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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

THE PEOPLE, Plaintiff and Respondent, v. VENUS DETRICE MOORE, Defendant and Appellant.	B272098 (Los Angeles County Super. Ct. No. NA051347)

APPEAL from an order of the Superior Court of Los Angeles County, Mark C. Kim, Judge. Affirmed.

Christopher L. Haberman, under appointment by the Court of Appeal, for Defendant and Appellant.

Xavier Becerra, Attorney General, Gerald A. Engler, Chief Assistant Attorney General, Lance E. Winters, Assistant Attorney General, Idan Ivri and Lindsay Boyd, Deputy Attorneys General, for Plaintiff and Respondent.

In January 2008, defendant Venus Detrice Moore was found not guilty by reason of insanity of a knife attack on her sister and was admitted to a state psychiatric hospital. In September 2012, defendant was found eligible for community outpatient treatment. In December 2015, defendant's outpatient status was revoked and she was returned to the state hospital.

Defendant appeals from the order revoking her outpatient status, asserting that the revocation hearing was not timely held and the revocation order was not supported by substantial evidence. We conclude that the trial court did not abuse its discretion in revoking defendant's outpatient status, and thus we affirm the revocation order.

FACTUAL AND PROCEDURAL BACKGROUND

I.

Background

Defendant has a lengthy documented history of tactile and visual hallucinations. On December 11, 2001, while experiencing a hallucination that caused her to believe she had been attacked by her sister, defendant entered her sister's residence, punched her sister in the face, and stabbed her sister with a kitchen knife while threatening to kill her. While her sister's boyfriend summoned the police, defendant shoved a towel into her sister's mouth, reportedly in an attempt to suffocate her. Defendant's sister survived the attack but suffered a punctured lung.

Immediately after the attack, defendant fled to Washington State, where she was admitted to a psychiatric hospital after having been found incompetent to stand trial for a separate assault. In February 2007, defendant was extradited to California to stand trial for the attack on her sister. Defendant was found not guilty by reason of insanity of violations of

Penal Code sections 245, subdivision (a)(1) (assault with a deadly weapon) and 12022.7, subdivision (a) (inflicting great bodily injury while committing or attempting a felony).[1]

In January 2008, defendant was admitted to the Department of State Hospitals (DSH) Patton, a forensic psychiatric hospital. She was transferred to DSH Metropolitan in January 2011.

In September 2012, defendant was found eligible to transition to a Forensic Conditional Release Program (CONREP) for community outpatient treatment. Initially, defendant was placed in a residential outpatient program; based on her progress there, defendant was transferred in December 2013 to a less restrictive outpatient setting through Gateways CONREP, through which she resided at a board-and-care facility and received treatment during program hours, typically 9:00 a.m. to 2:30 p.m.

II.

Request for Revocation of Outpatient Status

On November 13, 2015, defendant was rehospitalized at DSH Metropolitan. On December 7, 2015, the Gateways CONREP Community Program Director requested that the superior court revoke defendant's outpatient status. In relevant part, the request stated as follows:

"Throughout her time in outpatient treatment, Ms. Moore has presented with emotional dysregulation and maladaptive coping strategies, resistance to treatment and non-compliance with supervision, and ongoing interpersonal difficulties with a

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[1] All subsequent statutory references are to the Penal Code unless otherwise indicated.

multitude of others, including peers and staff. Ms. Moore has required a level of staff resources above that typically afforded a client in CONREP so as to contain her emotional instability, provide adequate supervision, and manage the fallout of her interpersonal conflicts. Yet, she has not shown that she has used these interventions to her own benefit; instead, her needs have only grown over time, as has her risk of dangerousness.

"On Thursday, November 12, 2015, the treatment team was informed that Ms. Moore had reportedly been provoking a peer and inciting other clients to ostracize said peer. . . . [¶] . . . [¶] [The next morning], a staffing was held with Ms. Moore. . . . [¶] . . . [¶] In the course of the special staffing, a number of Ms. Moore's incidents of non-compliance and withholding [of] information in the last few months were reviewed with her. It was apparent to the treatment team that Ms. Moore had not made progress in accepting responsibility for her actions or appreciating the seriousness and dangerousness of her behavior . . . . Instead, she was still splitting hairs, feigning confusion, and externalizing responsibility, all within a convoluted explanation that was difficult to follow.

