COVID-19, *Mink-Bowman*, and Court-Ordered Psychiatric Services in Oregon

Thomas E. Hansen, MD, Amela Blekic, MD, and Joseph D. Bloom, MD

COVID-19 strongly affected referral of individuals from Oregon's courts and the ability of Oregon State Hospital (OSH) to accept patients. Despite acceleration in the decline in civil commitment, competency to stand trial (CST) admissions increased, causing a bed crisis at OSH, which in turn affected community hospitals and jails. In 1993, the Ninth Circuit Court of Appeals mandated admission of jail detainees to OSH within seven days after a judicial order for CST evaluation or restoration. During COVID, as the number of such patients increased to crisis proportions, average jail detention times exceeded seven days. An inevitable judicial process intensified in the U.S. District Court of Oregon after OSH requested a COVID-related modification of the seven-day limit. This commentary demonstrates more clearly than in the past that there is a negative correlation between civil commitment and competency restoration as components of an interrelated system. After updating the situation in Oregon, this article ends with suggested interventions to improve Oregon's civil and criminal commitment processes, hoping for better care of patients and improved administration of justice.

J Am Acad Psychiatry Law 51(3) online, 2023. DOI:10.29158/JAAPL.230056-23

Key words: civil commitment; competency to stand trial; insanity defense; psychiatric hospital beds; state psychiatric hospitals

Two recent articles in the *Journal of the American Academy of Psychiatry and the Law* address the increase in competency to stand trial (CST) admissions per year at Oregon State Hospital (OSH) and the decline in civil commitment rates in the state and at OSH.[1,2] A commentary to these two articles[3] noted that similar problems affect Los Angeles County in California, concluding that civil and criminal commitment should be viewed as parts of a single underfunded mental health system when it comes to the psychiatric treatment of these legally derived patient groups.

This article takes the situation described in these articles three years forward, with data on competency to stand trial and civil commitment services in Oregon, into the period of the COVID-19 pandemic's intensification. The pandemic resulted in significant problems at OSH, as increasing CST referrals further displaced admissions of civil commitment patients. With OSH beds pushed beyond the hospital's limits, a mirror image problem developed in Oregon's jails, as large numbers of jail detainees who had been found incompetent to stand trial (IST)[4] waited in jails for restoration services at OSH. Similar problems have been reported in many states.[5,6] Oregon is different, however, and these jail detainees did not go unnoticed because of the 2003 Ninth Circuit Court of Appeals decision in *Oregon Advocacy Center v. Mink*.[7] This decision enjoined Oregon from keeping detainees with mental illness in jail for longer than seven days once found by a court to require competency evaluation or restoration services. In the years before the onset of the COVID-19 pandemic, compliance with the *Mink* injunction had become increasingly difficult. Lower-level legal proceedings were begun in the U.S. District Court of Oregon by Disability Rights Oregon (formerly the Oregon Advocacy Center) and the Metropolitan Public Defender Services

Published online August 7, 2023.

Dr. Hansen is Adjunct Associate Professor, and Dr. Blekic is Associate Professor, Department of Psychiatry, School of Medicine, Oregon Health and Sciences University, Portland, OR. Dr. Bloom is Clinical Professor of Psychiatry, University of Arizona, College of Medicine-Phoenix, Phoenix, AZ, and Dean Emeritus, Oregon Health and Sciences University, Portland, OR. Address correspondence to: Thomas Hansen, MD. E-mail: hansenmanley@comcast.net.

Disclosures of financial or other potential conflicts of interest: None.

(DRO-MPD), the original plaintiffs in the *Mink* case, who noted that IST defendants were being detained in jail longer than the seven-day limit.[1] The Oregon legislature, the federal courts, and the plaintiffs reached agreement in 2019 on how to improve the situation.[1] As the COVID-19 pandemic intensified, however, the informal process failed, and formal judicial proceedings began in the U.S. district court.

Ninth Circuit Court Proceedings 2020–2023

In the early days of the COVID pandemic, with a rising CST census, OSH's parent entity, the Oregon Health Authority (OHA), filed a motion in the U.S. District Court of Oregon in April 2020, requesting a modification of the original *Mink* injunction to allow detainees to remain in jail beyond the seven-day limit, "until such time as it is medically safe for OSH to begin accepting patients in the normal course" (Ref. 8, p 2). Senior Judge Michael Mosman agreed and requested regular reports on progress to return to the seven-day limit.

In September 2020, DRO-MPD filed a memorandum in the Ninth Circuit Court of Appeals requesting restoration of the original seven-day injunction,[9] arguing that the district court erred in granting an open-ended modification which ignored the constitutional rights of IST jail detainees. The memorandum noted that the state "watched" for many years as the number of jail detainees needing competency services at OSH "rose by leaps and bounds," while the state did little to deal with this increasing IST population (Ref. 9, p 6), and raised the concern that the return to the seven-day limit would be based solely on medical advice.

In August 2021, the Ninth Circuit of Appeals replied to DRO-MPD's memorandum. The court noted that the pandemic did make it difficult for OHA to adhere to the injunction but found that the trial court abused its discretion in its open-ended modification. The Ninth Circuit remanded the case back to the district court, declaring that an open-ended modification was not suited to a case based on constitutional rights and that a future injunction modification should be based on further fact finding and consideration of alternatives.[10]

In November 2021, *Bowman v. Matteucci*[11] was filed initially in an Oregon court on behalf of two plaintiffs who had been found guilty except for insanity (GEI; Oregon's version of the insanity verdict) and who were being detained in jail waiting for transfer to OSH under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB).[12] The state court judge recognized that these insanity acquittees raised constitutional concerns like those in *Mink*, ordered hospital transfer "without reasonable delay" and transfer of the case to the federal court for consideration of consolidating the case with *Mink*. A federal court judge then strongly agreed and referred the case to Judge Mosman.

