# RECORD IMPOUNDED



SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-3603-20

IN THE MATTER OF THE
COMMITMENT OF D.G.

_____

Submitted May 9, 2022 – Decided March 30, 2023

Before Judges Accurso and Rose.

On appeal from the Superior Court of New Jersey, Law Division, Union County, Indictment No. 15-08-0594.

Joseph E. Krakora, Public Defender, attorney for appellant D.G. (Susan Remis Silver, Assistant Deputy Public Defender, of counsel and on the briefs).

William A. Daniel, Union County Prosecutor, attorney for respondent State of New Jersey (Meredith L. Balo, Assistant Prosecutor, of counsel and on the brief).

The opinion of the court was delivered by

ACCURSO, J.A.D.

D.G. appeals from a July 15, 2021 order continuing his commitment on Krol[1] status[2] notwithstanding the testimony of the State's treating psychiatrist that D.G. was no longer a danger to himself or others, and hospital staff should begin planning for his discharge to a supervised group home.[3] We reverse. As our Supreme Court recently reaffirmed in In re Civil Commitment of W.W., 245 N.J. 438, 451-54 (2021), the State fails to carry its burden of establishing the need for continued commitment under the general civil commitment statute, N.J.S.A. 30:4-27.13(b), when its treating psychiatrist testifies against involuntary commitment. We see no principled reason to conclude the result should be different because D.G. is on Krol status.

---

[1] State v. Krol, 68 N.J. 236 (1975).

[2] In re Commitment of W.K., 159 N.J. 1, 2 (1999) (explaining New Jersey courts describe a person acquitted of a crime by reason of insanity who is thereafter involuntarily committed because a danger to self or others and needing medical treatment "as being on Krol status.").

[3] Although the court authorized D.G.'s treatment team to commence discharge planning for him, the relief he seeks by this appeal, and he has since been released to a supervised group home, we reject the State's argument we should dismiss the appeal as moot. Our courts generally consider appeals challenging civil commitment because of the importance of the committee's liberty interest and the likelihood of repetition of error that will escape review. See In re Commitment of N.N., 146 N.J. 112, 124 (1996); see also In re Commitment of P.D., 381 N.J. Super. 389, 393 (App Div. 2005), certif. granted and remanded, 186 N.J. 251 (2006). Both considerations are implicated here.

D.G. is a thirty-five-year-old man who has suffered with schizophrenia since his early twenties. In 2015, he eloped from Overlook Hospital while undergoing a crisis evaluation and once outside, pulled a woman from an idling car to escape a perceived threat, a result of his acute paranoia. He was charged with first-degree carjacking and found not guilty by reason of insanity (NGI).

D.G. was placed on Krol status in 2017 and discharged in 2018 to live with family and attend a partial care program. He decompensated fairly rapidly, however, after failing to take his medications. He was readmitted to inpatient treatment following his arrest in June 2018 for aggravated assault on a police officer, resisting arrest and obstruction. He pleaded guilty to fourth-degree obstruction and was sentenced to time served. The other charges were dismissed.

D.G. was again discharged in February 2019 on the condition he live with his brother, attend a partial care program four days a week and take his prescribed medications. D.G. stopped taking his medications, almost immediately left his brother's home and failed to attend his partial care program. The court issued a bench warrant for his arrest in March and the State filed a complaint charging him with fourth-degree contempt. D.G. was

finally arrested in August and admitted to a locked ward at Trenton Psychiatric Hospital in October 2019. The contempt charge was dismissed.

At a review hearing in July 2021, D.G.'s social worker testified D.G. was living in one of the cottages on the grounds of Trenton Psychiatric in the hospital's Transitional Living Unit, where he was responsible for washing his own clothes, keeping the cottage tidy, including cleaning the bathroom, and other like chores. She described it as similar to a group home with supervision, like one D.G.'s treatment team was recommending for him on discharge. She also noted D.G. was free to walk the hospital grounds during his structured leisure time and could purchase items from the trading post, an on-campus store, without supervision. The social worker, who regularly saw D.G. a few times a week, testified his level of engagement was markedly improved from a year ago when he was first assigned to the cottages, and he was focused and eager to engage in programming.

D.G.'s treating psychiatrist testified D.G., although suffering from schizophrenia, was without active symptoms of psychosis, and was not a danger to himself, others or property at the time of the review hearing.

