MEMORANDUM DECISION

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IN THE COURT OF APPEALS OF INDIANA

In the Matter of the Commitment of:

J.P.,

Appellant-Respondent,

v.

State of Indiana,

Appellee-Petitioner.

April 25, 2022

Court of Appeals Case No. 21A-MH-1493

Appeal from the Parke Circuit Court

The Honorable Samuel A. Swaim, Judge

Trial Court Cause Nos. 61C01-0505-FB-79 61C01-2101-MH-11

Tavitas, Judge.

Case Summary

[1] In this consolidated appeal, J.P. contests adverse results in both an involuntary civil commitment and a hearing on the State's proposed treatment plan. J.P. was determined by our Supreme Court to be not guilty by reason of insanity on several arson charges. Following the Supreme Court's ruling, the State sought to have J.P. involuntarily committed. The trial court ruled that J.P. was mentally ill, gravely disabled, and a danger to either himself or others. J.P. appealed. While that appeal was pending, the facility to which J.P. was committed filed a notice with the trial court that J.P. would be discharged, though the plan indicated that J.P. would merely be transferred to a different facility. The State, via the local prosecutor, contested the treatment plan, and the trial court rejected the plan. J.P. also appealed that finding, and we ordered the two appeals to be consolidated. We cannot say that the trial court erred in ordering that J.P. be committed. We do conclude, however, that the trial court erred by holding a hearing on the State's treatment plan and by issuing an order denying the plan without the requisite statutory authority. Accordingly, we affirm in part and vacate in part.

Issues

[2] In his consolidated brief, J.P. raises the following issues:

I. Whether the involuntary commitment was proper because clear and convincing evidence was presented to establish that J.P. is gravely disabled and dangerous.

II. Whether the trial court exceeded its statutory authority by deciding that J.P. could not be transferred to an outpatient facility.

Facts

[3] In 2005, the State accused J.P. of burning down two covered bridges in Parke County. J.P. confessed to burning down the bridges, but the State was aware that, at the time, J.P. had long suffered from paranoid schizophrenia and delusional disorder. Eleven years of competency proceedings ensued. Eventually, in April of 2018, J.P. was tried, and a jury found him guilty but mentally ill. This Court affirmed the verdict,[1] but our decision was vacated by our Supreme Court,[2] which ruled in a split decision that J.P. was not guilty by reason of insanity.[3]

[4] At the outset, we note that this is a consolidated appeal. In appeal #1, the trial court granted the State's petition to involuntarily commit J.P. to a state-run mental health facility, and J.P. contests that result.[4] In appeal #2, the superintendent of the facility wherein J.P. was committed filed a "Notice of Discharge," mistakenly signaling to the trial court that the State was seeking to have J.P. released from his commitment. As we will explain, however, the

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[1] *Payne v. State*, 124 N.E.3d 96 (Ind. Ct. App. 2019).

[2] *Payne v. State*, 146 N.E.3d 334 (Ind. 2020).

[3] *Payne v. State*, 144 N.E.3d 706 (Ind. 2020).

[4] Our hearing of appeal #1 was delayed by a series of filings regarding the correct categorization of the case as well as a request to incorporate the record of the prior criminal proceedings.

State sought no such thing and rather, merely planned to transfer J.P. to an out-patient facility. Such transfers do not involve trial courts as a matter of statute, but because of a series of procedural errors, the trial court held a hearing and issued a ruling. Accordingly, we must address those proceedings.

A. The Commitment Proceedings—Appeal #1

[5] On May 19, 2020, the State filed a petition to involuntarily commit J.P. to a state-run mental health facility pursuant to Indiana Code Section 35-36-2-4(a).[5] Under court order, Dr. Rebecca Mueller (named Moredock-Thomas at the time of her report) provided a report of a psychiatric evaluation for J.P. The report recorded no recent delusions or auditory hallucinations, though J.P. was apparently experiencing "noise" and visual hallucinations. Appellant's App. Vol. II p. 72. Dr. Mueller also noted that: "[b]y history, [J.P.] was non-compliant with taking medications." *Id*. The report indicated that J.P. denied recent suicidal or homicidal ideations and visual hallucinations; he reported being able to ignore voices heard "softly" in his head. *Id*. at 75. J.P. attributed this to the anti-psychotic medication Zyprexa, which had been prescribed to him, apparently for the first time, while he was at his most recent facility. This report is consistent with letters J.P. sent to the trial court while awaiting his release. *See id.* at 62-67. Dr. Mueller concluded that J.P. had benefitted greatly

