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

Board Certified in Psychiatry, Forensic Psychiatry, and Certified in Addiction Medicine

Neutral Expert First Report
Regarding the Consolidated *Mink and Bowman* Cases

Date of Report: January 30, 2022
Neutral Expert: Debra A. Pinals, M.D.

Background and Context of this Report

On 12/21/21, the Honorable Michael W. Mosman, U.S. District Judge for the United States District Court for the District of Oregon, Portland Division, entered an order appointing me, Dr. Debra Pinals, as a neutral expert in granting a Stipulated Motion from defendants at the Oregon Health Authority (OHA) and the Oregon State Hospital (OSH) and Plaintiffs Jarrod Bowman, Joshawn Douglas-Simpson, Disability Rights Oregon, Metropolitan Public Defender Services, Inc., and A.J. Madison. The Court's order consolidates two cases, *Bowman et al v. Matteucci* et al (Case Number: 3:21-cv-01637-MO) and *Oregon Advocacy Center et al v. Mink* et al (Case Number: 3:02-cv-00339-MO) and identifies *Mink* as the lead case. Through this consolidation, the *Bowman* case was reassigned from the Honorable Marco A. Hernandez to Judge Mosman.

Judge Mosman's order stipulates further that OHA enter into a contract with the neutral expert and provide any needed information to her. Further, the Court ordered that the neutral expert should "make recommendations to address capacity issues at the Oregon State Hospital." The order delineates that the first report from the neutral expert, due 1/31/22, shall include "suggested admissions protocol that addresses the admission of patients found unable to aid and assist in their own defense under ORS 161.370 (.370 patients) as well as patients found to be Guilty Except for Insanity (GEI patients)." The Court further ordered a second report by the neutral expert, due by 4/29/22 that should include "a short report and recommendations for a proposed long-term compliance plan for OSH."

This report represents the first report of the appointed Neutral Expert in this matter.

Background and Summary of the Two Consolidated Cases

Oregon Advocacy Center (now known as Disability Rights Oregon) filed a civil rights lawsuit against the state of Oregon alleging that the state was failing to timely admit individuals found incompetent to stand trial (unable to aid and assist) who were ordered to Oregon State Hospital for competence to stand trial restoration. The ruling out of the Ninth Circuit (*OAC v. Mink*) found on behalf of plaintiffs that the State was out of compliance and must admit these individuals within seven (7) days .In June 2019 the court compelled the state to get in compliance with *Mink* within 90 days, and although the state met its burden at the time, compliance with the ruling became challenging once again with the pandemic creating other barriers to compliance. The state filed a motion requesting greater latitude in admitting individuals in the aid and assist process to mitigate spread of COVID-19. That motion was granted, and Disability Rights Oregon appealed to the Ninth Circuit Court of Appeals. The Ninth Circuit issued an order vacating the modification but also sought review by the District Court Judge to review his admissions

order. In December 2021, the parties entered an interim settlement agreement that involved the appointment of the neutral expert to provide recommendations as noted above.

In November 2021, plaintiffs Jarod Bowman and Joshawn Douglas-Simpson brought action against the Oregon State Hospital (OSH) and Oregon Health Authority (OHA) for failure to timely admit them as individuals adjudicated Guilty Except for Insanity (GEI) by the Multnomah County Circuit Court, after the Honorable Nan Waller had ordered them to OSH for treatment, without unreasonable delay. The plaintiffs remained, however at the Multnomah County Detention Center for months (Plaintiff Bowman for nearly eight months, and Plaintiff Douglas-Simpson for nearly six months) after the commitment order was issued. Plaintiffs alleged a violation of their substantive due process rights, and filed a motion for a Temporary Restraining Order asking for plaintiffs to be transported to OSH within seven days of the order. The defendants argued that a lack of space at OSH, in part related to the need to timely admit individuals in the aid and assist process, contributed to the delays in admitting the patients. The court granted the plaintiffs' motion for a Temporary Restraining Order, noting that "The *Mink* injunction does not address the relative priority of aid-and-assist patients and GEI patients…" noting that "any prioritization stems from Defendant's failure to provide the funds, staff, and facilities necessary to satisfy the *constitutional rights* of both groups. When satisfying constitutional guarantees, Defendants cannot rob Peter to pay Paul." In that opinion, The Honorable Marco A. Hernandez, United States District Court Judge did agree with the defendants that a consolidation of the *Mink* and *Bowman* cases may make sense, thought the response to the motion would not be affected by that consolidation. As noted above, subsequent to that decision about the Temporary Restraining Order and the two specific plaintiffs and at the time of the appointment of the neutral expert, the parties entered an interim agreement that no individuals found GEI would wait longer than four months for admission to OSH.

Qualifications to Perform this Consultation

In rendering the opinions in this report, I relied upon my training and experience after almost twenty-five years as a clinical and academic and forensic psychiatrist, and over twenty years functioning in state and local level administrative leadership, management, clinical treatment, forensic evaluation, and consultative roles across several U.S. jurisdictions. My experience includes evaluating individuals in civil and criminal processes including competence to stand trial (Aid and Assist) and criminal responsibility (GEI), consulting to community and hospital behavioral health systems regarding care and treatment of complex patients and writing, advising on, and revising policy pertaining to individuals in forensic processes, among others.

Sources

In order to help inform the recommendations contained in this report, I reviewed the following information:

1. Mink 0339 COURT Order Consolidating Cases and Appointing Neutral Expert #240, signed 12/21/21;
2. Bowman 1637 COURT Order Consolidating Cases and Appointing Neutral Expert #21, signed 12/21/21;
3. Bowman 1637 COURT Notice of Judicial Reassignment from Judge Hernandez to Judge Mosman #20;
4. January 3, 2022, Report to Neutral Expert, received 1/6/22