In December 2021, Judge Mosman issued a new order[13] consolidating *Bowman* with *Mink* and appointing a neutral expert, Dr. Debra Pinals, to work with OSH and OHA on capacity concerns at OSH with reports to suggest admission protocols for ".370" patients (.370 designates CST patients based on ORS 161.370),[4] with the goal of restoring the seven-day injunction as quickly as possible.

Between January and June 2022, Dr. Pinals issued two reports[14,15] which analyzed CST concerns at OSH. These reports closely followed recommendations outlined in a 2020 report from the Council of State Governments Justice Center,[16] including recommendations for building community-based outpatient CST services and the diversion of certain CST clients out of the criminal justice system. The second report proposed a timetable of actions necessary to achieve a step-wise reduction in jail-time for detainees to re-establish the seven-day injunction (Ref. 15, p 33).

In August 2022, DRO-MPD submitted a detailed motion to Judge Mosman, unopposed by OHA and OSH, and with approval from the neutral expert.[17] The motion noted that "the number of days it takes to admit someone from jail is bad and getting worse" (Ref. 17, p 5); the delay was 39.2 days on August 1, 2022, compared with the neutral expert's hoped for target of 22 days.[15,17] The motion included four recommendations:

> The court should implement the neutral expert's recommendations and allow the expert to grant extensions as necessary after conferring with both parties.
>
> The court should specify which patients could be admitted to OSH depending on bed situation, effectively prohibiting civil commitment admissions unless cases met new stringent requirements well beyond Oregon's statutory criteria for civil commitment.[18,19]

> The court should set maximum lengths of hospital stay for the restoration of IST patients depending on the seriousness of crimes charged based on the recommendations of the neutral expert in her second report. The neutral expert had noted that these limits might require legislative changes (Ref. 15, p 28).
>
> The court should order that these conditions would continue until the seven-day limit was met for three consecutive months.

In response, Judge Mosman initially accepted the first and fourth requests but not the second and third, stating that those sections would require OSH and OHA to disregard state legal requirements.[20] He prohibited court cases attempting to find OHA and OSH officials in contempt of court for not admitting patients to OSH. Then, on September 1, 2022, after receiving additional briefing, Judge Mosman reversed the order from early August,[21] effectively accepting all four points in the suggested motion.[17] Specifically, civilly committed patients would only be admitted based on special criteria regarding dangerous behavior,[19] and maximum times for restoration would be established for pending misdemeanor and felony charges, based on seriousness of the charge, apparently even if treatment staff felt the patients remained IST.

Community reaction began soon after Judge Mosman's rulings. First, district attorneys from three Oregon counties filed a Motion for Leave to Appear as *Amici Curiae*,[22] indicating concerns that the court's actions would have negative effects on Oregon counties. Then on September 28, 2022, several large general hospital systems filed a lawsuit against OHA, asserting that the state had failed to provide care for patients who should have been civilly committed and contending that the state's inaction forced community hospitals to house patients needing mental health treatment for many months.[23]

Judge Mosman held a hearing on November 21, 2022, to give the expanded group of interested parties an opportunity to present their views in court. On January 9, 2023, he issued an opinion and order[24] in which he denied the motion to dissolve or modify his September 1 order. He extensively reviewed the history of the legal actions, including suggested approaches to this humanitarian crisis, and concluded that "all less-intrusive means have failed to rectify the constitutional violations" (Ref. 24, p 13). He noted that remedial measures can override conflicting state law if necessary to correct constitutional violations (Ref. 24, p 5). He ended his Order with the hope that following the plan will allow "compliance with the Constitution next year, for the first time in nearly half a decade" (Ref. 24, p 15).

A 21-Year Description of OSH's Patients

OSH, now the only state psychiatric hospital in Oregon, has about 558 hospital beds and 145 secure residential beds shared between two campuses (Salem and Junction City). OSH has served the people of Oregon since 1884 and for years cared mainly for voluntary and civilly committed patients, later developing a forensic program initially serving a small number of CST patients and insanity acquittees. The population of insanity acquittees increased dramatically after the establishment of the PSRB in 1977.[12] For the last two decades, OSH has only admitted involuntary patients committed from Oregon's civil or criminal courts.

The number and proportion of patients in these involuntary groups have changed over the past 21 years. Table 1 shows that the average daily population for civil commitment patients dropped from 410 in 2000 to 17 in 2021, whereas the CST average daily population increased dramatically from 74 in 2000 to 358 in 2021. Meanwhile, GEI average daily population increased yearly from 298 in 2000 to 369 in 2008, then decreased over time, and now has been relatively constant since 2015. Figure 1 illustrates the dramatic shifts for these three groups of patients at 10-year intervals over the last 20 years.