[5] The statute provides that a prosecuting attorney may file this petition under two different statutes. Here, the State opted to file its petition pursuant to Indiana Code Section 12-26-7-3(a)(2)(A), which requires a finding that a person is either "dangerous" or "gravely disabled" prior to the involuntary commitment of said person.

from his new medication and counselling administered at Pendleton Correctional Facility and that, though J.P. did suffer from mental illness, he was not gravely disabled or a danger to himself or others.

[6] The trial court also received a brief letter from a clinical social worker who stated—apparently on the basis of a single conversation with J.P.—that "if [J.P.] were to stop his meds, we would be back to square one with him." *Id*. at 84. The social worker, representing the Hamilton Center, recommended that J.P. be committed either to a state psychiatric hospital or to a supervised group home.

[7] The trial court held a commitment hearing on June 18, 2020.[6] Under questioning from the trial court, Dr. Mueller testified as follows:

> Q. All right [sic]. We're gonna [sic] talk about the term gravely disabled as is defined under Indiana law. In your opinion, can the Respondent, [J.P.], feed and clothe himself?
>
> A. Yes, Your Honor, I believe he can.
>
> Q. And provide shelter for himself?
>
> A. Yes, Your Honor, provided he - he has an income or such as the disability income he had prior to incarceration but, yes, sir.

[6] The record suggests that, at the time, J.P. was an inmate at the Parke County Jail.

> Q. All right [sic]. And other essential human needs?
>
> A. Yes, Your Honor, I believe he can.
>
> Q. Is there any substantial impairment or obvious deterioration in his judgment, reasoning or behavior that would result in his ability - or excuse me - inability to function independently?
>
> A. No, Your Honor, I don't believe there's an impairment there.
>
> Q. As a result of [J.P.'s] medical condition is he a danger to himself or others?
>
> A. I believe he no longer presents a danger to himself or others, sir.

Tr.-C p. 27.[7] Dr. Mueller further testified that her opinion was based on her evaluation of J.P. over the course of his long incarceration and her observation of his progress and lessening of his symptoms. Dr. Mueller believed that J.P. could function in the community if he received ongoing treatment and was assigned a case manager.

[8] On cross-examination, Dr. Mueller testified that, while she had not reviewed the recent Pendleton Correctional Facility records, she had performed an in-person evaluation of J.P. at that facility. She further testified that

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[7] Given the consolidated nature of this appeal, we denote references to the commitment hearing via Tr.-C and references to the discharge hearing via Tr.-D.

schizophrenics in general commonly cease taking medications once released from secure facilities. Dr. Mueller also explained that, "in this instance [J.P.] might not be arrested and placed in the Parke County Jail[,] but he could be sent to a state hospital until that team decided that he was able to live independently." *Id.* at 40. Finally, Dr. Mueller opined that she was concerned that J.P. would have trouble living independently in the absence of supervision and medications.

[9] Next, Dr. Jeffrey Huttinger—a clinical psychologist—testified. Dr. Huttinger testified at J.P.'s original criminal jury trial in order to evaluate whether J.P. met the definition for legal insanity. Dr. Huttinger also met with J.P. shortly before the commitment hearing. Dr. Huttinger testified that he noticed a marked improvement in J.P.'s functioning given J.P.'s then-current medication. He further testified that he could not predict whether J.P. would be able to function independently in an unsupervised living situation, but that J.P. would surely face great difficulties in such a scenario. Much of Dr. Huttinger's testimony pertained to J.P.'s lengthy medical history but not to his most recent medical history. Similar to Dr. Mueller, Dr. Huttinger had not examined any of J.P.'s medical records for the previous two-and-a-half years. Nevertheless, Dr. Huttinger testified that "[u]p until now, it's been kind of off and on where he does well and then he doesn't do well[,] and I think history just kind of speaks for itself. At least that's what I'm basing my judgment on with that." *Id.* at 52. Dr. Huttinger testified that his conclusions were based on his

knowledge from the arson trial and a meeting with J.P. from three days prior to the commitment hearing.