"A final discussion point in the staffing were the reports of Ms. Moore's bullying of a peer and harassment based upon her peer's sexual orientation. Ms. Moore again denied having done anything wrong or having any ongoing turmoil with another peer, but her presentation was disingenuous and not credible given how this behavior was in line with a multitude of incidents in which Ms. Moore has harassed her peers over the years. Ms. Moore was informed that such harassment was not tolerated in the program and that it had created a dangerous environment, one in which her safety was being jeopardized as well; yet, she

gave no indication that she recognized the seriousness of this situation or her role in creating it. [¶] . . . [¶]

"Given the above, it is the opinion of Gateways CONREP that, at this time, Ms. Moore represents a danger to the health and safety of the community elevated above that which can be safely and effectively treated in community outpatient treatment. As such, we respectfully recommend that the court revoke Ms. Moore's outpatient status, pursuant to [section] 1608."

III.

Revocation Hearing

An outpatient revocation hearing was held in the superior court on March 3 and April 6, 2016. The evidence presented at the hearing was as follows.

A. Prosecution Evidence

Dr. Catherine Barrett is a licensed clinical forensic psychologist and was defendant's forensic clinician. She testified that defendant was conditionally released in September 2012 based upon the consensus of medical professionals that defendant had been able to work with her treatment team, responded well to medication, and did not appear to be a danger to the community while under supervision. Defendant's release was conditional upon her compliance with the terms and conditions of her release—i.e., working with her treatment team, disclosing who she was in contact with, participating in a 12-step program, submitting to regular urinalysis, getting along with peers, and remaining emotionally regulated. Defendant was advised of and agreed to the conditions of her release.

Dr. Barrett said defendant had been diagnosed with depression with psychotic features. However, shortly before her rehospitalization, defendant began to demonstrate memory

problems, confusion, and some obsessive-compulsive behaviors, and therefore her treatment team was considering having her reevaluated to be sure she had been correctly diagnosed. Dr. Barrett said that at present, the team was not certain of defendant's diagnosis: "We're not really sure whether we're dealing with just depression, whether we're dealing with [a] personality disorder, whether we're dealing with someone who has trauma." As a result, Dr. Barrett said, it was extremely difficult to safely manage defendant in an out-patient setting.

Dr. Barrett testified that during the 14 months she had supervised defendant's treatment, she observed a "sort of a roller coaster with [defendant] where at times when she was doing . . . really, really well, and other times where that would drop very quickly and there would be sort of this trajectory of self-sabotaging behavior and her mood would change and things like that. So it was sort of an up and down with her."

Dr. Barrett described five categories of conduct that precipitated the recommendation that defendant's outpatient status be revoked. First, defendant demonstrated difficulty with emotional regulation and stability, becoming "very focused on her physical health to the point where it bec[ame] an obsession and compulsion." Dr. Barrett said defendant frequently would call in sick due to physical preoccupations such as migraines, bunions, and urinary tract infections, to the point that much of her treatment with Dr. Barrett was crisis management. "She would call in sick quite a bit, wanting to stay home, wanting to sleep. Her migraines would get too bad, her feet hurt too much. And then when she did come in to program, she requested to see the nurse a lot." As a result, "it was really hard to do any sort of mental health treatment with her. We had very few sessions

that addressed the reasons she was in CONREP. Most of it was around damage control, managing anxiety." Dr. Barrett said defendant missed more sessions than most clients, and when she came in, she often complained that she was not feeling well and either was disruptive or did not engage with her treatment team.

Second, during the months prior to her rehospitalization, defendant exhibited increasing levels of anxiety. As an example, Dr. Barrett testified defendant had an extreme response to a bed bug issue at the board-and-care where she lived. Dr. Barrett said defendant raised the issue almost every day, did not want to have roommates, did not want certain people to walk into her room, engaged in "obsessive compulsive rituals around her bedroom," and showered and changed her clothes multiple times per day. An increase in defendant's medication did not relieve her anxiety. Defendant's anxiety was of concern to the treatment staff because "[it] was obviously causing a lot of distress for [defendant]. She was having a hard time focusing. She was having a hard time managing just her daily living." Further, anxiety historically had been a precursor to defendant "becoming symptomatic and decompensating," and defendant had exhibited paranoia and anxiety before the attack on her sister. Accordingly, prior to rehospitalizing defendant, CONREP had moved defendant from an intermediate to an intensive level of care in order to provide her with additional treatment.