Civil Commitment and 14-Day Diversions

Oregon's first civil commitment statute was passed in 1862,[25] with a major revision in 1973. The statewide rate of civil commitment per 100,000 has decreased over time, from 53.2 in 1972 to 28.5 in 2000, and then to 9.2 in 2020.[2] When an Oregon county's Involuntary Commitment Program is notified that a patient is being held on a Notice of Mental Illness (usually in an emergency room or hospital), a precommitment investigator determines whether the person meets criteria for civil commitment and, if so, arranges a commitment hearing within five judicial days. The option for a 14-day diversion (14DD)[26] was added to the statute in 1993. The 14DD option allows the precommitment

Table 1. Oregon State Hospital Average Daily Population by Legal Category

Year	Civil Commitment	Competence to Stand Trial (.370)	Guilty Except for Insanity	Other	Total Beds
2000	410	74	298	6	788
2001	400	78	319	6	803
2002	375	85	320	4	784
2003	360	85	337	5	787
2004	352	90	383	6	830
2005	326	90	386	4	807
2006	328	90	355	5	779
2007	320	101	358	7	785
2008	296	99	369	6	769
2009	229	99	363	4	695
2010	200	98	357	3	658
2011	201	105	317	3	626
2012	208	109	299	4	621
2013	206	130	286	4	626
2014	200	150	252	4	605
2015	193	170	227	5	595
2016	174	219	215	5	612
2017	173	194	209	2	578
2018	147	228	217	2	595
2019	126	263	228	4	621
2020	68	285	246	3	602
2021	17	358	228	6	609

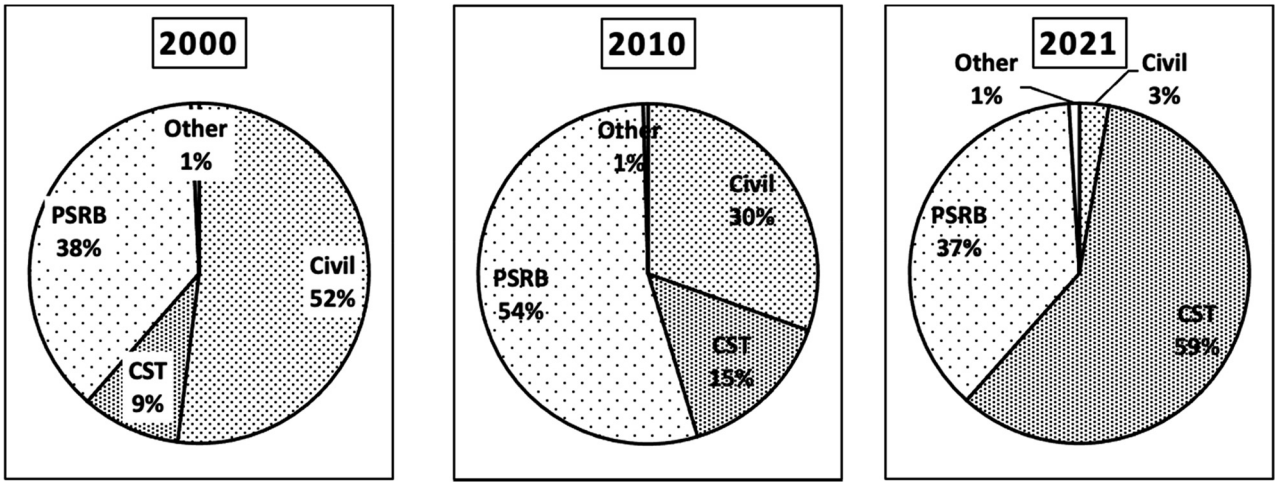

Figure 1. Oregon State Hospital census by legal category, years 2000, 2010, 2021. Each legal group's percentage of average daily census for specified years. Civil means civilly committed patients. CST means patients in hospital for competency evaluation/restoration (also referred to as .370 in Oregon). PSRB means patients found guilty except for insanity and placed under the Psychiatric Security Review Board.

investigator to recommend holding the commitment hearing in abeyance if the person agrees to intensive treatment for up to 14 days. Oregon Administrative Rules for 14DDs provide specific criteria for this diversion, including approval by the treating psychiatrist, preparation of a general treatment plan including medications, patient consent to medication, and informing the person that there may be a requirement to appear at a commitment hearing if the person refuses further participation.[27]

The lack of beds for civilly committed patients at OSH, exacerbated by COVID-19, brought increasing pressure on community hospitals, and the use of 14DDs has flourished. Data on 14DDs for the three Portland metropolitan-area counties demonstrate increasing use. In 2020, Multnomah County, including the city of Portland, had 19 percent of the state's population and accounted for the bulk of Oregon's civil commitments, 225 or 57 percent. Statewide data on use of 14DDs (not available before 2020) show 1,226

diversions in 2020, far more than the 390 civil commitments (28.8 and 9.2 per 100,000, respectively). Civil commitment data are not available for 2021, when there were 1,057 14DDs.

For at least the past 25 years, civilly committed patients usually were returned from commitment court to the prior community hospital for brief periods of additional treatment while being placed on an OSH waiting list. With the COVID-19 pandemic and the crush of CST admissions, the OSH waiting list for civil commitment patients became nearly meaningless, with only rare civil admissions to OSH. This number of admissions, and the pandemic itself, affected the capacity of community hospital acute care units and created another bed crisis. With beds tied up by committed patients who have not been able to move to OSH, general hospitals struggled as illustrated by a recent case[28] in which a patient with multiple past arrests and unsuccessful past competency restorations was civilly committed at a community hospital but not accepted to OSH or placed by OHA after 100 days. The hospital petitioned the county's circuit court to order OHA to take responsibility for the patient. The judge found for the community hospital, noting that warehousing the patient was not medically appropriate and that the general hospital was not designed for long-term committed patients. On appeal, the Oregon court of appeals vacated a temporary stay ordered by the trial court, and OHA then placed the patient in a secure residential facility.[28]