[10] Finally, the trial court heard testimony from Virgil Macke, a social worker with the Hamilton Center. Macke's role is to process those individuals either entering or exiting state-run mental health hospitals. Macke met with J.P. at the Parke County Jail approximately one month before the commitment hearing. Macke testified to using a self-developed system to evaluate J.P. over the course of an hour. J.P. reported to Macke that he was experiencing some delusions, hallucinations, feelings of hopelessness, and other symptoms generally associated with his diagnosed mental illness. J.P. indicated to Macke that he did not believe he would be able to function independently in the community. Macke testified that the stress associated with such a scenario could trigger a worsening of J.P.'s symptoms.

[11] On November 2, 2020, the trial court entered its findings of fact and conclusions thereon in an Order of Commitment. Appellant's App. Vol. II pp. 90-98. After recounting in detail J.P.'s history of mental illness and its implications, the trial court found as follows:

> 21. It is common for people with schizophrenia to stop taking their medications, and in fact, [J.P.] has a history of not taking his medications as prescribed. The record from the trial is replete with examples of this fact, particularly the Defendant's own testimony at trial, the Defendant's DOC records, and the records from the Parke County Jail. [J.P.] testified at trial that he had quit following his treatment with Hamilton Center prior to burning the bridges.

22. Dr. Mueller issued a report dated September 13, 2020. This report summarily concludes, without explanation, that although [J.P.] is clearly mental [sic] ill, he is "not gravely disabled or a danger to himself or others." At first blush, this conclusion seems to fly in the face of everything that is known of [J.P.] (other than his own testimony, this report is the only evidence suggesting that [J.P.] is not either dangerous or gravely disabled). However, at the commitment hearing, during Dr. Mueller's examination, she clarified that her conclusion assumes that the Defendant takes all treatment as prescribed and will be closely supervised. When asked what her [sic] treatment plan for [J.P.] would be, Dr. Mueller testified:

> I would strongly request that the Court order [J.P.] for ongoing treatment indefinitely. . . . Treatment such as with the Hamilton Center or other community mental health center would - it would consist of medication, ongoing therapy and case management. Case managers are very important to the mental health system. Unfortunately probably least recognized but most important to the mental health system. Case managers come into the home to make sure that you are clothed and eating and taking care of your hygiene. They make sure you get to your doctor's appointments, get to the grocery, basic necessities and activities of daily life. So[,] what the case managers do they make sure that all the components that you went over, Your Honor, are actually being provided by the defendant. So[,] at this point, although he's significantly improved, we have to take into account that he's been in a structured environment with technically care providers, being the corrections officers as well as the - the mental health staff, so going forward he would require psychiatric visits for medication. I do request that those be court[-]ordered visits as well as least a supportive group therapy environment as well as the case management which would, again, make sure he takes his

> medications, that his daily needs are met, such as food, shelter, things like that, and if those things are court[-]ordered then I do believe that [J.P.] would continue to remain stable psychiatrically.

23. When asked about any alternative medications [J.P.] should receive, Dr. Mueller testified:

> [T]ypically when we've had someone who has had significant threatening behaviors, such as arson, and that was a danger to the community we request that the defendant be on commitment for injectable medications. I know that's a complicated discussion but the - the issue that you have in the community is day to day functioning when it gets much better, such as what's happened with [J.P.], it's a natural course of the disorder that you begin to think that perhaps your schizophrenia has gone into full remission where you no longer need the same level of treatment. Your Honor, we find that quite frequently and then the defendant ends up in the judicial system again. So[,] one of the things that I would strongly request is that he be transitioned to an injectable anti-psychotic where it requires he has to see the psychiatrist. He really doesn't have a choice in whether he takes his medication and it improves compliance. I apologize. I would like to state for the Court it actually mandates compliance.