5. *Mink* and *Bowman* Interim Agreement, Filed 12/17/21
6. Oregon Health Authority Table of Organization;
7. Behavioral Health Services Table of Organization;
8. Commitment statues and rules as well as copies of forthcoming legislative changes as provided by Kailana Piimauna, Senior Assistant Attorney General, Health and Human Services, General Counsel Division, Oregon Department of Justice
9. OSH key data, trends, and additional data summaries provided by OSH and OHA in response to several requests
10. MHS 04 Aid and Assist [DIRECT] (GT#0705-19) FINAL 05.24.19"
11. Final 2021 CCO contract template 11302020", with a focus on Exhibit M pertaining to OSH.
12. Budget Note Data 10-1-21 - Full Review
13. County MHS 04 21-23 Biennium Funding
14. Directive to continue addressing the statewide Aid and Assist crisis
15. Pat Allen OSH Directive 6/20/19
16. 2019-0814 Rivers Run all staff re criteria changes
17. C-1 Aid and Assist Response- Rivers Run one-pager-updated
18. 21.12.29 OSH Overview changes and capacity PowerPoint
19. OHA OSH Staffing Request Dec 2021
20. Request for Expedited Admission to Oregon State Hospital-Forensic, 2/5/21
21. Request for Expedited Admission to Oregon State Hospital- Civil Commitments, 2/5/21
22. Request for Expedited Admission into Oregon State Hospital-Patients on the OSH Admission List Under Forensic Commitments, labeled 11/8/21
23. *Oregon Advocacy Center et al. v. Mink et al.,* Case No. 3:02-cv-00339-MO, Progress Report, November 17, 2021
24. *Oregon Advocacy Center et al. v. Mink et al.,* Case No. 3:02-cv-00339-MO, Progress Report, May 12, 2021
25. Net Bed Capacity Report 20220105
26. Documents for discharge planning including:

    a. A&A and Civil Process Map One and Two
    b. Protocol for Aid and Assist Discharge Policy
    c. Ready to Place Checklist
    d. Ready to Place Notification
    e. LOCUS Guidance to Court
    f. Ready to Place Withdrawal Notification
    g. HLOC Required
    h. Dual Jurisdiction Ready to Place
    i. HLOC FES Eval Submitted
    j. Example Clinical Hospital Level of Care Assessment
    k. Hospital Level of Care Process Map
    l. Hospital Level of Care Standard Work
    m. LOCUS Guidance Document to Court
    n. OSH FAQs Regarding Notice
    o. Policy 6.013 Discharge and Conditional Release Planning (overarching policy)
    p. Protocol for Civil Discharge Policy
    q. Policy 6.043 Risk Review for Civil Patients

r. RTT Flow Chart
s. A&A and Civil Process Map One
t. A&A and Civil Process Map Two
u. Continuing Care Discharge Plan (standard discharge plan for all jurisdictions)
v. ACT Referral Process Map (across jurisdictions)
w. Policy 6.013 Discharge and Conditional Release Planning (PSRB/GEI)
x. GEI Admission to Conditional Release
y. Policy 6.029 Forensic Risk Review and Privileges

27. OHA PSRB EOJ CHOICE process 7/23/18
28. Draft charter for the MOOVRS (Multi-Occupancy OSH Vacancy Resource & System Improvement Team) initiative
29. PowerPoint overview of the Person Directed Transition Team
30. Draft Forensic Evaluation Service Manual (edited)
31. 3 evaluation comparison worksheet
32. OSH Forensic evaluation checklist
33. 370 Initial Report Template -updated 01/14/2019
34. 370 Initial Report Template Annotated -updated 01/14/2019
35. 370 Progress Report Template-updated 01/14/2019
36. 370 Progress Report Template Annotated- updated 01/14/2019
37. FES Policy Opinions Regarding Hospital Level of Care-Updated
38. Hospital Level of Care Template provided by Ericia Leeper
39. FES Attorney Email Templates
40. Early Referral Process as of 04/01/2021
41. 2020 IMPACTS RFGP
42. IMPACTS Grant Reports to the Legislative Assembly for 2021 and 2022
43. PowerPoint Presentation from the Medical and Allied Health Professional (MAHP) Staff at OSH
44. PowerPoint Presentation regarding Forensic Evaluation Services
45. PowerPoints from legislative session regarding Behavioral Health Package of Resources Update, Update on Ballot Measure 110 Implementation, and Crisis Care Update, along with observing legislative testimony by Director Allen from 11/17/21
46. Program Design and Evaluation Services (PDES) Aid & Assist Progress Update—January 2022
47. Participation in the opening of the Oregon Behavioral Health Summit on 1/6/22 and review of Preliminary Reform Ideas for Aid & Assist System from OJD Oregon Behavioral Health Summit/ GAINS Community of Practice on Competence to Stand Trial/Competence Restoration for presentation to the neutral expert, dated 1/26/22
48. Preliminary Highlights of Ideas Relating Most Directly to OSH from OJD Summit
49. Data regarding level of care placement recommendations compiled by Dr. Chris Hamilton of OJD
50. Instructions that the Aid & Assist Coordinators work from specific to "most appropriate aid & assist placement" per Dr. Hamilton of OJD

In addition, to inform my opinions and this work as a whole, I spoke with and/or exchanged emails with numerous people, including but not limited to the following individuals:

1. Three individuals committed to OSH under a GEI legal status
2. Three individuals committed to OSH under an Aid & Assist legal status
3. From OHA and OSH:
    a. Steve Allen, Director of Behavioral Health, OHA

b. Dawn Jagger, Chief of Staff, OHA
c. Dolores Matteucci, OSH Superintendent-CEO
d. Carla Scott, DOJ Special Litigation Unit Counsel
e. Isela M. Ramos Gonzalez, Senior Policy Advisor, Government Relations, OHA
f. Shawna McDermott, Behavioral Health Operations Director, OHA
g. Kailana Piimauna, Senior Attorney General, Health and Human Services, General Counsel Division, Oregon DOJ
h. Derek Wehr, MSW, Deputy Superintendent OSH
i. Brandy Eurto, Director and Manager of Admissions, OSH
j. Cody Gabel, LPC, CADC 3, OPMA, Court and Corrections Liaison, Aid and Assist and Jail Diversion, OHA
k. Bill Osborne, BH Intensive Services Manager, OHA
l. Ryan Stafford, Forensic Utilization Coordinator, OHA
m. Isela M. Ramos Gonzalez, Senior Policy Advisor, Government Relations, OHA
n. Dr. Sara Walker, Interim Chief Medical Officer, OSH
o. Scott Hillier, Chief Data Analyst, OSH
p. Mandy Davies. Interim Director, Forensic Evaluation Service, OSH
q. Micky Logan, Legal Affairs Director at OSH
r. Della Huffman, Director of Social Work, OSH
s. Sheila Potter, Deputy Chief Counsel, Special Litigation Unit, Oregon DOJ
t. Tristan Fernandez, Senior Legislative Policy Analyst, OHA
u. Members of the Medical and Allied Health Professional Staff (MAHP) at OSH
v. Margaret J.F. Braun, Ph.D., Research Scientist, and colleagues working on the Program Design and Evaluation Services (PDES) review Aid & Assist individual characteristics, OHA

