension at the hospital. At the same time, a recent tour was offered for District Attorneys around the state that seemed to be well-received.

According to OSH staff, the hospital has had only a handful of delayed admissions beyond the seven days. The information reported by OSH is as follows:

> *All five late admissions were due to orders we received late (more than 7 days after the order was signed). Below are the details:*
>
> - *Umatilla County – signed 7/1/26, received 8/7/26, admitted 8/10/26 – order was received 37 days after it was signed, patient was admitted 3 days after the order was received*

- *Umatilla County – signed 7/4/26, received 7/31/26, admitted 8/4/26 – order was received 27 days after it was signed, patient was admitted 4 days after the order was received*
- *Lane County – signed 7/29/26, received 8/20/26, admitted 8/21/26 – order was received 22 days after it was signed, patient was admitted 1 day after the order was received*
- *Polk County – signed 8/13/26, received 8/27/26, admitted 8/31/26 – order was received 14 days after it was signed, patient was admitted 4 days after the order was received*
- *Polk County – signed 8/14/26, received 8/25/26, admitted 8/27/26 – order was received 11 days after it was signed, patient was admitted 2 days after the order was received*

Outside of those five late orders, all other patients were admitted within 7 days, including two who had transportation delays (the delays did not push the patients outside of the 7-day window). And these five patients are the only patients who have not been admitted within 7-days since our "return to compliance" date on 6/13/26.

Meeting with OSH Patients/Defendants:

On 6/10/26 I was able to meet with three individuals who had been committed to OSH for restoration. Two had been at the hospital for over five months, and one had been back and forth between homelessness and the hospital. The other two patients had also described transient living and the need for "housing, income resources, ID, food stamps and a social security card." Patients spoke about their need for income support, job training, as well as substance use services. They each spoke about their journey through fractured services without continuity of support. They each described needed more help with employment and income than with anything else. Restoration services appeared to be less important to them. At least one individual complimented the OSH staff for their help.

Forensic Evaluation Services:

Dr. Andy Bustos continues as the interim Director of the FES. He has met with me regularly and been available to answer questions when asked. His assistance is very much appreciated. He described recently that the staffing that they have available includes approximately 24 FTE of evaluators and that they have expanded staffing to meet needs.

Dr. Bustos indicated that all inpatient evaluations are completed timely in accordance with statutory requirements. Community evaluations have been evolving as for many years there were no timeline requirements. After HB2005 passed, there is a requirement for regular evaluations for individuals' abilities to AA in their case. Although the FES staff are within the statutorily required evaluations, on an individual level defendants can wait months for a secondary evaluation. Dr. Bustos is working with community providers to help educate them about forensic evaluation processes.

In another matter, there was discussion about expedited criteria changing recently to have patients who were at the private hospitals remain there if they were in need of ECT. In discussions with the state, it was the perception of the state that private psychiatric units can access ECT if needed. Upon further discussion, it appears that there is a limited resource in providers who can perform ECT. As I discussed the importance of ECT, OHA questioned whether any recommendations regarding ECT were within my scope as the Court Monitor. I noted that I viewed access to ECT as directly relevant to the speed of restoration for some cases, which could then help an individual move to the next placement and allow another individual to be admitted.

Summary of AOCMHP Discussions and Activities:

I am very appreciative of the regular meetings I have had with AOCMHP leadership and representatives from the counties with regard to supporting the mandated populations.

AOCMHP staff are active in tracking what has been happening with community restoration. They remain concerned that there is ever expanding work in this domain and yet there have been insufficient resources for the CMHP to handle these community restoration cases.

AOCMHP has been working on implementing a SAMHSA (Substance Abuse and Mental Health Administration) rural transformation grant that will allow some training opportunities regarding serving the community restoration population. To that end, there will be a statewide "Summit" on October 1 that will catalyze dialogue on the current environment and how to build proper pathways to support sufficient services. I plan to attend that Summit and have agreed to participate in one of the sessions.

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

There were no specific updates on legislative efforts this reporting period, other than hearing that the Governor's office continues to dialogue with legislators about the behavioral health and mandated population needs.

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.*

Public Consulting Group finalized a preliminary draft of their report during this reporting period. They provided OHA with a copy of that analysis but asked for clarification and identification of any factual errors. OHA returned the draft with comments and identified areas where they felt there were errors. Many of the errors they identified contradicted prior communications with PCG indicating that the data received had been approved as accurate. It was clear that there was confusion within OHA as to who was to provide final approval and which section of OHA could review which data. Another particular issue revolved around the lack of clear spending data especially as it pertained to Medicaid. As such, there have been several conversations with me, OHA and PCG to determine a path forward to resolve any factual errors and ensure that the OHA leadership is approving datasets with the right personnel. It is imperative that OHA put energy into completing this report, which will be very helpful in seeing efforts to date and planning for future needs.