Competency to Stand Trial

Examinations to determine competency to stand trial in Oregon take place in jail, at OSH by judicial order, or in the community, with restoration in the community or at OSH[4,29] both possible. A 2011 law, based in part on the legislature's awareness of an increasing need for community CST services, included a section stating that CST defendants could only be admitted to OSH if they were considered to be dangerous to self or others, or if community agencies could not provide needed services.[30] The statute also stated that CST patients found not restorable "in the foreseeable future" were to be released or entered into the civil commitment process.[31] By statute, commitment for restoration services could not exceed three years, depending on the length of the maximum possible sentence.[32] Senate Bill 24, passed by the 2019 legislature, established that misdemeanor defendants could only be admitted for restoration if the certified evaluator or the community mental health program director found hospital level of care was needed because of dangerousness or acuity.[33]

Table 2 Statewide Civil Commitments and Oregon State Hospital Admissions for Competency to Stand Trial

Year	Oregon State Hospital Competency to Stand Trial Admissions	Statewide Civil Commitments
1996	159	866
1997	168	882
1998	145	903
1999	141	970
2000	156	979
2001	159	1024
2002	192	896
2003	246	827
2004	292	783
2005	289	802
2006	311	828
2007	312	686
2008	301	602
2009	288	571
2010	283	593
2011	363	565
2012	365	665
2013	428	581
2014	461	489
2015	543	617
2016	623	575
2017	610	530
2018	720	514
2019	700	551
2020	627	390

Along with the increase in daily population, the number of CST admissions to OSH increased steadily from 159 in 1996 to 627 in 2020 (Table 2), and the percentage of hospital beds used by CST patients rose from nine percent in 2000 to 59 percent in 2021 (Fig. 1).

Civil Commitment and CST Admissions

Table 2 contrasts statewide civil commitment data with the annual number of CST admissions to OSH from 1996 through 2020. The civil commitment data are the actual number of commitments per year in the state, whereas the CST data are OSH admissions which include the bulk of evaluations and restorations and accordingly serve as a proxy for statewide CST activity (few CST services were community-based during the time covered). Figure 2 demonstrates a strong negative correlation between CST activity and civil commitment ($r = -.83$, $r^2 = .686$, $F = 50.3$, $df = 1,24$, $P < .001$). Although correlation is not the same as causation, this significant

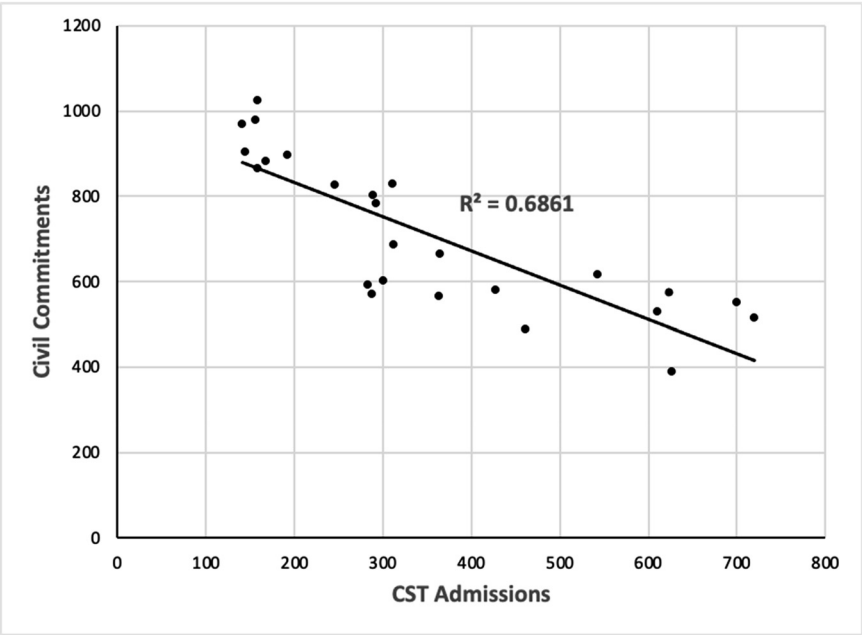

Figure 2. Correlation between competency to stand trial admissions at Oregon State Hospital and statewide number of civil commitments.

negative correlation suggests that neglecting civil commitment may well have contributed to the CST crisis in Oregon.

The Psychiatric Security Review Board

As mentioned earlier, PSRB clients (insanity acquittees in Oregon) waiting in jails for an OSH bed were recognized in the *Bowman* case as having the same constitutional rights as pretrial CST patients in the same situation, although they were not originally linked to the seven-day hospital transfer of the original *Mink* requirements.[11] The PSRB was created by the Oregon Legislature in 1977 to provide management and treatment of Oregon's insanity acquittees either at OSH or on conditional release (CR) in the community.[12,30] As discussed earlier and demonstrated in Table 1, PSRB clients have represented an important component of OSH's population for the last 20 years. In 2011, with increasing numbers of PSRB clients at OSH, the legislature eliminated misdemeanor insanity acquittees from PSRB jurisdiction and added a civil commitment-like hospitalization for misdemeanor insanity acquittees.[30,34] This statute eliminated approximately 15 to 20 percent of PSRB hospital admissions. The number of PSRB patients from 2012 to 2021 was lower than in the previous decade, and the number of clients on conditional release remained higher than those at OSH, 385 in 2012 and 382 in 2021 (Bort A, PSRB Executive Director, personal communication, 2021).