According to the psychiatrist, who began treating D.G. in July 2020[4] when he moved to the cottages, the hospital's least restrictive placement, D.G. was doing well on level three privileges, the highest available.

The doctor, a board-certified psychiatrist who had worked at Trenton Psychiatric for ten years, testified D.G. was compliant with his medication, a monthly injection of Haldol Decanoate, an anti-psychotic, as well as daily dosages of Depakote, a mood stabilizer, and Cogentin, to prevent side effects. D.G. was prescribed the long-acting injectable anti-psychotic to address his history of failing to take his medications after he was readmitted to the hospital in 2019 following his second failed discharge. She described him as no longer paranoid, "stable with current treatment," and she recommended his treatment team be permitted to begin planning for his discharge to the community.

The psychiatrist testified she'd met with D.G. at least seven or eight times prior to the hearing, most recently the day before. Although acknowledging D.G.'s long history of hospitalizations and two failed discharges to the community, the doctor testified he had good therapeutic

[4] The doctor testified another psychiatrist cared for D.G. while she was on leave for six months, but she had reassumed his care three months before the hearing.

levels of his medications, and they were benefitting him. He was no longer "irritable," but "focused" and "receptive," and his thought processes evidenced "good concentration." She also noted he was no longer experiencing audio or visual hallucinations and not engaged in any behavior that would suggest otherwise. D.G. was also compliant with therapy, which had until recently been conducted remotely owing to the pandemic. At the time of the hearing, D.G. was attending weekly in-person sessions with a social worker and a psychology intern under the supervision of a licensed psychologist.

Asked why she believed D.G. could be safely discharged now after so rapidly decompensating in his two prior attempts at living in the community, the doctor explained D.G.'s two prior discharges had been to his family, who although well-intended, were not professionals trained to monitor a psychiatric patient, detecting and reporting any early signs of stress or noncompliance with a discharge plan. She testified D.G.'s treatment team was recommending he not be discharged to his family but to a twenty-four-hour supervised group home, where he can be effectively monitored by staff who would intervene early to head off non-compliance. The doctor also recommended D.G. be required to attend a five-day-a-week partial care program. She explained those two components combined to provide D.G. the highest level of support

available to a psychiatric patient on an outpatient basis transitioning to the community.

The doctor testified the treatment team's recommendation for D.G.'s discharge plan had been approved by both Trenton Psychiatric's Special Status Patient Review Committee, (SSPRC), made up of the directors of the five principal departments of the hospital, and the Clinical Assessment and Review Panel (CARP), which reports to the Medical Director of the Division of Behavioral Health Services in the Department of Health, responsible for all four of the State's psychiatric hospitals.[5] She also explained discharge planning for a patient like D.G. who needs both a twenty-four hour supervised group home and a partial care program, can take from a few months to more than a year. Although D.G. would continue under the same treatment regimen while the treatment team planned for his discharge, the doctor explained the

[5] "The SSPRC provides review of recommendations made by a patient's treatment team balancing the patient's needs to 'successfully participate in treatment and rehabilitative programs, while maintaining a safe and secure therapeutic milieu for patients and staff . . . .'" In re Commitment of T.J., 401 N.J. Super. 111, 114 n.2 (App. Div. 2008) (quoting N.J.A.C. 10:36-1.1). The CARP advises the Medical Director "on the review of SSPRC decisions." N.J. Dep't of Hum. Servs., Div. of Mental Health Servs., Admin. Bull. 3:29: Designation of Special Status Patients 1, 3 (May 12, 2005) (delineating the authority of the Special Status Patient Review Committee and the Clinical Assessment and Review Panel to closely oversee patients at greatest risk of violent behavior at various stages of treatment).

hospital could not initiate discharge planning for D.G. without approval of the court based on D.G.'s Krol status.

In sum, the psychiatrist testified D.G. was stable, not a danger to himself or others so long as he adheres to his medication and therapy protocol, and he "wanted to continue the treatment as recommended" in order to fulfill his goal of returning home and finding a job to support his family. The doctor testified D.G. knows he suffers from a mental illness and if he does not take his medicine his symptoms will return, which he does not want. Although acknowledging there was, of course, no guarantee D.G. will be compliant with his treatment regimen on discharge, the doctor testified his progress at Trenton Psychiatric, coupled with the structure the team was recommending be put in place for his discharge, gave her confidence he would be successful.