4. From Disability Rights Oregon:
    a. Emily Cooper, Legal Director, DRO
    b. KC Lewis, Managing Attorney, DRO
    c. Timothy Roessel, Advocate, DRO
5. From Oregon Criminal Justice Commission (CJC)
    a. Katie Doldom, IMPACTS grant manager, CJC
    b. Andrew Powell, Research Analyst, CJC
6. Members of the Oregon Judiciary and representatives of the Office of the State Court Administrator including:
    a. State Court Administrator Nancy Cozine
    b. Judge Jonathan Hill, Tillamook
    c. Judge Matthew Donohue, Benton
    d. Judge Nan Waller, Multnomah
    e. Judge Laura Cromwell, Jackson
    f. Judge Cindee Matyas, Clatsop
    g. Judge Rachel Kittson-MaQatish, Linn
    h. Dr. Debra Maryanov, Senior Assistant General Counsel, Office of the State Court Administrator
    i. Dr. Christopher Hamilton, Behavioral Health Business Analyst, Office of the State Court Administrator
    j. Connor Wall, Data Analyst, OJD

Glossary of Acronyms and Terms Used in this Report

A&A: Aid and Assist
CCOs: Coordinated Care Organizations
CCBHCs: Certified Community Behavioral Health Clinics
CMHPs: Community Mental Health Programs
DOJ: Department of Justice Oregon
DRO: Disability Rights Oregon
GEI: Guilty Except for Insanity
HLOC: Hospital Level of Care
IMPACTS: Improving People's Access to Community-Based Treatment, Supports, and Services
MOOVRS: Multi-Occupancy OSH Vacancy Resource & System Improvement Team
OHA: Oregon Health Authority
OSH: Oregon State Hospital
PSRB: Psychiatric Security Review Board
SHRP: State Hospital Review Panel
SRTF: Secure Residential Treatment Facility

Background Information

Data Summaries

The following data charts and figures provide information as reference points throughout this report. **Table 1** directly delineates data regarding compliance with the *Mink/Bowman* orders and settlement agreements, respectively. The other data presented in this report supports factors that are related to compliance as explained throughout the body of this report.

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***
Total Number of individuals	46	93*
Average days waiting	15.8 days	22.5 days
Range of Days on waitlist	2-23 days	3-44 days
Average days waited for admissions in December 2021	15.4 days (range 11-20 days)	15.4 days (range 11-20 days)
2. Regarding individuals found GEI and ordered to OSH		
	As of 1/5/22	***As of 1/28/22***
Total number of individuals	15	4
Average days waiting	45.6 days	23 days
Range of Days on waitlist	1-110 days	17-28 days
Average days waited for admissions in December 2021	150.2 days (range 41-203 days)	150.2 days (range 41-203)

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

Table 2: OSH Bed Capacities as of 1/5/22

Site	Licensed Capacity	Active Capacity
Salem Main Campus HLOC	503	475
Salem Main Campus SRTF	90	87
Salem Main Campus Total	**593**	**562**
Junction City HLOC	75	72
Junction City SRTF	75	72
Junction City Total	150	144
OSH Total	**743**	**706**

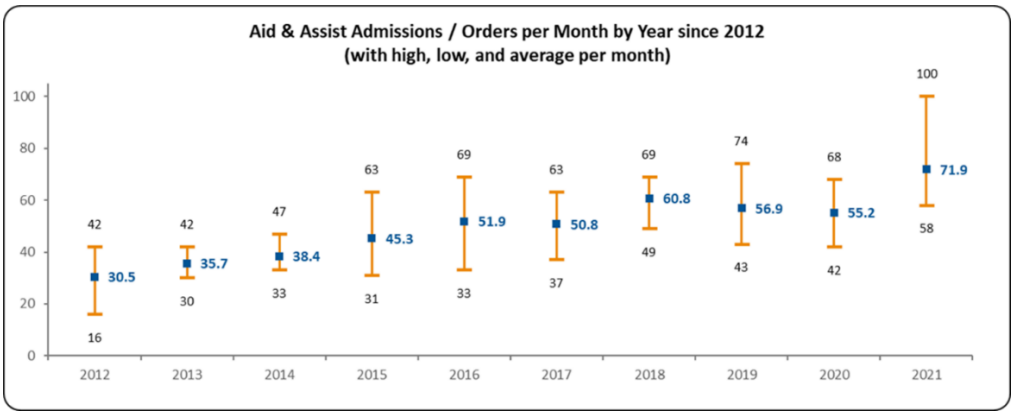
Table 3. Individuals determined to be clinically appropriate for discharge as of 1/11/22

Legal Status	Total on "ready to discharge list"	Numbers and level of care needed
Aid & Assist	85	8: SRTF 40: RTF/RTH 24: Community with support (ACT) 13: Independent housing with MH
GEI/PSRB	26	10: SRTF 13: RTF/RTH 1: I/DD Placement 1: DOC 1: Independent housing with MH
Civil	4	3: SRTF 1: pending updates on placement (TBD)

Table 4. Aid and Assist and GEI orders

Number of Orders Received	Aid & Assist	GEI
December 2021	76	8 (5 standard/3 revocations)
January 1-28, 2022	68	6 (3 standard/ 3 revocations)

Figure 1. Aid & Assist Admissions/Orders Trends



State Behavioral Health Services Background

OSH: I was provided an overview of OSH structure and function (See **Table 2** for basic capacity data). The two campuses have units that are divided largely into two distinct levels of care: hospital level of care (HLOC) and secure residential treatment facility (SRTF). The SRTF level does not require the same level of nursing or line staff.

Staffing challenges have been a major issue for OSH. Staffing allocations require approval from a nurse staffing committee that determines appropriate staffing levels per bargaining unit contracts. In addition to their assessments, a multidisciplinary workgroup with various union representatives identified needed staffing levels. To hire into positions, there must be both financial resources and staffing level authority for additional positions within OSH. Thus, at this time, the currently required staffing levels exceed budget allocations and staffing level authorization. A staffing report was presented to Ways and Means but OSH leadership, but has not yet been approved.