Discussion

This article follows recent articles addressing CST services and the decline in civil commitment in Oregon,[1,2] adding new data and subsequent legal developments, and addressing the apparent empirical relationship between longstanding decreases in statewide civil commitment rates and the alarming increase in the need for competency to stand trial services.

OSH's changing patient population over the past two decades, complicated by the COVID-19 pandemic period (2020–2022) presents a central theme in this article. The proportions of the three involuntary populations served by OSH have been very different over this 21-year time span (Fig. 1). Civilly committed patients occupied 52 percent of the hospital's average daily population in 2000, whereas PSRB clients occupied 54 percent of the beds in 2010, and CST patients occupied 59 percent of the beds in 2021. These long-term empirical trends are important to note. Civil commitments statewide and at OSH have been steadily decreasing for many decades, whereas the CST population only increased rapidly in the past 10 years. PSRB's average daily bed usage was highest of the three groups in 2008, whereas

its conditional release program reached consistently higher levels after legislative action in 2011 encouraged increased use of monitored conditional release.[30]

In 2019, the federal courts, OSH, and the legislature all became involved in the problems of a shortage of OSH beds focused specifically on violations of the seven-day *Mink* injunction and the subsequent increase in jail detainees found IST and waiting for an OSH bed.[1] The trends were visible in the 10 years before 2020 through 2022, when the COVID-19 pandemic intensified an already severe crisis. What followed in the federal courts was a nearly complete focus on the CST problem at OSH and in Oregon's jails, enlarged by the *Bowman* decision to include a small number of GEI-PSRB patients. This singular focus on *Mink-Bowman* occurred with neglect of statewide problems in civil commitment rates and an alarming drop in availability of civil commitment beds at OSH as the civil commitment average daily population fell from 410 in 2000 to only 17 in 2021. Civil commitment patients were pushed back to the communities without adequate planning or financing, while CST, with virtually no community component, overwhelmed the state hospital.

The Ninth Circuit Court decisions in *Mink* and the associated *Bowman* case occupy a significant role in this commentary by defining and emphasizing the important constitutional rights of CST and GEI-PSRB jail detainees even at the height of a global pandemic. The determination that admissions for CST restoration should happen within seven days in *Mink* was to achieve reasonably timely transport and used a previous Oregon statutory limit.[7] Despite plaintiffs' and defendants' conferring with the neutral expert for months, progress on achieving compliance was not made, leading to an unopposed motion to require, among other requests, the implementation of the neutral expert's report. Judge Mosman hesitated on several points as he felt that federal courts should only override state law when less intrusive measures fail (Ref. 20, pp 3–4). He subsequently reversed this decision,[21] greatly limiting the use of OSH beds for civil commitment and overriding the time allowed in statutes for restoration. After hearings, which included county district attorneys and general hospitals, he declined a request to change the order, explaining that all less-intrusive efforts had failed to rectify the constitutional violations (Ref. 24, p 13).

The legal events described here apply specifically to Oregon, but other states have similar matters involving the precipitous increase in jail detainees waiting for hospital beds to receive CST services.[5,35,36] The *Mink* decision, with its strong declaration of constitutional rights, has made jail detainees visible to important federal appeals courts around the nation. Other states are now reported to have *Mink*-like decisions. In 2017, The Treatment Advocacy Center noted that since 2014, more than a dozen states have been sued or threatened with legal action (Ref. 37, p 2, Appendix A) related to delays in hospitalization for CST services. In 2019, Tullis[38] reported that there were 11 states with lawsuits in this area. A complete review of all case law in this area is beyond the scope of the present article, but at least 12 states, including Oregon, have been ordered to admit detainees, or to follow settlement agreements, for IST concerns.[7,39–48] Other states may find Oregon's limitations and responses, including the longitudinal data on the empirical operation of important mental health statutes to be informative. Neglecting civil commitment while trying to control a significant rise in criminal confinement was problematic. CST and civil commitment statutes operate in concert with each other but in an inverse manner (when one goes down, the other goes up).[1,2] CST, with its place in the criminal justice system, is a very attractive alternative to a civil commitment system which had been failing over many years. Lower use of civil commitment, driven by many factors over the years, leaves undertreated patients in the community where many will be arrested for various crimes, thereby contributing to criminalization of mental illness.[6] Leong[3] notes similar problems in Los Angeles and advocates for considering civil and criminal commitment to be parts of a single mental health system when it comes to the provision of services for these two court-related populations of persons experiencing mental illness.

The increased use of 14DDs in Oregon[2] is noteworthy. The original intent for 14DDs was to offer a less restrictive path to treatment for seriously ill patients. In the COVID era and given the low rate of commitment for patients who have hearings, 14DDs provide a treatment option for seriously ill patients which also decreases the length of stay and burdens on community hospital inpatient units. Patients may also prefer 14DDs to avoid the risk of up to 180 days of civil commitment. With less treatment, however, vulnerability to homelessness, drug use, and crime could increase.[49,50] Based on the authors' anecdotal experiences, the rules required for the use of 14DDs

can be difficult to follow consistently. Attention to this aspect of the statute and its administrative rules may be needed to ensure patient rights are upheld while providing effective treatment.