The court, noting this was not its "first rodeo here with [D.G.]," advised the doctor "another learned psychiatrist just like you a couple of years ago said the exact same thing to me, the exact same thing; that he's very goal oriented. This is a highly structured program that we're releasing him to. And immediately, immediately he took off." Pointing to the "extensive record," the court asked the doctor if she didn't agree "that what the history indicates to us unambiguously" is that D.G. "when left to his own devices in the community,

structure or otherwise, decompensates, fails to take his medication, and poses a risk to himself and others."

The doctor acknowledged the court was right about the history but explained that when "somebody is not psychotic, not manic, not depressed," not imminently self-injurious, "we cannot recommend that the patient has to stay in the care of a psychiatric hospital." The doctor was adamant D.G. "needs treatment," and was trying to ensure he received it but could not and did not support continuing to maintain him in an inpatient psychiatric facility.

After hearing the doctor's testimony, the State made clear it did not agree with the treating psychiatrist's opinion that D.G. be approved for discharge planning. D.G.'s counsel countered it was the State's burden to establish dangerousness, which it failed to do based on the doctor's testimony, and thus the court should permit the hospital to begin the process of planning for D.G.'s discharge.

The judge began his oral opinion identifying the two-step analysis required by Krol, namely, whether the State can demonstrate by a preponderance of the evidence that the "defendant is mentally ill and, if permitted to remain at large in the general population without some restraints, is likely to pose a danger to himself or to society." Krol, 68 N.J. at 257

(footnotes omitted). The judge noted the parties had stipulated D.G. "was presently mentally ill, suffering from schizophrenia," which the judge described as "a well-chronicled, tragic, diagnosed psychiatric condition of the utmost severity which includes delusions and unfortunately, serial medical noncompliance." The judge credited the psychiatrist's testimony as to D.G.'s mental illness, understanding his symptoms have "quieted in light of the intense supervision and medication monitoring in the highly structured environment."

Although accepting the psychiatrist's testimony as to D.G.'s mental illness, the court otherwise characterized her testimony as "profoundly lacking." Specifically, the judge found the doctor had not mastered D.G.'s "longstanding history" of hospitalizations, to which she gave only "cursory attention" and was "dismissive" of his serial decompensation on discharge to the community. The judge bemoaned the lack of continuity in D.G.'s care and the case generally, observing "the only two people that have remained constant since December of 2018 here is [D.G.] and me." Although finding the psychiatrist "well-intentioned and . . . certainly qualified," the judge found she "did not in any meaningful way incorporate" D.G.'s "profound lapses and hospitalizations and failure to comply with medication monitoring to explain

why today [D.G.] presents differently, profoundly differently, such that discharge planning is entirely appropriate."

The judge found the psychiatrist "seemed to accept rather blindly as reliable what [D.G.] told her rather than his well-chronicled history of non-compliance," and again noted the testimony of the psychiatrist treating D.G. when the judge ordered his discharge in 2019, who "rendered the identical conclusion that [D.G.] was stable, compliant, and suitable for reintegration to a highly structured program with medication monitoring." The judge concluded D.G.'s current treating psychiatrist's testimony "was rather conclusory and aspirational," never explaining "why now there's any more likelihood of [D.G.'s] compliance with medication monitoring and therapeutic counseling than in the failed past." The judge also accused the doctor of picking and choosing among the facts in the record "that comport most favorably to her conclusion, rather than giv[ing] . . . a more honest, objective, and fair recitation."

To illustrate his point, the judge relied on the report of the psychologist on D.G.'s treatment team, not admitted in evidence and not included in the record on appeal, which the psychiatrist maintained reflected D.G.'s "risk for future violence and serious physical harm" as "in the moderate range." The

court found the psychiatrist's characterization "selected and skewed, because if one looks at [the psychologist's] actual report, there are other indicia of a higher risk." The court found

> if one were to look at the psychological assessment of [the treating psychologist], there were numerous indicators for the presence of risk — problems with violence, problems with other antisocial behavior, problems with substance abuse, problems with major mental disorder, problems with treatment or supervision or response, recent problems with insight, recent problems with symptoms of major mental disorder, recent problems with instability, future problems with treatment or supervision response, future problems with stress or coping.

The judge found all those risk factors "positively indicated by [the treating psychologist] yet were given either no reference by [the treating psychiatrist] . . . in the overwhelming aspects," or only "passing" reference, explaining, at least in part, why the judge rejected the psychiatrist's testimony as to D.G.'s dangerousness and his appropriateness for discharge planning.