The waitlist is managed regularly with staff assigned to admissions process especially. A protocol has been in place for some time to allow for sheriffs to request expedited admission. In Quarter 4 of 2021 (Oct, Nov, Dec), there was one (1) expedited admission for a patient on an OSH admission order as a GEI, and the admission was expedited due to a suicide attempt in the jail. There was some discussion with DRO regarding updating the expedited admissions protocol but the parties agreed that any efforts to examine this required further conversation. Two (2) patients went ahead in the waitlist during the fourth quarter of 2021. Both were admitted as GEI revocations per the PSRB.

The hospital leadership noted that there is a growing number of patients on the 9b list identified as no longer needing hospital level of care (see **Table 3**). There have been several initiatives that have proven some success in facilitating discharge of patients, including the recent MOOVRS group, which focuses on individuals in the A&A, GEI and 701 processes, as well as prior efforts with the Oregon Performance Plan with civil patients (that included metrics for length of stay and ready to place timelines), and the Person-Directed Transition Team supports.

Clinical staff explained their perspectives on delays in medicating for individuals who refuse medication related to their underlying mental health condition who may not have capacity to make treatment decisions. The legal processes can create delays and ultimate non-restorability determinations may be the result regardless due to the level of severity of the illnesses people exhibit.

According to OSH leadership, there are often several hearings per week addressing individual court contempt findings for failure to timely admit individuals. For each of these contempt hearings, there is a resource of testimony required from clinical and administrative staff who are then unable to perform the oversight and treatment functions that would expedite other admissions.

According to OSH staff with whom I spoke, it is not uncommon to be dealing with transport delays by some sheriffs for admissions. Although there may be legitimate issues with transport, this can extend waiting periods in jail and create additional administrative burden, not to mention distress and confusion for the persons committed to OSH who may be expecting to leave jail.

Despite its challenges, OSH offers many very promising services. The professional staff shared with me their backgrounds and passion for the work that they do, and even in these difficult times, their commitment is clear. They also noted that OSH continues to operate several accredited training programs for psychologists and psychiatrists and others that have been great sources for recruitment and retention of new professional staff.

Meetings regarding Forensic Evaluation Services: Initial competency evaluations were discussed across meetings. The increased volume of A&A orders had been striking (See **Figure 1** above). The demand for evaluations and re-evaluations made it difficult to achieve timely evaluations. There was a common theme among persons I spoke with that seemed to suggest there were inefficiencies in evaluation processes as it relates to compliance, yet there were several solutions offered including centralization and decentralization of the evaluation services. It appeared that certification had not shifted the efficiencies and there can be limited qualified evaluators in particular regions. Besides initial evaluations, re-evaluations of A&A for those committed to OSH are increasingly impacted, and there are delays in A&A evaluations in light of the additional demands on FES. Forensic evaluators at OSH often are spending time gathering information for cases that are dismissed. In addition, I was told that time is spent locating defendants who no-show, yet continue to be awaiting an evaluation service.

Community Behavioral Health and OHA: In my preliminary meeting with several OHA staff, I was given a primer on Oregon services pertaining to the A&A, GEI and civil populations vis a vis admission to OSH. In order to best understand how to form recommendations regarding admissions, it also is important to understand discharges and potential strategies to divert from arrest and sustain community stability to avoid rehospitalization. Data indicated that those in the A&A process were most likely to return to OSH compared to other populations. Thus much of this information relates to both aspects of the system.

Community restoration services have recently been funded by OHA to augment funding through Medicaid of "treatment as usual" services in the community. OHA developed contracts to assist with community restoration services, and counties have chosen different uses for those dollars.
Of note, the current statute for community restoration has no requirement of maximum time spent in restoration or timing for evaluations. There are also community funds for jail diversion as well as some localities that have CCBHCs, which promote collaboration between behavioral health and other community members including law enforcement and jails to reduce likelihood of arrest. According to a presentation to the legislature, there have been some CCBHCs that were closed but some that were able to open, and OHA is interested in sustaining these programs. IMPACTS grants have been made available to several counties as another innovation for the state, managed by CJC.

Staff indicated that the Psychiatric Security Review Board (PSRB) manages approximately 650 GEI cases involving approximately 640 unique individuals, and that 240 of those are at OSH, and the other 400 are in the community. The PSRB reviews risk mitigation plans for admissions and for discharges from OSH. Several years ago there was the initiation of the State Hospital Review Panel (SHRP), which was invoked to review discharges in lieu of the PSRB for individuals found GEI on less severe offenses such as misdemeanor and non-person crimes. The SHRP was dissolved by statute when the low-level misdemeanors were ultimately discharged from OSH. There is some effort to track whether this improvement in timely discharges has reversed itself since the SHRP was dissolved.

OHA has identified Northwest Regional Reentry Center (NWRRC) as a potential stepdown site for some individuals committed to OSH when appropriate clinically. However, there has been mixed engagement

regarding the use of the NWRRC facilities across counties. Also, there have been some concerns raised as this facility is not designed as a psychiatric treatment facility, and as such it is important that appropriate level of care determinations and monitoring is conducted for these placements.

OHA described numerous innovations to help expand community capacity, and the staff with whom I spoke were knowledgeable and dedicated to these efforts.

Meetings with Patients at OSH

I met with six (6) patients all together. Three (3) were in the A&A process and three (3) were in the GEI system, all of whom agreed to speak to me. I focused my meetings on their current status and their experiences in the community and gathered no personal identifying information in order to preserve confidentiality. I explained my role to the individuals and told them that my speaking to them was solely to inform my thinking about systems issues and decreasing jail wait-times as a whole and that nothing specific about them would be identified in the report.

Patient 1. This man appeared to be approximately in his 20s. He was in the GEI system having been at OSH for about five (5) years. He noted that he would be returning to live with his parents, and would need rides, and a place to go for his medications. He stated that his admission was a result of his step down from a group home where his medication adherence was monitored, and his having stopped medications at his next placement. He was not sure of what wrap-around supports he received at the second placement.

Patient 2. This man also was in the GEI system, and was estimated to be approximately in his 30s. He had been at OSH since approximately 2018. He recalled waiting in jail prior to admission. He felt that the community system had been pretty good, but that his doctor told him he could go off his medication. He had been homeless prior to admission. He was not sure where he would be living after discharge. He stated that there are many steps involved in the PSRB process. He felt he had family supports and was hoping to become a peer support specialist.

