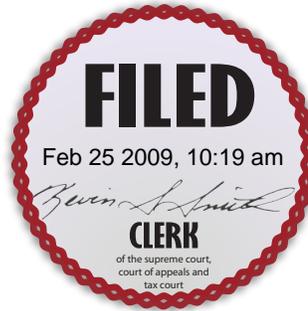


Pursuant to Ind.Appellate Rule 65(D), this Memorandum Decision shall not be regarded as precedent or cited before any court except for the purpose of establishing the defense of res judicata, collateral estoppel, or the law of the case.



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**IN THE  
COURT OF APPEALS OF INDIANA**

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IN THE MATTER OF THE COMMITMENT, )  
OF D.C., )  
 )  
Appellant, )  
 )  
vs. )  
 )  
STATE OF INDIANA and LARUE D. CARTER )  
MEMORIAL HOSPITAL )  
 )  
Appellee. )

No. 49A04-0807-CV-433

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APPEAL FROM THE MARION SUPERIOR COURT  
The Honorable Charles Deiter, Judge  
Cause No. 49D08-0603-MH-13431

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February 25, 2009

**MEMORANDUM DECISION - NOT FOR PUBLICATION**

**FRIEDLANDER, Judge**

Appellant-respondent, D.C., appeals her involuntary commitment to a mental health facility. Upon appeal, she challenges the sufficiency of the evidence supporting the trial court's findings that she is mentally ill, that her mental illness presents a danger to herself, and that she is gravely disabled.

We affirm.

The facts favorable to the commitment order are that after two months at the St. Vincent Stress Center (St. Vincent), D.C. was transferred to LaRue Carter Memorial Hospital (LaRue) on May 21, 2008. D.C. had been hospitalized at St. Vincent on two previous occasions in 2008. D.C. suffers from diabetes, morbid obesity, hypertension, asthma, and elevated cholesterol. Also, "she has a recurrent, and chronic mental disorder, which is called Bi Polar Disorder, formally called Maniac [sic] Depressive Illness. Which consisted of primary bouts of depression in her case, occasional bouts of hyperactivity, and delusional thinking [sic]." *Transcript* at 7. As a result of her condition, D.C. has been hospitalized "many times" over the years. *Id.* In addition, D.C. has a history of outpatient treatment in which her participation has been "very sporadic" and D.C. has been "non-compliant" and "very uncooperative". *Id.*

During her stay at LaRue, D.C.'s bipolar disorder was in remission, but St. Vincent did not release her into the community because of the bleak prospect of success for home treatment. According to St. Vincent, D.C. was physically incapable of going places outside of her home because of her morbid obesity. As a result, "the psychiatric team has to come to her home, almost on a daily basis." *Id.* at 8. D.C. takes many prescribed medications but periodically stops taking her medications. When she does, "[s]he becomes very depressed

very quickly” and “becomes very negative.” *Id.* In fact, when she relapses, she has refused to let St. Vincent’s team into her house. One such time, D.C. informed St. Vincent “that if there was one pill that she could take that would kill her, she would do so.” *Id.* at 8-9. When she is home, D.C.’s medical problems require that personnel from a home healthcare agency come to her house daily, for several hours a day.

After D.C. had been at LaRue for approximately one month, Patty Hopkins of the Cummins Mental Health Center asked LaRue to seek a regular commitment “[b]ecause of [D.C.’s] history of non-compliance with treatment, so they will have the option to bring her back to the hospital”, *id.* at 9, if and when she relapses, which she does “very quickly.” *Id.* at 10. After a hearing, the court granted LaRue’s request and entered an Order of Regular Commitment upon its findings that D.C. is mentally ill, dangerous to herself, and gravely disabled. D.C. contends the evidence is insufficient to support these findings.

Generally, there are three types of involuntary commitments: (1) emergency, (2) temporary, and (3) regular. *J.S. v. Ctr. for Behavioral Health*, 846 N.E.2d 1106 (Ind. Ct. App. 2006), *trans. denied*. At issue here is regular commitment, which is the most restrictive form of involuntary treatment and is appropriate for an individual whose commitment is expected to exceed ninety days. *Id.* To demonstrate a person should be committed involuntarily, a petitioner must 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 Ann. § 12-26-2-5(e) (West, PREMISE through 2008 2nd Regular Sess.). When reviewing a challenge to the sufficiency

of the evidence with respect to commitment proceedings, we look only at the evidence and reasonable inferences therefrom most favorable to the trial court's judgment. *In re A. W.D.*, 861 N.E.2d 1260 (Ind. Ct. App. 2007), *trans. denied*. In so doing, we may not reweigh the evidence or judge witness credibility. *Id.* "If the trial court's commitment order represents a conclusion that a reasonable person could have drawn, we will affirm the order even if other reasonable conclusions are possible." *Id.* at 1264 (quoting *Commitment of M.M. v. Clarian Health Partners*, 826 N.E.2d 90, 96 (Ind. Ct. App. 2005), *trans. denied*).