24. Therefore, despite her September l3, 2020 report, it is clear Dr. Mueller believes [J.P.] is dangerous and disabled. Although Dr. Mueller apparently believes, as [sic] result of [J.P.'s] current mental status (which has been achieved by highly supervised medication compliance) that [J.P.] could benefit from an outpatient treatment regime, the Court finds that all other evidence ever presented under this cause number indicates that neither [J.P.] or [sic] the public in general would be safe via an "outpatient" treatment program.

Id. at 92-93. The trial court concluded that the State had demonstrated by clear and convincing evidence that J.P. was mentally ill, gravely disabled, and dangerous. The trial court then ordered J.P. committed to the Indiana State Division of Mental health and placed in a secure facility to receive inpatient treatment until further orders may be issued. J.P. timely appealed.[8]

B. The Transfer Proceedings—Appeal #2

[12] Approximately ten months later, on August 4, 2021, while J.P.'s appeal of the trial court's commitment order remained pending, Richmond State Hospital filed a "Notification of Intent to Discharge" J.P. from the hospital with the trial court. Appellant's App. Vol. II pp. 135-38. The accompanying Plan of Action ("treatment plan") describes a plan to "transition [J.P.] to a less restrictive environment that would allow him to reintegrate into the community and allow him to be closer to his family." *Id*. at 137. The proposed community group home would be a less restrictive commitment than hospitalization and would provide twenty-four-hour supervision along with regular programming and services. *Id*. On August 6, 2021, the Parke County prosecutor filed a motion for a hearing with respect to the "Notification of Intent to Discharge," which the trial court granted four days later. *Id.* at 123. On August 13, 2021, the Division of Mental Health & Addiction ("DMHA") filed a "Tender of

[8] Initially, the appeal was filed under Cause number 20A-CR-2248. After it became apparent to us, however, that the substance of the case concerned matters of mental health, we assigned the present cause number, in accordance with Indiana Administrative Rule 8.1(B)(2)(ii), on July 15, 2021.

Discharge Plan" via the Attorney General's office, which recommended transfer to an outpatient facility.

[13] The trial court held an evidentiary hearing, without statutory authority, on August 26, 2021. J.P.'s treating psychiatrist testified that: (1) J.P. had not experienced hallucinations, delusions, or psychosis in the preceding six months; (2) J.P. was taking an antipsychotic named Olanzapine and a mood stabilizer named Depakote; (3) the medications directly contributed to J.P.'s stability; (4) the proposed outpatient facility would allow for J.P. to continue taking his medications; (5) J.P. had been compliant with his medical treatment plan, including medications; and (6) the treatment plan "adequately meets [J.P.'s] needs while also preserving the public safety." Tr.-D p. 22. The treatment plan further establishes a curfew and calls for J.P.'s return to the hospital in the event that he stops taking his medications or starts using drugs or alcohol.

[14] The trial court asked the treating psychiatrist a series of questions about: (1) J.P.'s past, including statements J.P. made prior to his hospitalization at Richmond; (2) the Supreme Court decision that overturned his guilty verdict; and (3) whether the psychiatrist was aware of the testimony from the commitment hearing. The trial court took judicial notice of the testimony from the commitment hearing and the Supreme Court decision. J.P.'s social worker also testified that the discharge plan was in J.P.'s best interest and would preserve the public's safety.

[15] On August 21, 2021, the trial court issued an order as follows:

> The Court finds that I.C. 12-26-12-7 gives this Court the authority to deny the discharge of [J.P]. The evidence shows that [J.P.] continues to suffer from mental illness and continues to be dangerous and gravely disabled. The "discharge plan" submitted (a half-page letter from Hamilton Center which references a hand-written letter from the Respondent) contains information that is patently inaccurate and fails to establish a safe and detailed plan. The Court attached [J.P.'s] Indiana Supreme Court case to this Court's Findings issued last November. The Court strongly recommends that all of [J.P.'s] treatment providers read those documents prior to make [sic] further discharge plans for [J.P]. The Indiana Supreme Court has found [J.P.'s] history of mental illness is so profound that no "demeanor evidence" (evidence tending to show he understands right from wrong) is of "any" probative value.[9] The discharge suggested here fully underappreciates the level of danger posed by [J.P.] IT IS THERFORE ORDERED, ADJUDGED AND DECREED that the Notice of Intent to Discharge filed by the Richmond State Hospital is Denied. This Court's Order of Commitment from November 6, 2020 shall remain in full force and effect.