Patient 3. This woman appeared to be approximately in her 20s. She had been in the Aid & Assist process for 50 days. She described waiting in jail for about one month, and that one day she was told she would be going to OSH. She stated in the jail she was not given her medication. She said she felt "pushed aside." She was very complimentary of OSH. She liked the groups and the activities. She was excited to be determined able to proceed but also aware she might be facing homelessness.

Patient 4. This man was approximately in his 30s and in the A&A process. He described having been at OSH for about two (2) months and having waited in jail about two (2) months prior to his admission. He stated his parents provided many of his supports but he was looking for ways to not rely on them and would need assistance with that. He described having manic and psychotic symptoms that needed injectable medication for longterm stability. He stated he enjoyed doing drugs and wants to continue that though was worried his mental health might worsen. He noted he had stopped his medication prior to arrest. He also stated there needed to homeless supports. He stated he was unable to afford bail even though his charges were fairly minor.

Patient 5. This man indicated he had been at OSH for three (3) months in the A&A process. He had waited in jail for about a month. He had not been to OSH before, but had been in community mental

health services. He noted the community services were "slim pickings" in his small county, they were short-staffed and therefore services were difficult to access. Although he stated the system considered him homeless, he stated he preferred "rough living" except for how people treat him like "less of a human" as a result. He felt that he would likely therefore be recommended for a group home. And though he preferred a different lifestyle, he also recognized he had a daughter to think about and wanted to get SSDI. He stated that confidence boosters help, and that his family could help. He felt peer support or community workers would not help him. He stated that he felt as a grown man that he is treated like a 13-year old in the system. He thought the psychiatric and legal system needed an overhaul.

Patient 6. This man appeared to be approximately in his 60s. He was well-read and brought in an article announcing my appointment. He was in the GEI system, stating he had been in and out of the hospital many times. He stated that one of his revocations involved use of oxycodone though it had been officially medically prescribed after an accident. He noted homelessness and lack of access to crisis services as some of the biggest barriers for him. He stated he was familiar with the CAHOOTS model (a non-police crisis response model), and felt that law enforcement scares people who are having a mental health issue. He also stated housing is difficult to access due to stigma. He lived in his car for six months while working. He stated he felt guilty taking up a bed at OSH when others needed it. He was somewhat worried about how he would manage when he got to end of jurisdiction as he would continue to need supports.

Patient 6 had an advocate with him who anonymously made observations that the PSRB makes conservative decisions thinking of "doing time" as a "treatment", typically recommending PSRB supervision for the maximum allotted times as a routine. He stated the hospital is just in the middle and not able to help control their front or back door.

OHA Progress Reported in the January 3, 2022, Report to Neutral Expert

This progress report highlighted several areas of recent action by the state. First, OSH opened the first of two remaining Junction City units on 11/15/21, with one more slated to be opened 1/18/22 (of note this was delayed, however until later in January due to COVID-19 and revising admissions strategy per the below recommendations). This created capacity, and lead to the movement of 24 GEI patients from the main campus to the Junction City Campus. Additionally, 24 A&A patients were able to be moved to a SRTF level of care on the OSH campus, allowing for 24 beds to be open at the hospital level of care. Additionally, OSH opened 10 more admissions beds related to some COVID-19 unit re-adjustments.

Additionally, the state expanded criteria, now including patients whose most serious charge is a non-person C felony, on the "Ready-to-Place list" when they no longer meet HLOC.

OSH is meeting weekly with the Northwest Regional Reentry Center (NWRCC) and is attempting to work with the home counties for those individuals on the "Ready-to-Place" list. This has met with only limited success, related at least in part to county resistance to using the NWRRC, according to OSH.

The Oregon Department of Justice (DOJ) has been working with state courts to help support the processes outlined in Senate Bill 295 to increase the use of community-based restoration placements for the A&A population committed to OSH.

Regarding GEI patients, OHA has worked with the PSRB to facilitate discharge of GEI patients and reduce their length of stay once at OSH. The 1/3/22 progress report indicates that OHS/OSH and PSRB identify those who could be referred for evaluation for community-based services. DOJ has participated in GEI cases where the court has not ordered community evaluations.

Information from OJD

State Court Administrator Nancy Cozine and her colleagues at OJD, along with several judges with whom I met, provided a wealth of information regarding their views of some of the barriers to compliance with regard to the A&A and GEI populations. Because of their deep commitment to convening and strengthening the overall system for individuals in the behavioral health and justice systems, in January 2022, OJD hosted a two-day Oregon Behavioral Health Summit (with several exercises for stakeholders prior to the summit) to help gather feedback to identify a bill of rights for individuals in the behavioral health and justice system and identify gaps that could be addressed to improve outcomes.

In my meetings, I was provided preliminary recommendations from the Summit. In their preliminary findings report to me, they provided historical context of a phased plan with the first phase from a GAINS Community of Practice on Competence to Stand Trial/Competence Restoration, in which a workgroup identified the following objectives embedded in an idea for regional behavioral health resource centers in its August 2020 strategic plan:

- *Divert individuals with behavioral health issues from the criminal justice system to services and supports that reduce risk of reentry to the criminal justice system and emergency rooms*
- *Expand availability of timely evaluations and community-based restoration services*
- *Ensure geographic, racial, ethnic, and language equity of aid and assist services statewide*
- *Make effective use of existing state and federal funds to deliver on systemwide goals and address behavioral health needs (e.g., housing, treatment, transportation, etc.)*

OJD noted that since there were significant appropriations to OHA to enhance behavioral health crisis stabilization services and other features, the GAINS workgroup paused its meetings to observe the implementation of new OHA initiatives.

Based on the Summit's findings, gleaned from all the attendees, preliminary objectives for improvements were described in the each of the following goal areas: Evaluations, Treatment and Services, Transition, Equity, Access, Coordination, and Data. Their recommendations continue to be distilled, and their will be a formal report from the Summit issued.