Availability of psychiatric beds underlies much of this commentary. Beds are necessary whether they are at OSH, in Oregon's community hospitals, or in step-down care facilities. Beds provide safe settings for stabilization of people with acute mental conditions as well as longer-term care for people with complicated and refractory conditions who need specialized treatment. Beds are important components of a mental health system of care.[51,52] Many reports address the need for state hospital and general psychiatric beds, often also noting the importance of other community resources.[53–59]

Oregon falls short in psychiatric beds. An estimate for beds proposed by the Treatment Advocacy Center (TAC) in 2008 ranged from 40 to 60 per 100,000.[55] The American Psychiatric Association (APA) recently developed a model to predict the bed needs of a given community.[59] Although focused on nonforensic bed use, forensic service parameters were included in the model because changing capacities in one part of the system would affect other types of services. The starting point of the model would suggest 90 beds per 250,000 people in Oregon, or 1500 beds. The annual National Mental Health Survey (N-MHSS) included bed capacity for each state in 2010 and 2020 and found that Oregon had 1,049 in 2010 and 871 total beds in 2020, including a decrease of 122 acute care beds. The total capacity in 2010 was 27.3 per 100,000, 10.2 of which were acute care beds, whereas in 2020, the total was 20.5 per 100,000, 6.3 of which were acute care.[60,61] To directly examine similar data, the authors surveyed community hospitals with psychiatric beds in February 2022 and compared the numbers with a state database from 2005. In 2005 there were 32.2 total beds per 100,000 (9.8 acute beds per 100,000), whereas the authors' 2022 survey found 8.9 per 100,000 acute beds (382 total) which, combined with the OSH census, totaled 991 (23.1 beds per 100,000), well short of recommendations.

Increasing the availability of beds can, however, be daunting. In a study modeling patient flow at a state hospital providing backup to community hospitals, the state hospital would need to increase beds by 165 percent to reduce waiting times.[62] Leong[3] noted that a proposal to add 500 beds in Los Angeles County may be unrealistic as the county appears to plan a reduction of beds.

In conclusion, the state of Oregon, with two statutory processes in near complete disrepair, has systematic problems that go far beyond the violation of the *Mink-Bowman* seven-day injunction. CST and civil commitment services need to be addressed simultaneously, and solutions will no longer reside only at OSH. OSH alone will never have the requisite number of beds to meaningfully serve the needs of the civil and criminal courts. OSH, as it has done for the past two decades, will need to continue to provide services to the courts, hopefully with a slightly increased number of beds, but the real long-term answer is now to be found in the community.

The neutral expert has proposed a roadmap for the development of both institutional and community services for CST patients, but with an approach to initial solutions directed almost entirely at the OSH census and the *Mink* injunction. Other national groups have presented broader proposals to reduce the CST crisis.[16,63,64] At this point, the focus needs to be expanded to the Oregon jails, which have the potential to provide acceptable restoration services for certain CST jail detainees, as has been described in the current psychiatric literature.[65] It is very important to approach the jails with the same rigor as was done in the expert's reports on OSH and community planning. Options might include consolidation of some detainees in a single or several jails or the development of a mental health team sponsored by OHA or OSH to provide consultation to jails and treatment for some jail detainees. It is important to note that the original *Mink* decision itself allowed OSH to seek a modification of the original seven-day injunction if evidence shows that Oregon county jails "can and will provide timely and adequate restorative treatment" (Ref. 7, Footnote 13).

In civil commitment, there needs to be a parallel critical review of the status of the current program and what is needed to restore a serviceable statute. To some extent this is happening with a current task force on civil commitment sponsored by the Chief Justice of the Oregon Supreme Court. This group, however, seems to be focused on statutory review and not on the restoration of civil commitment services at OSH and in the community. OHA should be heavily involved in the leadership of this review, with a focus on redefining and financing of civil commitment services in community hospitals and step-down

units, along with residential and community treatment programs. In addition, support for services related to the use of 14DD and for assisted community outpatient programs can enhance community treatment for involuntary patients.

Finally, should the state of Oregon complete a comprehensive review of both areas and provide plans for improvements in each area, the Ninth Circuit might be willing to approve a new approach if it is presented with details, financial commitments, and timelines. Such a plan is in the best interest of all involved.

Acknowledgments

Data were provided by the Oregon Health Authority Office of Health Analytics, Behavioral Health Departments for counties in the Portland metropolitan area (Multnomah, Washington, and Clackamas), the Oregon Judicial Division, and Multnomah County Circuit Court. In addition, data used in this commentary were provided to the authors directly from the Oregon Psychiatric Security Review Board or from its web site, https://www.oregon.gov/prb/pages/index.aspx.

This project was reviewed by the Oregon Health & Science University IRB (Office of Research Integrity) and waived from monitoring because it was determined to not be Human Research.