Turning to an assessment of D.G.'s risk of dangerousness, the court acknowledged "it is not sufficient that the State establish a possibility that defendant might commit some dangerous acts at some time in the indefinite future," but must show "[t]he risk of danger, a product of the likelihood of such conduct and the degree of harm which may ensue, must be substantial

within the reasonably foreseeable future." Krol, 68 N.J. at 260. The judge pronounced himself "thrilled" D.G. was "doing well," and noted "[h]e appears to be motivated," but found "the track record is quite limited" and the "pandemic has limited his ability to meaningfully obtain therapeutic programming."

The judge ultimately concluded "[d]ischarging or contemplating the discharge of [D.G.] at present does not adequately or reasonably protect the public from [D.G.] at this juncture." The court found D.G.'s involuntary confinement was "not punitive," and the State had "met its burden by a preponderance of the evidence that his continued involuntary confinement is constitutionally valid."

D.G. appeals, contending the court improperly continued his commitment when the State failed to present the testimony of a psychiatrist in support of continued commitment and competent proof he posed a risk of danger to himself or others; violated his due process rights; and made findings based on incompetent evidence not properly admitted in the record.

It is axiomatic that appellate review of a Krol order is "extremely narrow, with the utmost deference accorded the reviewing judge's determination as to the appropriate accommodation of the competing interests

of individual liberty and societal safety in the particular case." State v. Fields, 77 N.J. 282, 311 (1978). Our Supreme Court has held "[s]uch sensitive decisions will be subject to appellate modification only where the record reveals a clear mistake in the exercise of the reviewing judge's broad discretion in evaluating the committee's present condition and formulating a suitable order." Ibid. "So long as the trial court's findings are supported by 'sufficient credible evidence present in the record,' those findings should not be disturbed." In re Civ. Commitment of R.F., 217 N.J. 152, 175 (2014) (quoting State v. Johnson, 42 N.J. 146, 162 (1964)). We are to canvass the expert testimony in the record for credible evidence to support the judge's fact findings before determining those findings were clearly erroneous. See In re D.C., 146 N.J. 31, 58-59 (1996).

The issue in this case is whether the judge's determination the State carried its burden by a preponderance of the evidence that D.G. posed a substantial risk of dangerous conduct to himself or others within the reasonably foreseeable future is supported by substantial credible evidence in the record. D.G., relying on the Court's recent opinion in W.W., contends the court erred in finding the State met its burden to establish the need for D.G.'s continued commitment by producing a psychiatrist who did not support D.G.'s

commitment but instead testified the State should be planning for his discharge.

In W.W., a case brought under the Sexually Violent Predator Act (SVPA), N.J.S.A. 30:4-27.24 to -27.38, W.W. was convicted of sexually assaulting a five-year-old girl and was sentenced to seven years in State prison, five of which he served at the Adult Diagnostic and Treatment Center. 245 N.J. at 442. On his release from prison, he was committed to the Special Treatment Unit (STU), where he spent the next twenty years. Id. at 443. At a review hearing when he was seventy-one years old, the State presented two experts, a psychiatrist and a psychologist who held conflicting opinions — the psychiatrist supporting conditional discharge and the psychologist recommending continued commitment. Id. at 444.

When the State realized on the day of the hearing the psychiatrist would not testify in support of commitment, it attempted to avoid calling her in its case. Ibid. The judge rejected the State's gambit, advising the deputy attorney general "[i]t's your obligation under the statute to produce psychiatric testimony. . . . If you don't do that, you can't possibly prevail." Ibid. See N.J.S.A. 30:4-27.30(b). The State called the psychiatrist, who testified W.W. did not meet the statutory threshold of being "highly likely" to reoffend and

recommended he be conditionally discharged, N.J.S.A. 30:4-27.32. W.W., 245 N.J. at 444-45. The State also called W.W.'s treating psychologist, who disagreed, testifying conditions had not changed from the time of a prior unsuccessful furlough, and W.W. should remain committed. Id. at 445.