Taken together, it is laudable that key personnel and judges working within OJD have been very invested in Aid & Assist issues for some time. An impressive database has been created for the court officials to be able to track both systems and granular data related to particular cases and trends. There have also been several innovations, such as Judge Nan Waller's 'rapid Aid & Assist' evaluation effort and her consolidated A&A docket. OJD personnel indicated that there had been a robust pretrial program that was eliminated due to funding but that the courts were able to secure 40 pretrial coordinators now hired at local courts to help input data and track A&A cases.

There are Behavioral Health Advisory Committees (BHAC) within OJD established at state and local levels. The judges noted that there was also a similar meeting set by the legislature. With COVID-19, some of the meeting duplication dissipated, but OJD continues to have regular meetings with a behavioral health judicial consortium. They noted also that there had been a Behavioral Health Justice Counsel that included DRO, members of OJD and the behavioral health system.

There was much discussion regarding the disconnect between criminogenic risks and needs that help determine security needed for public safety, and the clinical level of care determinations that involve more secure placements. The OJD representatives commented on the frequency of homelessness and substance use disorders in the A&A populations, and a lack of ability to divert through civil processes while reducing recidivism.

In reviewing the OJD data dashboard, it was noted that of the A&A cases, 59% were ultimately found guilty (often via a plea, and some few were found GEI), and 33% were dismissed (some of whom were determined Never Able to proceed). Approximately 1% were dismissed pre-disposition. It was noted in discussion that primary factors in dismissals involved: having a reasonable community plan, factoring in the duration of stay in a carceral setting, and consideration of whether probation might be an effective option.

OJD noted some barriers to data sharing including OHA concerns about HIPAA issues. They noted for example that they do not have awareness of which of the individuals on their A&A caseloads are in OSH or other community placements.

The OJD comments included that there can be confusion between overlapping roles of CMHPs, CCOs, and CCBHCs. They noted in discussion with me that there are also frequent recommendations for level 5 and 6 placements from clinical teams or evaluators, and that judges would not likely release to a lower level of care if that is the clinical recommendation. They described a desire to be more aware of bed availability in community settings to also know where the state might need more level 5 or 6 placements.

Information from CJC

I met with key leaders at CJC who were overseeing the IMPACTS grants. These grants were established to decrease recidivism and state hospital utilization and expand jail diversion. They indicated that in July 2020 awards were made to 11 grantees across the state (five (5) tribes and six (6) counties) with $10M appropriated by the legislature. The grants run on a biennium cycle from 2020-2022 and there is the possibility of extension with an additional $10M appropriated at the end of the 2021 legislative session. Due to COVID-19 there have been delays in getting these initiatives off the ground. The total allocations have the potential to run through 2024. Data collected has been difficult to interpret due to the impact of COVID-19 on programs, but data is beginning to come in and will be analyzed as it does to help establish the program successes and challenges. Preliminary reports on these grants were presented to the legislature. For additional sites to be funded through this mechanism, there would need to be an additional appropriation separate from the existing appropriations.

Summary of Contextual Factors Considered in Recommendations

Hospital Context

OSH is a state-run facility with an active capacity of 706 beds (though it is licensed for 743, there is an operational need to manage beds at the active capacity) (See **Table 1**). There has been recent expansion on the Junction City Campus, and Table 1 reflects accurate data projected for the week of 1/31/22. Without getting into too many details about the hospital specifics, it is important to highlight four main contextual factors facing OSH that have emerged as themes from my meetings relevant to timely admissions of A&A and GEI populations. I will outline them here.

1) OSH, like institutions throughout the world, has been facing clinical dilemmas related to COVID-19. The hospital administration has explained to me their protocols that follow specific guidelines aimed at reducing the spread of the virus, and, when necessary, managing those who do get COVID-19 safely. To date the hospital has done a very good job with this. The leadership reported to me that no patient at OSH has had serious medical sequelae and there have been no deaths associated with COVID-19 among patients. That said, to do so they have had to make some very difficult decisions, including a decision to pause admissions periodically. When admissions are paused, the waitlist numbers increase, making these administrative and clinical decisions so complex. With the evolving COVID-19 situation, this balance will undoubtedly continue to need to be deliberated in the best interests of individuals waiting in jails for admission and those at the hospital.

   In 2022 Dates of Paused Admissions to OSH due to COVID-19 included:
   1) January 4 through January 11
   2) January 17 through January 21

2) Staffing shortages have reached at times critical levels. The hospital has called upon the National Guard to assist, and per their discussion with me that has helped alleviate some of the strain with the National Guard members assigned to duties within their skillset. Staffing shortages of the licensed professional staff and the non-licensed staff remain, and as such the hospital has conducted a staffing gap analysis and presented staffing requests in the hopes of a fiscal appropriation and an administrative allowance to expand FTEs. Timely admissions and safe discharges depend on sufficient staff.

3) Increased referrals create more demand. Data trends show ever increasing Aid and Assist evaluation orders (see **Table 4** and **Figure 1**). Compared to prior years, even "slow" months with fewer referrals show higher numbers of referrals than the busiest months in years past. This pace of referrals creates an impossible dilemma for OSH. Forensic evaluators at FES are increasingly called in to do first evaluations, and there seem to be increasing numbers of second opinion evaluations, also creating delay- and statistically in terms of ultimate findings, it is not clear whether this creates any meaningful change in ultimate adjudication for many defendants, besides longer wait times.

4) Delayed discharges reduce the ability to timely admit new patients. Data reports (see **Table 3** above) indicate that there is a growing "Discharge Pending Placement" waitlist. Reports from staff at OSH and OHA indicate that even with the enactment of SB 295, it is not always followed and little traction has been made on many cases of individuals who do not require a hospital level of care per clinical determinations. This creates other *Olmstead* issues with regard to not placing indivduals in a

less restrictive level of care when clinically appropriate. Because of the many fingers in the discharge process, including the individual themselves whose discharge relates to County actors, local actors, State actors, Courts, CCOs, CMHPs, and others, it is a challenging process under the best of circumstances. That said, as reported by nearly every group with whom I spoke there are barriers at the county and community levels that warrant further scrutiny and attention in order to achieve compliance with admissions.

Community Context

The community context also has several complexities that have emerged as themes in my meetings. Some notable contextual factors that are important to note with regard to compliance include the following:

1. The impact of COVID-19 has completely shifted community services, and created fraying of an already fragile workforce. As noted by Director Allen in his 11/17/21 report to the legislature, there has been an unprecedented set of challenges to community systems, who daily struggle to maintain staffing levels of direct service providers at the ground level, and stay afloat financially. Although resources are being allocated in generous amounts through recent appropriations, pouring money into a frayed system will not be an immediate remedy. Moreover, the dollars must be distributed in a way that also shows accountability to taxpayers, and this additional scrutiny puts pressure on community systems to perform better, at a time when many are simply trying to survive.