References

1. Bloom JD, Hansen T, Blekic A. Competency to stand trial, civil commitment, and Oregon State Hospital. J Am Acad Psychiatry Law. 2022 Jan; 50(1):67–73
2. Hansen TE, Bloom JD, Blekic A. The dramatic decline of civil commitment in Oregon, 1972 to 2020. J Am Acad Psychiatry Law. 2022 Dec; 50(4):533–40
3. Leong GB. Underfunding of psychiatric services for the civilly and criminally committed. J Am Acad Psychiatry Law. 2022 Dec; 50 (4):541–4
4. Or. Rev. Stat. § 161.370 (2021)
5. Warburton KM, McDermott BE, Gale A, Stahl SM. A survey of national trends in psychiatric patients found incompetent to stand trial: Reason for the reinstitutionalization of people with serious mental illness in the United States. CNS Spectr. 2020; 25 (2):245–51
6. Dvoskin JA, Knoll JL, Silva M. A brief history of the criminalization of mental illness. CNS Spectr. 2020; 25(5):638–50
7. Or. Advocacy Ctr. v. Mink, 322 F.3d 1101 (9th Cir. 2003)
8. Motion for Modification to Injunction, Disablilty Rights Oregon v. Allen, No. 3:02-cv-00339-MO (D. Or. June 16, 2020)
9. Opening Brief of Appellants, Disability Rights Oregon v. Allen, No. 3:02-CV-00339-MO(D. Or. June 16, 2020)
10. Memorandum, Metropolitan Public Defender Services, Inc. v. Allen, No. 3:02-CV-00339-MO (9th Cir. June 16, 2020)
11. Bowman v. Matteucci, No. 3:21-cv-01637-HZ (D. Or. Nov. 15, 2021)
12. Bloom JD, Buckley MC. The Oregon Psychiatric Security Review Board: 1978-2012. J Am Acad Psychiatry Law. 2013 Dec; 41 (4):560–7
13. Disability Rights Oregon v. Allen, No. 3:02-cv00339-MO (D. Or. December 17, 2021)
14. Pinals DA. Neutral expert first report regarding the consolidated Mink and Bowman cases [Internet]; 2022 January 30. Available from: https://www.oregon.gov/oha/OSH/Documents/Oregon-Mink-Bowman-Neutral-Expert-Pinals-Report.pdf?utm_medium=email&utm_source=govdelivery. Accessed September 30, 2022
15. Pinals DA. Neutral expert second report regarding the consolidated Mink and Bowman cases [Internet]; 2022 June 5. Available from: https://digital.osl.state.or.us/islandora/object/osl:985898. Accessed September 30, 2022
16. Fader-Towe H, Kelly E. Just and well: Rethinking how states approach competency to stand trial. The Council of State Governments Justice Center [Internet]; 2020. Available from: https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf. Accessed September 30, 2022
17. Disability Rights Or. v. Allen, No. 3:02-cv-00339-MO (D. Or. Sept. 2, 2022)
18. Or. Rev. Stat. § 426.005(f) (2021)
19. Expedited Admission for Patients under Civil Commitment. Oregon Health Authority/Oregon State Hospital [Internet]; 2022 Available from: https://www.oregon.gov/oha/OSH/LEGAL/Documents/Expedited_Admission_for_Patients_Under_CIVIL_Commitments.pdf. Accessed September 30, 2022
20. Opinion and Order, Disability Rights Or. v. Allen, No. 3:02-cv-00339-MO (D. Or. Sept. 2, 2022), Document 256
21. Order to Implement Neutral Expert's Recommendations, Disability Rights Or. v. Allen, No. 3:02-cv-00339-MO (D. Or. Sept. 2, 2022), Document 271
22. Motion for Leave to Appear as Amici Curiae by the District Attorneys for Washington, Clackamas, and Marion Counties, Disability Rights Or. v. Allen, No. 3:02-cv-00339-MO (D. Or. Sept. 2, 2022)., Document 252-1
23. Ramakrishnan J. Hospitals sue Oregon Health Authority over failure to provide mental health facilities for patients. The Oregonian [Internet]; 2022 Sept 28. Available from: https://www.oregonlive.com/health/2022/09/hospitals-sue-oregon-health-authority-over-failure-to-provide-mental-health-facilities-for-patients.html. Accessed March 17, 2023
24. Opinion and Order, Disability Rights Or. v. Allen, No. 3:02-cv-00339-MO, 3:21-cv-01637-MO, 6:22-cv-01460-MO (D. Or. January 9, 2023)
25. Bloom JD, Williams MH. Oregon's civil commitment law: 140 years of change. Hosp Community Psychiatry. 1994; 45:466–70
26. Or. Rev. Stat. § 426.237 (1993)
27. Or. Admin. R. 309-033-0260 (2021)
28. Jaquiss N. A novel court case reveals yet another crisis in Oregon's mental health system. Willamette Week [Internet]; 2022 June 1. Available from: https://www.wweek.com/news/2022/06/01/a-novel-court-case-reveals-yet-another-crisis-in-oregons-mental-health-system/. Accessed September 30, 2022
29. Or. Rev. Stat. § 161.365 (2021)
30. Bloom JD. CRIPA, Olmstead, and the transformation of the Oregon Psychiatric Security Review Board. J Am Acad Psychiatry Law. 2012 Sep; 40(3):383–9
31. Or. Rev. Stat. § 161.367 (2021)
32. Or. Rev. Stat. § 161.371 (2021)
33. Or. Senate Bill 24 (2019)
34. Or. Rev. Stat. § 161.328 (2021)
35. Callahan LP, Pinals DA. Challenges to reforming the competence to stand trial and competence restoration system. Psychiatr Serv. 2020; 71(7):691–7
36. McDermott BE, Warburton K, Auletta-Young C. A longitudinal description of incompetent to stand trial admissions to a state hospital. CNS Spectr. 2020; 25(2):223–36
37. Fuller DA, Sinclair E, Lamb HR, *et al*. Emptying the 'New Asylums.' Arlington, VA: Treatment Advocacy Center; 2017.