Appellant's App. Vol. II p. 146.

[16] J.P. appealed. We consolidated the appeal of the commitment determination and the appeal of the trial court's rejection of the treatment plan on October 18, 2021.

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[9] Of course, the Supreme Court was considering an entirely different legal question than the trial court in the instant matter, namely, whether J.P.'s mental illness prevented him from knowing the difference between right and wrong at the time of the actions resulting in the arson charges.

Analysis[10]

I. Commitment Proceedings

[17] J.P. argues that "[t]he trial court improperly relied upon [J.P.]'s history of pre-treatment criminal conduct, symptomatic behavior and hospitalizations, rather than his present condition as determined by experts." Appellant's Br. p. 11. "'[T]he purpose of civil commitment proceedings is dual: to protect the public and to ensure the rights of the person whose liberty is at stake.'" *Commitment of B.J. v. Eskenazi Hosp./Midtown CMHC*, 67 N.E.3d 1034, 1038 (Ind. Ct. App. 2016) (quoting *Civil Commitment of T.K. v. Dep't of Veterans Affairs*, 27 N.E.3d 271, 273 (Ind. 2015)). A deprivation of one's liberty is, of course, a deprivation of a constitutional dimension. *See Addington v. Texas,* 441 U.S. 418, 425-26, 99 S. Ct. 1804 (1979). "The liberty interest at stake in a civil commitment proceeding goes beyond a loss of one's physical freedom, and given the serious stigma and adverse social consequences that accompany such physical confinement, a proceeding for an involuntary civil commitment is subject to due process requirements." *Id*. *See also* U.S. Const. amend. XIV.

> To satisfy the requirements of due process, the facts justifying an involuntary commitment must be shown by evidence which not only communicates the relative importance our legal system

[10] J.P. contends that the Attorney General's office has taken inconsistent positions for different State parties and, therefore, suffers from a conflict of interest. This is because the Attorney General's office appeared on behalf of the DMHA below, arguing that commitment was too restrictive and now argues on behalf of the State itself (in the form of the Parke County Prosecutor's Office), which argues in favor of commitment. J.P. has not, however, filed a motion to disqualify the Attorney General's office from representation, nor does J.P. explain why the putative conflict of interest is problematic or prejudicial. Moreover, J.P. does not identify the remedy that he seeks. Consequently, we deem this issue waived.

> attaches to a decision ordering an involuntary commitment, but also has the function of reducing the chance of inappropriate involuntary commitments.

B.J., 67 N.E.3d at 1038. (internal quotations omitted).

[18] In order to secure an involuntary commitment, "[t]he petitioner is required to prove by clear and convincing evidence that: (1) the individual is mentally ill and either dangerous or gravely disabled; and (2) detention or commitment of that individual is appropriate." Ind. Code § 12-26-2-5. "The clear and convincing evidence standard 'is defined as an intermediate standard of proof greater than a preponderance of the evidence and less than proof beyond a reasonable doubt.'" *Civ. Commitment of J.B. v. Cmty. Hosp. N.*, 88 N.E.3d 792, 795 (Ind. Ct. App. 2017) (quoting *B.J.*, 67 N.E.3d at 1038). "Clear and convincing evidence requires the existence of a fact to be highly probable." *Id.* "In reviewing the sufficiency of the evidence supporting a civil commitment, we will not reweigh the evidence or assess witness credibility. Moreover, we will consider only the probative evidence and the reasonable inferences supporting the judgment." *B.J.*, 67 N.E.3d at 1038 (citing *T.D. v. Eskenazi Midtown Cmty. Mental Health Ctr.*, 40 N.E.3d 507, 510 (Ind. Ct. App. 2015)).