2. Justice-involved behavioral health populations present unique challenges. As is seen in countless studies, it is clear that there are many factors that make criminal recidivism for individuals with serious mental illness--and especially those with co-occurring substance use disorders and those with homelessness—difficult to tackle. The population of persons in the Aid & Assist and GEI systems quite often have those complexities. Studies show that most often their repeated criminal conduct involves lower-level offenses. Nevertheless disrupting the cycle of arrest, incarceration and rehospitalization requires more intensive and intentional service components to address their complex needs. It was reported by people I spoke with that community providers often feel ill-equipped and under-resourced to work across the behavioral health and justice system to help break these negative cycles for persons served. Furthermore, justice system partners such as probation and parole can play a role in reducing recidivism, which is outside the behavioral health system's purview. Even with additional financial resources, the community systems may need additional support and training to best serve these populations.

3. Substance use disorders commonly co-occur with mental illness for those in the Aid & Assist and GEI process. Community behavioral health leadership and the judges with whom I spoke raised a number of concerns about how to best address substance use disorders among the Aid & Assist population in particular, and especially with regard to the nature of methamphetamine use and its relationship to psychosis and paranoia. These symptoms can often lead an individual to appear unfit to proceed during acute phases of use, and the forensic evaluators described how this can impact their forensic evaluations. With the passage of Measure 110, there is movement afoot through OHA to help shore up treatment resources for individuals with substance use disorders, though this again is not an overnight solution. At the same time, individuals in the Aid & Assist and GEI processes have not traditionally been part of the "substance use treatment systems." There has been and will

continue to be discussion regarding how and whether this factors into compliance with timely admissions.

4. The structure of the community services is complex, and there can be silos between counties and state responsibilities, leaving the state unable to shift policy and practice without county support. Also managed care entities responsible for providing care or overseeing care delivery for beneficiaries have their own metrics and incentives. Periods of detention/incarceration can disrupt continuity of care for individuals adding to the challenges of providers. Within Oregon the CCOs and the CMHPs as well as the counties and municipalities themselves are not as directly impacted by the compliance demands and they may have different priorities that can even contradict addressing barriers to timely admission and discharge of individuals in these forensic processes. According to observations from the parties, the SB 295 legislation was designed to address some of the challenges in part, but it is at times misunderstood or appears to not be consistently followed. Recommendations below attempt to begin addressing some of these issues.

Unique population needs

For this report and recommendations, specific information was not gathered regarding how many individuals in the A&A or GEI systems represented populations in need of specialized services within OHA and across other agencies. These include individuals with individuals with intellectual and developmental disability services, neurocognitive conditions (i.e., the so-called dementias), traumatic brain injury or primary substance use disorders. In addition, this report did not focus on veterans or persons with a history of military service who may have access to additional housing or other supports. These special populations may be relevant for focus in future recommendations pertaining to compliance issues.

Recommendations:

As noted above, Judge Mosman ordered the neutral expert to make recommendations to: 1) address capacity issues at the Oregon State Hospital; and 2) include a suggested admissions protocol that addresses the admission of patients found unable to aid and assist in their own defense under ORS 161.370 (.370 patients). The following represent my recommendations, which have been agreed to by the parties:

Regarding addressing capacity issues at OSH, I recommend that OHA take the following actions:

1. Pursue avenues to expedite and improve discharge processes, including but not limited to:
   a. Advocacy for legislation that would require county fiscal responsibility for individuals in OSH who do not require that level of care
   b. Development of methods to enhance SB 295 processes
   c. Refinement of discharge policies/protocols utilizing discharge practices that have been shown to be effective

2. Continue to examine community barriers to preventing unnecessary admissions and diverting individuals from admission and from HLOC when those levels of care or placements are not clinically appropriate, maximizing the utilization of hospital beds for those in need of a hospital to support their recovery

3. Consider evaluation order trends and determine if there are areas that can be addressed to gain efficiencies and reduce wait times that may impact compliance
4. Advocate for the adoption of the OSH staffing request
5. Regularly continue to meet with Plaintiffs and Neutral Expert
6. Regularly meet, along with plaintiffs, with leadership from OJD including at least State Court Administrator Nancy Cozine and one judge to inform discussion that can lead to progress vis a vis compliance (State Court Administrator Cozine and Judge Nan Waller have agreed to this recommendation).

Regarding an admissions protocol, I recommend the following:

1. Coordinate admissions lists between GEI patients and A&A patients to reduce overall jail times of both groups.
2. Utilize the opening of the additional Junction City unit to facilitate admission of patients into OSH, including GEI patients to equalize waitlist times to create the ability for a more uniform admissions protocol.
3. Develop data infrastructure improvements to help monitor compliance and tracking through a data dashboard to be shared across entities and to further develop admissions strategies and hospital capacity by tracking data in a consistent manner. Data elements should include but not be limited to:

    a. *Admissions Data*: Number of individuals currently awaiting admission from jail by legal status (GEI/A&A), average time individuals are waiting (including range), average times individuals who were admitted waited for admission by month, performance metric measuring trends in wait times. These elements should be able to be viewed at a state level, and broken down by county. Establishment of additional metrics for these same data elements sorted by severity of charges and whether individuals represent unique populations (persons with mental illness or intellectual/developmental disabilities, for example) may be added to the dashboard if feasible over time. Additional data elements should be further discussed by the parties with consultation from the neutral expert.

    b. *Discharge/Ready to Place Data*: Ready to Place data should include number of individuals ready to place, level of care needed, and days identified as no longer needing OSH services but still awaiting placement in an alternative setting. This data should be able to be tracked over time. This information should be available at a state level and by county. Establishment of additional metrics for these same data elements sorted by severity of charges and whether individuals represent unique populations (persons with mental illness or intellectual/developmental disabilities, for example) may be added to the dashboard if feasible over time. Additional data elements should be further discussed by the parties with consultation from the neutral expert.

