Pursuant to Indiana Appellate Rule 65(E), the trial court and parties shall not take any action in reliance upon this memorandum decision until it is certified.

MEMORANDUM DECISION

Pursuant to Ind. Appellate Rule 65(D), this Memorandum Decision is not binding precedent for any court and may be cited only for persuasive value or to establish res judicata, collateral estoppel, or law of the case.

IN THE

Court of Appeals of Indiana

FILED
Oct 26 2026, 9:59 am
CLERK
Indiana Supreme Court
Court of Appeals
and Tax Court

In the Matter of the Civil Commitment of W.S.,

Appellant-Respondent

v.

Sandra Eskenazi Mental Health Center,

Appellee-Petitioner

October 26, 2026

Court of Appeals Case No.
26A-MH-883

Appeal from the Marion Superior Court

The Honorable David Certo, Judge
The Honorable Sarah Glasser, Magistrate

Trial Court Cause No.
49D08-2603-MH-11102

Memorandum Decision by Judge Kenworthy

Judges Brown and Scheele concur.

Kenworthy, Judge.

Case Summary

[1] W.S. appeals his involuntary temporary commitment to Sandra Eskenazi Mental Health Center ("Eskenazi"), presenting one issue for our review: Was there sufficient evidence to support his commitment?[1] We affirm.

Facts and Procedural History

[2] Twenty-three-year-old W.S. lived with his grandmother. In late February 2026, she took W.S. to the hospital because he "wasn't feeling really well." *Tr. Vol. 2* at 29. He had no history of cognitive impairment, but within forty-eight hours of his arrival, Eskenazi filed an application for emergency detention alleging W.S. was mentally ill due to a psychiatric disorder and was gravely disabled. The attesting doctor stated W.S. has "extreme thought blocking and cognitive issues[,] [m]ost likely as a result of first episode psychosis. [W.S.] has high

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[1] W.S. filed his Notice of Appeal on April 2, 2026. On April 29, Eskenazi moved for W.S.'s commitment to be terminated because he had elected to enter voluntary treatment, receiving individual therapy and psychiatry services. The trial court terminated his commitment the same day.

W.S. preemptively argues his appeal is not moot just because his temporary commitment has ended. *See Appellant's Br.* at 11–12. Pursuant to our Supreme Court's decision in *J.F. v. St. Vincent Hospital & Health Center, Inc.*, "timely appeals of temporary commitment orders generally do not become moot when the orders expire." 256 N.E.3d 1260, 1269 (Ind. 2025). Eskenazi does not argue the appeal is moot. Accordingly, we address the merits of W.S.'s appeal.

paranoia and is refusing to eat. Has lost [more than] 40 pounds and is malnourished now. Very concerned he will come to greater harm if not hospitalized." *Appellant's App. Vol. 2* at 9. The trial court found probable cause to grant the application and ordered Eskenazi to request a hearing within seven days if it believed a temporary or regular commitment was necessary.

[3] Eskenazi timely filed a petition for final hearing. Dr. Sarah Laudon, a psychiatry physician resident, completed the physician's statement attached to the petition. In her professional opinion, W.S. was suffering from an unspecified psychosis that "substantially disturbs [his] thinking, feelings, or behavior, and impairs [his] ability to function." *Id.* at 14. She believed W.S. was gravely disabled because "[h]is thought process is so impaired he cannot communicate his needs at all. His lack of attention, ability to comprehend, reason, and memory are all affected in that it is impossible to engage in meaningful conversation." *Id.* at 15.

[4] Dr. Laudon testified at the commitment hearing on March 18.[2] She had seen W.S. every weekday since his admission. At her first meeting with him, he was very slow to respond to questions, struggled to understand what was being asked, asked her to repeat almost every question, and was ultimately unable to communicate information or complete a thought. She called this "thought blocking." *Tr. Vol. 2* at 9. W.S. took a cognitive assessment that tests

[2] W.S. stipulated to Dr. Laudon's expertise in psychiatry. *See Tr. Vol. 2* at 8.

"memory, attention and concentration and language, . . . executive functioning skills and orientation." *Id.* at 13. An adult of W.S.'s age would be expected to score twenty-four or more out of thirty; W.S. scored seven.