[19] Understandably, J.P. does not contest the trial court's findings that he is mentally ill.[11] J.P. suffers from schizophrenia and delusional disorder and has a long and documented history of mental illness. Rather, he contends that the trial court erred in concluding that there was clear and convincing evidence that J.P. was gravely disabled and dangerous.

A. Gravely Disabled

[20] J.P. first challenges the trial court's determination that J.P. is gravely disabled. "Gravely disabled" is defined as:

> a condition in which an individual, as a result of mental illness, is in danger of coming to harm because the individual:
>
> > (1) is unable to provide for that individual's food, clothing, shelter, or other essential human needs; or
> >
> > (2) has a substantial impairment or an obvious deterioration of that individual's judgment, reasoning, or behavior that results in the individual's inability to function independently.

Ind. Code § 12-7-2-96. This definition is written in the disjunctive; thus, a trial court's finding of grave disability can be sustained if there is clear and

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[11] "'Mental illness' means the following:(1) For purposes of IC 12-23-5, IC 12-24, and IC 12-26, a psychiatric disorder that: (A) substantially disturbs an individual's thinking, feeling, or behavior; and (B) impairs the individual's ability to function." Ind. Code § 12-7-2-130.

convincing evidence that either enumerated prong has been satisfied. *See, e.g., B.J.*, 67 N.E.3d at 1034.

[21] In *B.J.*,[12] a physician filed a report indicating that B.J. suffered from a psychiatric disorder and noted that B.J. had been:

> making death threats, rape threats, [and] lawsuit threats to multiple people. Multiple people [were] in fear for safety because of this patient [.] [He] prev[iously] attempted to choke [his] ex-wife due to delusions/impairing judgment[.] [He]'s a danger to others.

B.J., 67 N.E.3d at 1036. The physician also indicated that B.J. appeared to have no insight into his illness. At a commitment hearing, a different physician testified that B.J.: (1) had missed several appointments; (2) continued to make threats via body language; (3) and could be a threat to others if he chose to stop taking his medications. B.J. had continued to take his medications during a temporary commitment. The trial court extended the temporary commitment.

[22] At B.J.'s permanent commitment hearing, a physician testified that she had:

> prescribed [B.J.] a monthly injection, haliperidone, and she acknowledged that B.J. had complied with receiving those injections. However, she also testified that she believed B.J. was "gravely disabled" because of his mental illness and that his delusional disorder affected his ability to function independently because "the constant sense of paranoia, sense that he is being

[12] *B.J.* was originally a memorandum decision. However, upon motion from B.J. we published the opinion on November 15, 2016.

> tracked and watched makes him get very angry easily." When asked whether she believed there was a risk that B.J. would harm himself or others, Dr. Salama responded, "If he does not—if he does not stick with the treatment and treatment plan, he will eventually deteriorate to—to where (indiscernible)." When asked whether B.J. could provide himself with food, clothing, shelter or other essential human needs, Dr. Salama replied, "Well, there is going to be a[n] escalation in the symptoms which at the one point he's not going to be able to reach that. He's always supported now by his parents. He lives with them and they—they help him out."

Id. at 1036-37 (internal citation omitted). The trial court granted the petition to convert B.J.'s temporary commitment into a permanent commitment.

[23] We reversed. With respect to both the question of whether B.J. was gravely disabled and the question of whether B.J. was dangerous, we held:

> Dr. Salama evaluated B.J.'s **hypothetical state based on future contingencies.** We do not find this testimony persuasive as the statute clearly requires the trier of fact to assess the individual's state at the time of the hearing prior to ordering a commitment. *See* I.C. § 12-7-2-96 (stating—in present tense—that a person is gravely disabled if that person "(1) *is* unable to provide for . . . food, clothing, shelter, or other essential human needs; or (2) *has* a substantial impairment or an obvious deterioration of . . . judgment, reasoning, or behavior that *results* in the individual's inability to function independently") (emphasis added).

Id. at 1040 (emphasis added). In other words, the fact that a patient might become gravely disabled in the future if he stops taking his medication is of no moment.