I have discussed the principles embedded within each of the above recommendations with the parties, and they have indicated agreement with them. Also of note, coordinating and executing the admissions between GEI and A&A individuals into OSH with the goal of using the Junction City new unit already began prior to this report, and the total wait times of GEIs was significantly reduced. Due to COVID-19-related pauses in admissions, the waitlist for individuals on A&A increased, but this will continue to be tracked now that admissions are no longer on pause.

In order to develop action items related to these first short-term recommendations, I also suggested that the parties jointly develop steps that could be taken along similar domains, including data, policy/protocol, legislative and any other dimension to address capacity issues at OSH and move toward compliance. The parties worked diligently to accomplish that request. Their jointly constructed short-term action items are in line with my recommendations and I therefore recommend that they be pursued to help move toward compliance. I applaud the efforts of the parties in developing them.

Short-Term Action Items as Agreed Upon by the Parties (and Supported by the Neutral Expert)

A. Data Improvements

1. *Data dashboard.* By March 1, 2022, the parties, with input of the neutral expert, will develop a data-dashboard with agreed-upon elements to show progress in reaching compliance and a plan for implementation, including a reporting cadence and distribution list. Anticipated distribution of this data would be by April 1.

   OHA will review whether additional staff are required to support this effort in a sustained capacity and, if so, bring that request to the legislature. DRO/MPD will actively support that request if made.

B. Policy/Protocol Actions

1. *Use of the Junction City units.* In accordance with the Neutral Expert preliminary recommendations and with the agreement of the parties, OSH will prioritize admissions of GEI patients to its Salem campus for assessment and placement, so that the GEI and A&A populations to be admitted from jail are waiting about the same length of time. For COVID-19 safety and protocols as well as overall speed of admission, at the time of this report, people are only admitted to the Salem campus, where the admissions monitoring units and staff are centralized. After the admission process is complete to OSH, OSH will assess for appropriate movement to Junction City placements based on all appropriate clinical and patient safety considerations, thereby opening up subsequent additional beds for admission on the admissions unit.

2. *Discharge processes.* By March 1, 2022, OSH Social Work Department in coordination with OHA Office of Behavioral Health will review internal discharge processes for all commitment types with the intent to streamline multiple processes that have shown beneficial outcomes into one process with nuance between legal status clearly defined. The results of this review will be presented in MOOVRS on March 3, 2022, and will be shown to the neutral expert and the parties with the goal of implementation of new protocol by March 14. Progress on this will be summarized in the March 3, 2022, progress report to Dr. Pinals.

3. *Reduction in hospital admissions for individuals that can appropriately be served in other settings.* In its February 3, 2022, progress report to Dr. Pinals, OHA will describe what it

is currently doing to prevent or reduce the growth of hospital admissions of individuals who can be clinically served in a less medically intensive level of care (particularly aid and assist patients).

4. *Supports in the community.* In its February 3, 2022, progress report to Dr. Pinals, OHA will describe the ways in which it has identified and funded additional supports in the community for people who are restored to competency, which will generate ongoing discussion with the parties regarding impacts on compliance.

C. Legislative Actions

1. *County financial risk sharing.* OHA has proposed legislation that would allow charging counties for patients who no longer require hospital level of care on the OSH 9b list beyond a date threshold. DRO will support this legislative effort and/or engage with stakeholders in developing an alternative that promotes enhanced county engagement and accountability in supporting timely transitions to community.

2. *OSH staffing.* OSH has submitted a request to the legislature for increased position authority and funding. DRO will actively support this legislative request.

3. *Other legislative actions.* In its February 3, 2022 report to Dr. Pinals, OHA will further describe any additional relevant legislation it has proposed that may impact compliance. DRO/MPD will support OHA's legislative requests as appropriate.

D. Court Case Specific Actions

Focus on maximizing adherence to SB 295. Adherence to SB 295 (law providing for discharge of .370 patients who no longer require HLOC) is critical to make room for new admissions to OSH and to have individuals who no longer need hospital level institutional care placed in a less restrictive setting. According to tracking by the State, some state courts and CMHPs are not following this law as it is written, which results in .370 patients on the Ready to Place List staying at OSH for longer than necessary or allowed by law. To support adherence to SB 295, the parties will do the following:

1. *Education.* DOJ/OHA, DRO, and MPD will develop a one-hour CLE on SB 295 for defense lawyers. They will coordinate with the Oregon Criminal Defense Lawyers Association for a virtual presentation in the near future. The parties will continue to work together and consult with OJD to determine whether a similar presentation for OJD and prosecutors would also be beneficial.

2. *Informal support.* General counsel for OSH will continue already ongoing efforts to support compliance through targeted communications with individual defense lawyers and prosecutors. MPD will now also make themselves available to try and intervene with defense lawyers to ensure they follow SB 295.

3. *Advocacy.* DOJ will evaluate cases on a state-wide basis for direct legal intervention on behalf of OSH where they determine that SB 295 is not being followed by state courts or CMHPs. DRO will develop, and revise as needed, an amicus brief that it will file such cases where appropriate. DOJ will notify DRO about the OSH intervention and will provide information needed for DRO to evaluate whether to submit such an amicus brief.

4. *Tracking*: OSH will evaluate the impact on bed space of measures taken under this section to reduce discharge wait times, and report to Dr. Pinals and DRO in currently-scheduled regular meetings.

Concluding Comments

This matter has involved a good faith effort to develop recommendations that are aimed primarily to reduce wait times to access OSH services when appropriate for individuals within the Aid and Assist and GEI context. These recommendations are preliminary, and several additional items were considered and thought to be more appropriate for longer-term recommendations as they will require further deliberation and prioritization determinations.

That these initial recommendations were developed collaboratively with the potential to leverage the strengths and roles of each side of the litigation has been critical. I note that in my meetings with them, it has appeared that both parties are committed to and rooted in the values of ensuring that individuals in A&A and GEI processes receive timely and appropriate care and treatment, and eliminating barriers to achieving those goals.

I appreciate the help of the leadership and staff at OSH, OHA, DRO, CJC, and OJD in offering their thoughts to support the compilation of this first report. I also am grateful especially to Mr. Cody Gabel who assisted me in better understanding the Oregon behavioral health and justice system while coordinating meetings and tracking information I requested to inform these recommendations.

Respectfully Submitted by:

Debra A. Pinals, M.D.
Clinical Professor of Psychiatry
Director, Program in Law, Psychiatry, and Ethics
University of Michigan