Available from: https://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf. Accessed March 17, 2023
38. Tullis P. When mental illness becomes a jail sentence. The Atlantic [Internet]; 2019 December 19. Available from: https://www.theatlantic.com/politics/archive/2019/12/when-mental-illness-becomes-jail-sentence/603154/. Accessed March 17, 2023
39. Hunter v. Beshear, No. 2:16cv798-MHT (WO) (M.D. Ala. Jan. 25, 2018)
40. Stiavetti v. Ahlin, No. RG15779731 (Cal. Sup. Ct. 2015)
41. Center for Legal Advocacy v. Marshall, No. 1:11-cv-02285 (D. Colo. Aug. 31, 2011)
42. Advocacy Center for the Elderly and Disabled v. Louisiana Department of Health and Hospitals, No. 2:10-cv-01088 (E.D. La. Dec. 8, 2014)
43. Powell v. Maryland Department of Health, No. 24-C-16-003484 (Md. June 8, 2016)
44. Burnside v. Whitley, No. 2:13-cv-01102-MMD-GWF (D. Nev. Dec. 22, 2015)
45. Settlement Agreement, J.H. v. Dallas, No. 1:15-cv-02057-SHR (M.D. Pa. Oct. 22, 2015)
46. Ward v. Hellerstedt, No. 1:16-cv-00917 (W.D. Tex. July 29, 2016)
47. Disability Law Center v. Utah, No. 2:15-cv-00645-RJS (D. Utah Sept. 27, 2016)
48. Trueblood v. Washington State Department of Social and Health Services, 822 F.3d 1037 (9th Cir. 2016)
49. Markowitz FE. Psychiatric hospital capacity, homelessness, and crime and arrest rates. Criminology. 2006; 44(1):45–72
50. Lamb HR, Weinberger LE. Deinstitutionalization and other factors in the criminalization of persons with serious mental illness and how it is being addressed. CNS Spectr. 2020; 25(2):173–80
51. Pinals DA, Fuller DA. Beyond beds: The vital role of a full continuum of psychiatric care [Internet]. National Association of State Mental Health Program Directors and Treatment Advocacy Center; 2017. Available from: https://www.treatmentadvocacycenter.org/beyond-beds. Accessed September 30, 2022
52. Parks J, Radke AQ. The vital role of state psychiatric hospitals [Internet]. Alexandria, VA: National Association of State Mental Health Program Directors; 2014. Available from: https://www.nasmhpd.org/content/vital-role-state-psychiatric-hospitals-0. Accessed September 30, 2022
53. Fuller DA, Sinclair E, Geller J, *et al*. Going, going, gone: Trends and consequences of eliminating state psychiatric beds [Internet]. Arlington, VA: Treatment Advocacy Center; 2016. Available from: TACReports.org/going-going-gone. Accessed September 30, 2022
54. Fisher W, Geller J, Pandiani J. The changing role of the state psychiatric hospital. Health Aff (Millwood). 2009; 28(3):676–84
55. Torrey EF, Entsminger K, Geller J, *et al*. The shortage of public hospital beds for mentally ill persons [Internet]. Arlington, VA: Treatment Advocacy Center; 2008 Available from: https://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf. Accessed September 30, 2022
56. National Association of State Mental Health Program Directors. Tracking the history of state psychiatric hospital closures from 1997 to 2015. National Association of State Mental Health Program Directors National Research Institute [Internet]; 2015. Available from: https://www.nri-inc.org/media/1111/2015-tracking-the-history-of-state-psychiatric-hospital-closures-lutterman.pdf. Accessed September 30, 2022
57. Mundt AP, Rozas Serri E, Irarrázaval M, *et al*. Minimum and optimal numbers of psychiatric beds: Expert consensus using a Delphi process. Mol Psychiatry. 2022; 27(4):1873–9
58. McBain RK, Cantor JH, Eberhart NK, *et al*. Adult psychiatric bed capacity, need, and shortage estimates in California—2021 [Internet]; 2022. Available from: https://www.rand.org/pubs/periodicals/health-quarterly/issues/v9/n4/16.html. Accessed September 30, 2022
59. Everett A. The psychiatric bed crisis in the U.S.: Understanding the problem and moving toward solutions. Washington, DC: American Psychiatric Association; 2022. Available from: https://www.psychiatry.org/getmedia/81f685f1-036e-4311-8dfc-e13ac425380f/APA-Psychiatric-Bed-Crisis-Report-Full.pdf. Accessed July 5, 2022
60. Substance Abuse Mental Health Services Administration. National Mental Health Services Survey. (N-MHSS): 2010. Data on Mental Health Treatment Facilities [Internet]; 2014. Available from: https://www.samhsa.gov/data/sites/default/files/NMHSS2010_Web/NMHSS2010_Web/NMHSS2010_Web.pdf. Accessed September 30, 2022
61. Substance Abuse Mental Health Services Administration. National Mental Health Services Survey (N-MHSS). 2020 Data on Mental Health Treatment Facilities [Internet]; 2021. Available from: https://www.samhsa.gov/data/sites/default/files/reports/rpt35336/2020_NMHSS_final.pdf. Accessed September 30, 2022
62. La EM, Lich KH, Wells R, *et al*. Increasing access to state psychiatric hospital beds: Exploring supply-side solutions. Psychiatr Serv. 2016; 67(5):523–8
63. Reiber PL, Marks LK. National judicial task force to examine state courts' response to mental illness [Internet]; 2023. Available from: https://www.ncsc.org/__data/assets/pdf_file/0031/84469/MHTF_State_Courts_Leading_Change.pdf. Accessed March 17, 2023
64. Atchity V. Model legal processes to support clinical intervention for persons with serious mental illnesses: The Equitas Project (Mental Health Colorado) [Internet]; 2022 August. Available from: https://www.mentalhealthcolorado.org/wp-content/uploads/2022/09/Model-Legal-Processes-to-Support-Clinical-Intervention-for-Persons-with-Serious-Mental-Illnesses-Final-9.2.2022.pdf. Accessed March 17, 2023
65. Felthous AR, Bloom JD. Jail-based competency restoration. J Am Acad Psychiatry Law. 2018 Sep; 46(3):364–72