[5] W.S.'s memory was impaired; for instance, he was unable to remember what he had for breakfast in the morning later in the day or even if he had eaten at all. Doctors were worried enough about his memory to consult neurology, but any neurological causes—like stroke or epilepsy—were ruled out. W.S. also exhibited paranoia, especially around food, saying Eskenazi did not have "the right food for him[,]" eating very small portions if at all, and scrutinizing food labels. *Id.* at 16. He was also paranoid about signing paperwork, believing the standard acknowledgement of the unit's rules and regulations that he signed when admitted led to his confinement. He was willing for doctors to speak with his family but refused to sign the form that would allow them to do so even though doctors and his family repeatedly explained to him verbal consent was not enough.

[6] Dr. Laudon said W.S. struggled with reasoning and understanding the implications of medical decisions. For instance, W.S. reported physical symptoms such as constipation but refused half the doses of the laxative prescribed to help. Doctors discussed with W.S. nearly every day the importance of taking his prescribed anti-psychotic medication, but he had only taken three or four doses, claiming "he does not need this medication[,] . . . he does not want to be on medication for the rest of his life[,] and . . . he does not have a mental health condition." *Id.* at 12. When doctors talked to him about

treatment, "[h]e can't seem to comprehend risk, benefits or consequences" and is not capable of "making safe, clear decisions for himself[.]" *Id.* at 14. In short, "[h]e's not been able to participate in any sort of meaningful treatment conversation" or discharge planning. *Id.* at 17.

[7] After having been at Eskenazi for nearly three weeks at the time of the hearing, W.S.'s thought blocking and communication with doctors and staff had improved slightly in that he was "able to speak in clear sentences that are at least five to six words long . . . and he's able to answer questions . . . on a surface level." *Id.* at 25. But his memory impairment, reasoning, and paranoia had not improved. Dr. Laudon said W.S. was not experiencing delusions but "that comes with time with psychosis especially when it's not treated" so she worried "by not treating now he will develop those and that will significantly impair his prognosis[.]" *Id.* at 17. She believed W.S. could not function independently in his current state because he lacked insight into his illness and would not even acknowledge it. She also believed his medication and treatment compliance would be "[n]early zero" without a commitment. *Id.* at 18. If Dr. Laudon were able to talk to W.S.'s mother and grandmother about supporting him in his treatment, and if a commitment order required W.S. to take his medications, she hoped W.S. would be inpatient for only another week or two.

[8] W.S. also testified. He said if the trial court did not order the commitment, he would live with his grandmother, who takes care of him. But he did not know her address and had no plan for getting to her house. He said he had taken his

medication since he got to the hospital and would continue to do so if released.[3] But then he had an exchange with his counsel that demonstrated he did not understand what he was prescribed or for what purpose. He did not agree "with what the doctor has diagnosed [him] with" and did not think a commitment was necessary going forward. *Id.* at 30–31.

[9] The trial court subsequently issued an order finding W.S. was suffering from "unspecified psychosis[,]" was gravely disabled, and was in need of custody, care, and treatment for a time not expected to exceed ninety days. *Appellant's App. Vol. 2* at 58. As to whether W.S. was gravely disabled, the court stated it "consider[ed] the evidence collectively . . ., including but not limited to, thought blocking, significant amount of memory loss, deni[al] of illness, scored 7 out of 30 on cognative [sic] test, issues with eating, and paranoia." *Id.* at 59. The trial court ordered W.S. to remain in inpatient treatment until Eskenazi "determines that an appropriate outpatient treatment plan and placement have been established[,]" with placement in his grandmother's home "the preferred and least restrictive environment[.]" *Id.* The trial court also ordered W.S. to take all medications as prescribed and attend all clinic sessions as scheduled.

[3] Dr. Laudon was recalled and again stated W.S. had refused the anti-psychotic medications other than "a handful of times[.]" *Id.* at 36.

Sufficient evidence supports the trial court's temporary commitment order.

[10] A petitioner seeking an involuntary commitment must prove by clear and convincing evidence both that (1) the individual "is mentally ill and either dangerous or gravely disabled" and (2) commitment "is appropriate." Ind. Code § 12-26-2-5(e) (2007). When we review the sufficiency of evidence in a civil commitment case, we do not reweigh the evidence or assess witness credibility and we consider only the probative evidence and the reasonable inferences supporting the judgment. *Civil Commitment of T.K. v. Dep't of Veterans Affs.*, 27 N.E.3d 271, 273 (Ind. 2015). We will affirm if a reasonable trier of fact could find the necessary elements were proven by clear and convincing evidence. *Id.* Clear and convincing evidence requires proof that the existence of a fact is "highly probable." *J.W. v. Cmty. Fairbanks Behav. Health*, 260 N.E.3d 946, 951 (Ind. 2025).