D.C.'s challenge to each element is premised upon the same basic argument, i.e., that they cannot be proven when, as here, the subject's mental illness is in remission at the time of the commitment hearing. We will first examine the evidence supporting the finding that D.C. is mentally ill. Dr. Helio Perez was one of D.C.'s treating physicians at LaRue. He testified that D.C. suffers from bipolar disorder. D.C. essentially concedes as much,<sup>1</sup> but notes Dr. Perez also testified that D.C.'s bipolar disorder was in remission at the time of the hearing. D.C. contends her "successfully treated psychiatric disorder does not meet the statutory definition of a mental illness because it was not disturbing her thinking, feeling or behavior or impairing her ability to function and the court erred when it committed her without clear and convincing evidence otherwise." *Appellant's Brief* at 7. Put another way, D.C. contends, without citation to authority, that in order to establish that a person is mentally ill

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<sup>1</sup> Although D.C. notes that the original diagnosis of bipolar disorder was made more than thirty years ago and that "Dr. Perez relied on D.C.'s medical records, not any current symptoms, to support his diagnosis", *Appellant's Brief* at 6, a thorough examination of the transcript of the hearing reveals that D.C. did not contend that she no longer suffers from bipolar disorder. Rather, her defense at the hearing, and on appeal, is that she is currently asymptomatic, or in remission.

within the meaning of I.C. § 12-26-2-5(e), it must be shown that he or she is currently exhibiting symptoms of mental illness.

According to the National Institute of Mental Health, bipolar disorder is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. Often, with proper treatment, including medication, the symptoms of bipolar disorder can largely be controlled and minimized. This is not to say, however, that during periods of remission, i.e., when the subject is asymptomatic, the disease is "cured" within the classic meaning of that term. By definition, an individual with bipolar disorder will experience alternating periods of depression, hyperactivity, and relative normalcy. A mental illness is defined as "a psychiatric disorder that substantially disturbs an individual's thinking, feeling or behavior and impairs the individual's ability to function." *In re Commitment of Steinberg*, 821 N.E.2d 385, 388 (Ind. Ct. App. 2004) (citing Ind. Code Ann. § 12-7-2-130 (West, PREMISE through 2008 2nd Regular Sess.)). D.C. does not dispute that during periods when her mood swings away from normalcy, her thinking, behavior, and ability to function are impaired. Nor does D.C. dispute that bipolar disorder is a mental illness as defined by statute. She merely contends that during periods of normalcy, i.e., when she is asymptomatic, she is not mentally ill within the meaning of I.C. § 12-26-2-5(e). We disagree. Even during periods when her symptoms are in remission, a person with bipolar disorder still has the disorder. We hasten to add that the mere fact that a person has bipolar disorder does not, by itself, justify involuntary, regular commitment under I.C. § 12-26-2-5(e). Because of the cyclical nature in which D.C.'s symptoms manifest themselves, however, and especially in combination with evidence of

D.C.'s particular medical and psychiatric history, we conclude that the "mentally ill" element was sufficiently proven by evidence that she suffers from bipolar disorder, notwithstanding that she was asymptomatic at the time.

We stress that we do not wish to be interpreted as holding that the current presence or absence of active symptoms of this or any other mental illness is irrelevant to this inquiry. To the contrary, it *is* relevant. But, in cases such as this where the subject's asymptomatic condition is not reliably attributable to the subject's independent conduct and decisions, and in fact is attributable to services the subject predictably might forego if left to his or her own volition, then the absence of symptoms is not conclusive. In this case, Dr. Perez testified that D.C. historically has been hospitalized "many times." *Transcript* at 7. He testified that when not in the hospital, D.C. has "been non-compliant, and very uncooperative with outpatient treatment." *Id.* He also testified that "she will relapse very quickly without treatment." *Transcript* at 12.