The SVP judge determined the State's psychologist had "the better half of the argument," and the State was not bound by the psychiatrist's testimony. In re Civ. Commitment of W.W., No. A-2972-18 (App. Div. Dec. 17, 2019) (slip. op at 9). We affirmed, rejecting W.W.'s argument that the State failed to meet its burden to produce the testimony of a psychiatrist that W.W. met the standards for commitment. Id. at 12. Relying on R.F., we found the commitment court "is 'not required to accept all or any part of' an expert's opinion," ibid. (quoting R.F., 217 N.J. at 174), especially because the court's determination of whether a person previously convicted of a sexually violent offense is highly likely to sexually reoffend is "a legal one, not a medical one, even though guided by medical expert testimony," ibid. (quoting R.F., 217 N.J. at 174).

The Supreme Court reversed. W.W., 245 N.J. at 442. The Court rejected the State's argument that it met its burden by producing the testimony of the treating psychiatrist, which the SVP court was free to accept or reject.

Id. at 447. The Court explained "[c]ommitment under the SVPA is closely connected to the general civil commitment statute, N.J.S.A. 30:4-27.1," and "[t]he key provision . . . N.J.S.A. 30:4-27.30(b), is identical to its corollary in the general civil commitment statute." Id. at 451. See N.J.S.A. 30:4-27.13(b) ("A psychiatrist on the patient's treatment team . . . shall testify at the hearing to the clinical basis for the need for involuntary commitment to treatment."). The Court further noted the wording of N.J.S.A. 30:4-27.30(b) "is also substantially similar to the language used in the court rule governing civil commitment of adults." W.W., 245 N.J. at 451. See R. 4:74-7(e) ("The application for commitment to treatment shall be supported by the oral testimony of a psychiatrist on the patient's treatment team.").

The Court found we'd previously interpreted the meaning of "the phrase 'clinical basis for the need for involuntary commitment,'" in a general civil commitment context, In re Commitment of Raymond S., 263 N.J. Super. 428, 432 (App. Div. 1993), and under the SVPA, In re Civ. Commitment of A.H.B., 386 N.J. Super. 16, 24-25 (App. Div. 2006), concluding in both contexts that "N.J.S.A. 30:4-27.13 and Rule 4:74-7(e) 'require that a psychiatrist on the patient's treatment team testify at the hearing, and provide medical testimony supporting the need for commitment.'" W.W., 245 N.J. at 452

(quoting A.H.B., 386 N.J. Super. at 25). The Court approved those holdings, concluding "the Legislature intended for N.J.S.A. 30:4-27.30(b) to require a psychiatrist to testify in support of commitment," and thus the State failed to carry "its burden by producing a psychiatrist who did not support commitment." Ibid. The Court held "the clear language" of N.J.S.A. 30:4-27.30(b) "indicates that a psychiatrist must testify to those underlying facts that require involuntary commitment of the individual. It is not enough, under the statute's plain terms, that a psychiatrist testifies — even if that testimony is against involuntary commitment — and that someone else testifies to the need for commitment." Id. at 453.

Finally, although finding no need to look beyond the statute's plain language, the Court took pains to note N.J.S.A. 30:4-27.30(b)'s "plain meaning accords with both the legislative history of the [SVPA] and the overarching statutory scheme." Ibid. Specifically, the Court noted "the Legislature clearly intended the SVPA's procedure to follow that of the general civil commitment statute," which we had already interpreted in Raymond S. to require the State to produce the testimony of a psychiatrist in support of commitment. Id. at 454. The Court reasoned the Legislature's use of "the exact same phrasing in the SVPA, without a corrective definition," was clear evidence of the

"legislative intent to require psychiatric testimony in support of commitment under the SVPA as well." Ibid.

The State distinguishes W.W. because D.G. is on Krol status committed under N.J.S.A. 2C:4-8, requiring the State to establish only that he "is a danger to self or others and is in need of medical treatment" by a preponderance of the evidence. W.K., 159 N.J. at 2, 4, 6 (holding "an NGI defendant may remain under Krol commitment for the maximum ordinary aggregate terms that defendant would have received if convicted of the offenses charged, taking into account the usual principles of sentencing").