[11] W.S. asserts Eskenazi did not prove by clear and convincing evidence that he was gravely disabled.[4] "Gravely disabled" means:

> 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

[4] W.S. does not challenge the trial court's finding that he is mentally ill.

> (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.

I.C. § 12-7-2-96 (1992).[5] Because the definition is phrased in the present tense, the trier of fact should assess the individual's state at the time of the hearing. *Commitment of B.J. v. Eskenazi Hosp./Midtown CMHC*, 67 N.E.3d 1034, 1040 (Ind. Ct. App. 2016). Further, the statute is written in the disjunctive, so proof of either prong of the definition is sufficient. *Id.* at 1039.

[12] Specifically, W.S. claims Eskenazi failed to show he was in danger of coming to harm if released because assistance was available from his family. W.S. relies on *O'Connor v. Donaldson*, 422 U.S. 563 (1975), and *In re Linderman*, 417 N.E.2d 1140 (Ind. Ct. App. 1981), for this proposition. *O'Connor*—in the context of a civil lawsuit claiming violation of the constitutional right to liberty—held the state "cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." 422 U.S. at 576. Noting this holding, the court in *Linderman* stated the "burden rests with the State to prove a reasonable attempt has been made to contact family members in this regard." 417 N.E.2d at 1142.

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[5] Effective July 1, 2026, the definition of "gravely disabled" was recodified at Indiana Code Section 12-7-2.1-170. The definition remains the same but for the addition of a provision for finding a person gravely disabled if they lack a "fixed, regular, and adequate shelter" under certain conditions. I.C. § 12-7-2.1-170(3) (2026). The change does not affect the issue W.S. raises. *See Appellant's Br.* at 9 n.2.

[13] Both cases are distinguishable from this one. In *O'Connor*, there was no evidence the patient posed a danger to himself or others at any point. "A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement." 422 U.S. at 575. The patient's commitment in *Linderman* was reversed not only because the State "failed to negate the possibility that [the patient] could be cared for by family or other responsible community members" but also because there was no evidence he was dangerous or gravely disabled. 417 N.E.2d at 1141–42. Neither of these cases stands for the proposition that the existence of a willing caregiver alone makes confinement inappropriate; rather, their purpose is to "prevent *nondangerous*, mentally ill patients, who have family members . . . willing to care for them, from being involuntarily committed." *GPH v. Giles*, 578 N.E.2d 729, 734 (Ind. Ct. App. 1991) (emphasis added), *trans. denied*.

[14] Here, W.S. is not confined simply because he is mentally ill; the trial court found he is also gravely disabled. Danger to self is a component of being gravely disabled. In cases where a court finds a patient is dangerous, the State is not required to negate the possibility family or friends could care for him. *Id.* (holding that because the trial court determined the patient was "mentally ill, dangerous to himself, and gravely disabled[,]" it was not necessary to prove there was no one to take on the responsibility of caring for him). Moreover, Eskenazi *did* reach out to W.S.'s grandmother and mother. However, because W.S. would not sign a release of information form, Dr. Laudon could talk with

them only about general information and could not assess their ability to assist W.S. in treatment and decision-making. Dr. Laudon testified she intended to include them in discharge planning if able, and the trial court authorized confinement only until Eskenazi could establish an appropriate outpatient treatment plan with grandmother's home as the preferred and least restrictive placement.

[15] Dr. Laudon's testimony showed even with mild improvement to the thought blocking and inability to communicate W.S. had exhibited, his severe cognitive impairment prevented him from making safe medical and treatment decisions. He was in danger of coming to harm because substantial impairment of his judgment and reasoning resulted in his inability to function independently and self-manage his care. Clear and convincing evidence established that W.S. was gravely disabled.

Conclusion

[16] Sufficient evidence supports W.S.'s temporary involuntary commitment.

[17] Affirmed.

Brown, J., and Scheele, J., concur.

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