In affirming the order of commitment, we reject the contention that courts must disregard a person's medical and psychiatric history when making this determination. *See J.S. v. Ctr. for Behavioral Health*, 846 N.E.2d 1106 (the evidence supported a finding that the mental health patient would be gravely disabled if she stopped taking her antipsychotic medication, where a psychiatrist testified that the major factor in the patient's repeated hospitalizations was her failure to take her medications, and that if the patient did not take her medications for a period of several months she would manifest severe, serious symptoms of mental illness that would lead to her becoming gravely disabled); *see also Golub v. Giles*,

814 N.E.2d 1034 (Ind. Ct. App. 2004) (evidence supported the trial court’s conclusion in a mental commitment proceeding that the patient suffered from bipolar disorder, psychotic, although the physician did not observe the psychotic symptoms during the hospitalization giving rise to the commitment proceeding; the physician concluded that the patient suffered from psychotic illness based in part upon a review of medical records from past admissions, *trans. denied*). We hold that a court may consider both the patient’s current condition and the patient’s psychiatric and treatment history because that patient’s history informs our understanding of the present circumstances and often is necessary to accurately interpret the present situation. Considering D.C.’s psychiatric and treatment history and current condition, the State presented clear and convincing evidence to support the conclusion that D.C. suffers from a mental illness.

D.C. next contends the court erred in finding that she was dangerous to self. The term “dangerous,” for involuntary commitment purposes, 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 (West, PREMISE through 2008 2nd Regular Sess.). “Dangerousness must be shown by clear and convincing evidence indicating that the behavior used as an index of a person’s dangerousness would not occur but for the person’s mental illness.” *C.J. v. Health & Hosp. Corp. of Marion County*, 842 N.E.2d 407, 410 (Ind. Ct. App. 2006). “Importantly, a trial court is not required to wait until harm has nearly or actually occurred before determining that an individual poses a substantial risk of harm to others.” *Id.*

As with her argument above concerning proof of the mental-illness element, D.C. contends the evidence of dangerousness is pure “speculation”, amounting to little more than “Dr. Perez’s fear she could stop taking her medication and could then suffer from neglect or depression.” *Appellant’s Brief* at 7. Again, D.C. focuses her argument on the evidence relative to her condition at the time of the hearing.

We need not rehash the comments above concerning the propriety and indeed importance of considering D.C.’s history in assessing her current condition. Although by all counts D.C. did not present a danger to herself at the time of the hearing, that is not to say that she would not soon do so if released to take care of herself. We reiterate that a trial court is not required to wait until harm has nearly or actually occurred before determining that an individual poses a substantial risk of harm to self. *See C.J. v. Health & Hosp. Corp. of Marion County*, 842 N.E.2d 407. Dr. Perez testified that D.C.’s history of outpatient treatment is “very sporadic” and she has been “non-compliant” and “very uncooperative with outpatient services.” *Transcript* at 7. According to the doctor, “She stops taking her medications. She becomes depressed very quickly. And, when she relapses, she becomes very negative.” *Id.* at 8. At that point, she “neglects both her physical and psychiatric care.” *Id.* at 9. Dr. Perez was asked whether, in his opinion, D.C. was dangerous to herself or others, as a result of her mental illness. He responded, “If she’s off the medications, and without treatment yes, due to neglect or depression.” *Id.* at 8.

We conclude that the element of dangerousness was established by clear and convincing evidence, notwithstanding that it includes a prediction of future conduct based

upon present circumstances and past conduct. *Cf. Matter of Commitment of Gerke*, 696 N.E.2d 416, 421 (Ind. Ct. App. 1998) (“[w]e disagree with Gerke’s implication, albeit unstated, that a commitment premised upon a trial court’s prediction of dangerous future behavior, without prior evidence of the predicted conduct, must be, in all cases, invalid”). Contrary to D.C.’s contention upon appeal, Dr. Perez’s opinion is neither unduly “speculative” nor “unfounded.” *Appellant’s Brief* at 8. To the contrary, it is based upon his assessment of D.C.’s current condition, coupled with his knowledge of D.C.’s lengthy medical and psychiatric treatment history.

In light of the above evidence, the trial court could properly find that as a result of her mental illness, D.C. poses a danger to herself. Because the commitment is warranted upon the basis of D.C.’s dangerous behavior, we need not address the propriety of the trial court’s determination that D.C. is gravely disabled. *See Commitment of C.A. v. Ctr. for Mental Health*, 776 N.E.2d 1216 (Ind. Ct. App. 2002). We conclude the commitment order was supported by clear and convincing evidence.

Judgment affirmed.

MAY, J., and BRADFORD, J., concur.