[24] Here, the evidence most favorable to the trial court's decision is: (1) J.P.'s mental illness impairs his judgment, reasoning, and behavior; (2) there is a risk that J.P. may stop taking his necessary medications in the future;[13] (3) nothing in the record suggests that J.P. has ever lived alone and supported himself; (4) Dr. Mueller does not believe that J.P. can provide for his essential needs on his own; (5) J.P. was considered in 2018 to be at a high risk to reoffend; and (6) Macke approved of and recommended commitment. Given our standard of review, we cannot say that the trial court erred in concluding that J.P. was gravely disabled.

B. Dangerous

[25] J.P. next challenges the trial court's conclusion that he presents a risk of danger, either to himself or to others. "'Dangerous', for purposes of IC 12-26, means a condition in which an individual as a result of mental illness, presents a substantial risk that the individual will harm the individual or others." I.C. § 12-7-2-53.

[26] In *T.K.*, our Supreme Court considered a commitment in which the petitioner presented only the testimony of Dr. Joseph Bishara who treated T.K. during T.K's emergency detention." *T.K.*, 27 N.E.3d at 274. Like J.P., T.K. had schizophrenia. The Supreme Court noted:

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[13] *B.J.*, thus, is distinguishable, as this is not the only piece of evidence favorable to the judgment.

> Regarding whether T.K. is dangerous, the Department's expert witness, Dr. Bishara, acknowledged, "I personally did not believe that he would be a danger to self or others . . . ." The doctor's personal uncertainty was further displayed when he responded to the trial court's direct question to him: "Doctor, I'm sorry I'm not really clear. Do you consider [T.K. a] danger to himself, and others, or just others?" Dr. Bishara answered by saying that he would not have found dangerousness, but that T.K.'s estranged son, who did not testify at trial, "forced [his] hand that way."

Id. at 276 (internal citations omitted). In the absence of any additional evidence, the Court concluded that the State had not carried its burden to establish that T.K. was dangerous.

[27] We are constrained by our standard of review to consider only that evidence that is favorable to the judgment. Here the evidence most favorable to the judgment is: (1) J.P.'s history of dangerous acts; (2) the fact that J.P.'s mental illness inherently increases his chances of committing dangerous acts; (3) the fact that he might at some point cease taking his medications and has a history of doing so; (4) J.P.'s substantial impairment of judgment makes him more likely to harm himself; (5) schizophrenic medication may lose effectiveness over time; (6) J.P. had made statements in the past indicating his intent to commit future violence; (7) J.P. is a substantial risk to reoffend; and (8) J.P.'s prior criminal acts were relatively sophisticated. Under these circumstances, we cannot conclude that the trial court erred in finding that J.P. presents a risk of danger to himself or others. Accordingly, we cannot say the trial court erred by granting the petition for involuntary commitment.

II. Transfer to Outpatient Facility

[28] We first note the confusion in the record between a discharge from commitment and a transfer to a different facility. Indiana Code Chapter 12-26-12 governs the discharge of a committed individual; Indiana Code Chapter 12-26-11 governs the transfer of a committed individual to a different facility. Once it became apparent that the State was not seeking discharge from commitment, the trial court had no authority to deny a transfer to another State facility.

[29] The record clearly demonstrates that the DMHA was not seeking to have J.P. *discharged* from commitment, nor does J.P. wish to be discharged from commitment. Rather, both J.P. and the DMHA are seeking *transfer* from an inpatient facility to an outpatient facility, without terminating the commitment. Even at the commitment hearing, J.P. was seeking outpatient services, including supervision of medication. *See, e.g.*, Tr.-C p. 46.

[30] The Attorney General, representing the DMHA, opened the evidentiary hearing with the following remarks:

> Commitments are reviewed annually, under 12-26, and additionally, Judge, *we are not seeking to terminate the commitment today*. A very important piece of this is that [J.P.] will remain committed, and that when the bed becomes available, per the discharge plan, the commitment will be transferred to outpatient status, and in that event, there's another statute that comes into play that might assist the Court, 12-26-14-8 allows an individual who has been transferred to an outpatient status to be apprehended and returned if not in compliance with the

> commitment order. So, [ ] he will continue to be under Court supervision and subject to that Court order. And, finally, Judge, I'm getting a little bit away from the judicial notice question, but the case law is clear that once a commitment is entered, the discretion of where to provide services to that individual lies with DMHA. Thank you.