While the State is correct that its burden of proof is only by a preponderance of the evidence, see Krol, 68 N.J. at 257, it is beyond peradventure since Krol that persons committed in New Jersey following an NGI verdict are "entitled to substantially the same treatment as civil committees," In re Commitment of Edward S., 118 N.J. 118, 125 (1990), "the difference in treatment of the mentally ill based on whether or not the illness was manifested in criminal conduct [having been] constitutionally obliterated," ibid. (citing Jackson v. Indiana, 406 U.S. 715 (1972); and then citing Baxstrom v. Herold, 383 U.S. 107 (1966)). Indeed, N.J.S.A. 2C:4-8, the statute on which the State relies, expressly provides a person acquitted by reason of insanity,

who is "thereafter determined by the court to constitute a danger to the community or to self if released shall be committed and thereafter 'treated as a person civilly committed.'" Id. at 126-27 (quoting N.J.S.A. 2C:4-8b(3)).

We see no principled basis after W.W., a case involving an SVP committee — a person who, by definition, had been convicted of at least one sexually violent offense — to conclude the State could meet its burden to establish the continued involuntary confinement of a Krol committee by producing a psychiatrist who did not support commitment. That the State need only carry its evidentiary burden by a preponderance of the evidence in a Krol context does not lessen its burden to produce the testimony of a psychiatrist who supports commitment in accordance with N.J.S.A. 30:4-27.13(b), Rule 4:74-7(e) and W.W.

The Legislature has plainly and explicitly decreed in N.J.S.A. 2C:4-9(d) that the cases of persons committed under N.J.S.A. 2C:4-8 "shall be specifically reviewed as provided by the law governing civil commitment." Edward S., 118 N.J. at 134-35 (quoting N.J.S.A. 2C:4-9(d)). N.J.S.A. 30:4-27.13(b), Rule 4:74-7(e), Raymond S., 263 N.J. Super. at 432, A.H.B., 386 N.J. Super. at 25, and now W.W., 245 N.J. at 455, all state unequivocally that

means a psychiatrist on the patient's treatment team must testify at the hearing in support of the need for commitment.

We are, of course, aware the Court has noted that "[n]o case has ever suggested any requirement of absolute equality of procedure or treatment" between civil and NGI committees "in all respects," Edward S., 118 N.J. at 129, and that it has singled out an aspect of dangerousness as supporting "a legally cognizable distinction between the two groups," Fields, 77 N.J. at 308. Specifically, in Fields, the Court noted that "[w]ith respect to an NGI committee, his propensity, by reason of his mental illness, to engage in serious antisocial conduct has on at least one occasion crystallized into the commission of what otherwise would constitute a criminal offense." Ibid. Yet the same is true of an SVP committee, and the Court has still unequivocally held the State must present a psychiatrist at the review hearing to testify in support of commitment in order to continue an SVP's confinement at the STU. W.W., 245 N.J. at 454-55.

Nor, it appears clear, may we overlook the State's failure to produce a psychiatrist on D.G.'s treatment team to testify in support of commitment by relying on the Court's admonition in D.C. and R.F. that "[a] trial judge is 'not required to accept all or any part of [an] expert opinion[]'" and that "[t]he

ultimate determination" of dangerousness is "'a legal one, not a medical one, even though it is guided by medical expert testimony,'" points the State makes here. R.F., 217 N.J. at 174 (quoting D.C., 146 N.J. at 59, 61). We relied on both statements in affirming the trial court in W.W., in the face of the State's failure to produce psychiatric testimony in support of commitment, slip op. at 12, a determination the Court reversed, W.W., 245 N.J. at 442.

Tellingly, the State does not argue here that it was not obligated to produce the testimony of a treating psychiatrist to support D.G.'s continued confinement. And it concedes D.G.'s psychiatrist testified D.G. was not dangerous to himself or others, "did not need continued commitment and could be safely discharged to a group home." But it argues the trial court did not abuse its discretion in continuing D.G.'s confinement despite that testimony because the psychiatrist's testimony "was equivocal" in that she also testified she couldn't guarantee D.G. "would continue to take his medication or attend treatment sessions" on discharge, admitted there was a concern he would not do so based on his prior history, and if he "stopped taking his medication, he would become psychotic, manic, and dangerous."

We reject that argument. No fair reading of the psychiatrist's testimony could make it equivocal on D.G.'s dangerousness and need for continued

commitment. D.G.'s treating psychiatrist testified unqualifiedly that he was not a danger to himself or others so long as he continued to take his medication, including the anti-psychotic drug he received by intramuscular injection every twenty-eight days, and that the hospital should begin planning for his discharge to a twenty-four-hour supervised group home and a five-day-a-week partial care program, which she claimed was "the highest level of support" available to a psychiatric patient on an outpatient basis transitioning to the community.