Table 8. PCG Project Timeline with Milestones

Tasks	Owner	Updated Date	Status
PCG Provides Updated Draft Report to Dr. Pinals & OHA	PCG	7/1/2026	Complete
Meet with OHA to review preliminary Draft Report	PCG/Dr. Pinals/OHA	7/1/2026	Complete
OHA Provide Feedback on the Draft Report to PCG	OHA	8/19/2026* *originally scheduled for 7/22/2026	Complete
Dr. Pinals, OHA and PCG meeting to review report feedback and next steps	PCG/Dr. Pinals	9/3/2026	Complete
PCG emailed action items and next steps to OHA	PCG	9/4/2026	Complete

Fines Updates:

The defendants have reported to the court that the only fines due since 6/13/26 were related to cases where Court orders that were not received timely in the month of August, totaling $28,500. There were fines that accumulated prior to 6/13/26 for the earlier part of month and the prior month that totaled $213,000.

Conclusions and Comments:

During the interim period since the last status hearing, and beginning 6/13/26, the defendants have admitted patients within seven days of their court orders. The only exceptions to that relate to those cases in which the courts have delayed getting orders to the hospital. Those delays have received some follow-up with the committing courts. Plaintiffs have raised concerns that the follow ups are insufficient. It appears on the whole that the Court's 6/1/26 remedial order did what it was intended to do- by limiting who could get admitted, it catalyzed the state's return to being able to timely admit most individuals into the hospital. The unintended consequence of that, however, was that court orders dropped very low, shifting the pace at OSH with many fewer admissions each day, and ultimately contributing to a low census at OSH.

What all this means is that there is now a need to look at what can be done to recalibrate. The defendants and I have been to discuss what options might be available to maximize hospital utilization for appropriate reasons. The goal of next decisions is to consider what might help the system to return to sustained compliance in the absence of federal court orders.

Another broad issue is the urgent need to complete the PCG report and finalize its recommendations. The report has taken much longer than originally anticipated.

Several conversations have included ideas about how to use the fines money. In speaking with Judge Nelson, I did not delve further into those discussions with the parties or the stakeholders as Judge Nelson indicated in the last hearing that she thought decisions about spending fines

money should wait. This may be partly related to the appellate case pertaining to the fines being under appeal.

Taken together, I would recommend the following for helping move this case forward at this time:

1. **OSH Census Review and Expanded Utilization**: Review with OSH leadership the management of beds at OSH and the overall census. This could perhaps start with allowing patients who are already there to stay there if they meet regular commitment criteria for treatment rather than discharging them if they do not meet expedited admissions criteria. This will require some review of data analysis. There are also concerns that court orders could surge and whether beds need to be "held" for such a potential event. I plan to work with the defendants to examine options to ensure that the AA and GEI populations, as well as others, can appropriately access an important statewide resource.

2. **PCG Report and Financial Analysis**: The draft PCG report was a thorough review of many sources of funding and how allocations had been expended across the state. However, there were aspects of the report where data appeared inaccurate to OHA upon their review of the draft, which included sections that had been "approved as accurate" previously by other OHA staff. There is a question of which data source provides the most accurate picture. Regardless, the Court has ordered this report, and much time has passed. To reconcile the current draft into its final form that would be useful, I have asked OHA to complete their task of sending what is considered accurate data and then allow time for PCG to do its analysis, with an overall completion date for a preliminary report within 60 days. OHA and PCG believe it will likely be possible to complete the remaining data clean up and report refinements within this period of time.

3. **Legislative Review**: During my next reporting phase I hope to meet with the Governor's office more to learn about current progress pertaining to HB2005 review and potential revisions.

4. **Data Improvements**: I recommend continuing to work with the behavioral health leadership at OHA and with Medicaid to examine data related to service delivery as it applies to community navigators, outcomes for individuals who have been committed to OSH and Community Restoration and other aspects of service delivery relevant to this case.

5. **Statewide Summit to Identify Strategies for Sustained Compliance:** The defendant's ability to maintain compliance absent the Court's remedial orders or equivalent statutory reform remains unlikely. It is imperative that the state have plans to move the needle independently or this case will continue with Court oversight for many years to come. Several states have hosted Summits, to examine aspects of care and services and explore recommendations for future action. It is my opinion that Oregon is ripe for such an endeavor, and I would recommend that this be driven by the Court in its planning. Whether this uses Fines money or not, it would be my recommendation that OHA work with the Court and the Court Monitor to establish such a summit with leadership from each branch of government and persons with lived experience to help share current state of the case and develop ideas for next steps.

6. **Training with Community System leaders:** I strongly support the efforts of AOCMHP to develop training and learning collaboratives to help address the mandated AA population and better serve individuals found GEI. I would recommend that the defendants support this work as part of the recommendation for enhancing and standardizing community restoration services.

As described previously, OHA and OSH should continue to work through the items in the project tracker to address my prior recommendations. I look forward to continuing that work with OHA and DOJ staff.

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*