Tr.-D pp. 10-11 (emphasis added).

[31] Though the treatment plan uses the term "discharge" in what appears to be the colloquial manner common to hospitals and other inpatient medical facilities,[14] the treatment plan clearly contemplates "transition into a less restrictive environment," on-site supervision for forty hours a week, and on-call supervision twenty-four hours a day. Appellant's App. Vol. II p. 137. This is clearly a transfer plan, not a discharge plan. Transfers are governed by Indiana Code Section 12-26-11.

[32] Under Indiana Code Section 12-26-11-1, the superintendent of the facility can transfer the commitment of the individual to:

> (1) a state institution;
>
> (2) a community mental health center;

[14] A discharge from a commitment under Indiana Code Section 12-26-12 is not the same thing as a "discharge" from a medical facility.

> (3) a community intellectual disability and other developmental disabilities center;
>
> (4) a federal facility;
>
> (5) a psychiatric unit of a hospital licensed under IC 16-21;
>
> (6) a private psychiatric facility licensed under IC 12-25;
>
> (7) a community residential program for the developmentally disabled described in IC 12-11-1.1-1(e)(1) or IC 12-11-1.1-1(e)(2); or
>
> (8) an intermediate care facility for individuals with intellectual disabilities (ICF/IID) that is licensed under IC 16-28 and is not owned by the state;
>
> if the transfer is likely to be in the best interest of the individual or other patients.

[33] Furthermore, pursuant to Indiana Code 12-16-11-4, the transferring facility is required to give "written notice" to: "(1) The individual's legal guardian. (2) The individual's parents. (3) The individual's spouse. (4) The individual's attorney, if any." Notice is not required to be given to the trial court or the local prosecutor because, once a patient is committed to the State for mental health purposes, our statutes do not contemplate further involvement of the courts. The transfer statutes, however, do contemplate a mechanism for the *patient* to challenge a transfer, but only if the transfer is to a *more restrictive* facility, and only in the form of an administrative hearing at the transferring

facility. I.C. § 12-26-11-5. The transfer statutes contemplate only a single, narrow circumstance meriting trial court involvement.

> An individual whose commitment is transferred under section 1 of this chapter may, within thirty (30) days after the transfer, petition the committing court for an order setting aside the transfer and ordering the individual and the individual's medical and treatment records returned to the facility to which the court originally committed the individual.

I.C. § 12-26-11-6. This statute, however, is not applicable here. Because both the trial court below and the parties on appeal have applied the incorrect statutes and the incorrect standard, we must vacate the trial court's order denying the requested transfer of J.P. to a less-restrictive facility. These transfers are unilateral actions of agents of the State. While we recognize the confusion of both the trial court and the prosecutor upon receipt of the "notice of discharge," such confusion should have been cleared up upon hearing the explanation of the Attorney General representing DMHA at the start of the evidentiary hearing.

[34] By the plain letter of the law, all that is required for purposes of transfer is that the superintendent of the facility wherein the patient is committed believes that

the transfer is likely to be in the best interest of the patient.[15] Accordingly, the trial court was without the statutory authority to deny the transfer.

Conclusion

[35] Sufficient evidence was presented to support the involuntary commitment of J.P. Because the trial court incorrectly considered the State's request to be one of discharge rather than transfer, however, we reverse its decision and vacate its order with respect to the treatment plan. Accordingly, we affirm in part and vacate in part.

[36] Affirmed in part and vacated in part.

Bradford, C.J., and Crone, J., concur.

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[15] Only the *individual being transferred* may contest his transfer if a more restrictive placement is sought. *See, e.g.*, *In re Commitment of J.W.B.*, 921 N.E.2d 513, 515 (Ind. Ct. App. 2010) ("However, Chapter 12-26-11 provides no mechanism for the trial court or the county to contest the State's transfer. Rather, the trial court is the forum in which the individual may challenge his transfer. Ind.Code § 12–26–11–6.").