We've held the possibility of a committee not taking required medication on discharge is not a sufficient reason to continue involuntary commitment, albeit when the evidentiary standard is clear and convincing evidence. See In re Commitment of J.R., 390 N.J. Super. 523, 532 (App. Div. 2007); In re Commitment of W.H., 324 N.J. Super. 519, 524 (App. Div. 1999). See also Fields, 77 N.J. at 307 ("It is not sufficient that the state establish a possibility that defendant might commit some dangerous acts at some time in the indefinite future."). We cannot find the psychiatrist's acknowledgment here that D.G. might not take his medication on discharge, notwithstanding the hospital's plan to combat the possibility by having his injectable long-acting anti-psychotic medication administered by a partial care program and his daily

medications administered by staff at a twenty-four-hour supervised group home, as somehow fulfilling the State's requirement to produce the testimony of a treating psychiatrist in support of the need for D.G.'s continued commitment.

Although we conclude the trial court erred in refusing to allow the hospital to begin planning for D.G.'s discharge when the State failed to carry its burden of producing a treating psychiatrist to testify in support of continuing commitment, we do not suggest the trial court is without tools to satisfy itself an NGI committee can be safely discharged to the community in such circumstances. Permitting a psychiatric hospital to begin planning for an NGI committee's discharge is obviously not the same as approving a conditional discharge. The Court has made abundantly clear that "even where the committee's condition shows marked improvement, only the most extraordinary case would justify modification in any manner other than by a gradual deescalation of the restraints upon the committee's liberty." Fields, 77 N.J. at 303.

The trial court, of course, is responsible for oversight of that "gradual deescalation," which the Court has determined "will substantially minimize the risk of erroneous determinations of non-dangerousness and will thus protect

the State's compelling interest in maintaining the safety and security of its citizens." Ibid. The trial court did so in this case when it subsequently permitted Trenton Psychiatric to begin discharge planning in October 2022, allowing the hospital to initiate efforts to locate an appropriate twenty-four-hour supervised group home and a partial care program for D.G., while prohibiting his administrative discharge without the express approval of the court following a hearing. See In re S.L., 94 N.J. 128, 140 (1983) (permitting the continued confinement of persons involuntarily committed "on a provisional or conditional basis" pending efforts to secure an appropriate placement outside the institution). The court, however, should have initiated the process in July 2021, when the State failed to produce a treating psychiatrist at the review hearing to testify to D.G.'s need for continued confinement.

As the Court emphasized in R.F., New Jersey law on civil commitment "has emphasized the importance of 'provid[ing] the needed level of care'" to committees "'in the least restrictive manner,'" 217 N.J. at 180 (quoting S.L., 94 N.J. at 141), "and not infringing on an individual's 'liberty or autonomy any more than appears reasonably necessary to accomplish' the State's goals of public safety and effective treatment," ibid. (quoting Krol, 68 N.J. at 261-62).

That is as true of NGI committees as any others. Krol, 68 N.J. at 257-58. While we reverse the order under review, we make no finding that D.G.'s commitment was unnecessarily prolonged by the court's failure to institute discharge planning in July 2021. The State's psychiatrist testified discharge planning for a patient with D.G.'s needs could take well over a year. The record before us permits no conclusion as to an appropriate date for D.G.'s conditional discharge.[6]

Reversed.



[6] Our disposition makes it unnecessary to consider D.G.'s remaining issue, specifically that the court improperly relied on an outdated psychological assessment from a non-testifying expert not in evidence, but referenced by the treating psychiatrist, to continue D.G.'s commitment. We note only that although the trial judge was permitted to consider the assessment in weighing the credibility of the testifying psychiatrist, In re Commitment of A.X.D., 370 N.J. Super. 198, 202 (App. Div. 2004), which appears to be at least one reason for his reference to the report, he would not have been permitted to rely on any complex diagnoses it contained, N.J.R.E. 808; Nowacki v. Cmty. Med. Ctr., 279 N.J. Super. 276, 281-83 (App. Div. 1995). Accordingly, the better practice would have been for the judge to admit the document and state clearly exactly how he relied on it and why. See In re Commitment of E.S.T., 371 N.J. Super. 562, 575 (App. Div. 2004) (noting "[i]t does not comport with fundamental fairness to have the opinions of the non-testifying experts bootstrapped into evidence through the testimony of the testifying experts without an opportunity for cross-examination of the underlying opinions").