Third, defendant had a number of undisclosed contacts with people not approved by her therapists, in violation of the terms of her release. Dr. Barrett gave two examples. In 2014, someone posing as defendant's brother called to ask whether defendant was at the program. Dr. Barrett met with defendant, who admitted the man was a friend of her former romantic

partner. Defendant said she and her former partner had had an abusive, tumultuous relationship. Defendant ultimately disclosed to Dr. Barrett that she had been speaking with her former partner every couple of months and had not disclosed this to her therapists. Then, in the spring or summer of 2015, defendant began speaking to a homeless man who was living outside one of the board-and-care facilities. Defendant disclosed the contact to Dr. Barrett, who told her she should not have further contact with the man. Defendant did not disclose any further contact, but in July 2015, Dr. Barrett discovered that the man was making sexual advances to defendant by text. When Dr. Barrett discussed the texts with defendant, she "sort of feigned this confusion, didn't understand why this would be a risk, that she had told me about this individual and that she had thought that I had known that there was ongoing communication." This undisclosed contact concerned defendant's treatment team because "[w]e want to make sure that [each of defendant's contacts] is a safe contact. We want to make sure that it isn't anybody who is going to be destabilizing." Dr. Barrett explained that "it [is] really difficult to manage someone in the community when they are not being forthcoming about their whereabouts, who they are talking to, things like that."

Fourth, Dr. Barrett said that defendant failed to comply with several of the terms of her outpatient status. For example, immediately before defendant was rehospitalized, another client said she had seen defendant asking for money and selling cell phones. When defendant was asked about this, she appeared confused, but she did admit to asking fellow residents for bus money and having multiple cell phones, which she had not disclosed to the treatment team.

Fifth, Dr. Barrett testified that immediately before defendant's rehospitalization, the treatment team had become aware of several incidents in which defendant had bullied other patients, including three of her roommates. According to the reports of other patients, defendant told one roommate she smelled like urine, and told another she was going bald. She called another patient "a homosexual," which was upsetting to the patient. Dr. Barrett said these incidents were problematic because the individuals participating in the program were emotionally and psychiatrically fragile and could destabilize quickly. As a result, conduct that increased a patient's stress level increased the risk for violence within the program.

Dr. Barrett characterized the reports of bullying as the "tipping point" in the decision to rehospitalize defendant: "If you look at [defendant's] trajectory while she was at Patton State Hospital, . . . when she becomes stressed and anxious and paranoid, she tends to become verbally and physically aggressive. So sometimes it will start with just verbal assaults. Saying things to peers, threatening them, saying things that are degrading, demoralizing. And then oftentimes, like I was mentioning, you have clients who are emotionally fragile, psychiatrically fragile. If they react to that, then we have an increase in danger and risk right within our own program. [¶] So what we were noticing was, as she was starting to feel as though her needs were not getting met, her anxiety was heightening. We're also starting to see some of these clients come forward and say 'I was – I was a victim of her bullying. . . .' Three of them were her roommates. And within, I think, a four month span, she had been through four – four roommates at least." After her outpatient status was revoked in November

2015, defendant was sent to DSH Metropolitan. The treatment team there told Dr. Barrett that defendant initially did well, but then started to show more anxiety and agitation. Subsequently, she threw feces at a staff member because she believed that her needs were not being met.

B. Defense Evidence

Katherine Mason testified that she had known defendant since she began volunteering at the Hollywood Community Housing Corporation in March 2014. Mason said defendant's job performance was excellent, and that defendant treated Hollywood Community Housing's clients with dignity and respect. When a group of individuals appealed the City Council's decision to allow Hollywood Community Housing to build affordable housing, defendant came and spoke to the City Council; defendant was both eloquent and poised. Mason did not observe any deterioration in defendant's level of functioning during the time she volunteered at Hollywood Community Housing.

Janell Moore (Janell), defendant's sister, testified that she had had regular communication with each of defendant's doctors, with the exception of Dr. Barrett, during the three years defendant had been with CONREP. She had only one telephone conversation with Dr. Barrett, after she learned defendant had been rehospitalized. When Janell asked whether defendant was decompensating or having a mental breakdown, Dr. Barrett said no, it was a "personality issue." When Janell pressed, Dr. Barrett hung up on her.

Janell said that when defendant initially was hospitalized, her family "was onboard. She needed to be where she was. And upon arriving at Metro Hospital, she was on an upward

trajectory mentally from being released into CONREP and from going within CONREP from the most intensive care and graduating up this social ladder . . . to where she only needed to check in a couple of times a week. There was nothing to indicate that this upward trajectory was stopping or that she was mentally deteriorating. [¶] The yearly progress reports written by Dr. Barrett as recently as September 2015, and the other doctors prior to that, also noted that this was an upward trajectory." These reports were consistent with what Janell observed during weekly visits with her sister. Janell believed her sister's rehospitalization was unjustified: "There was nothing, in my opinion, to account for whatever sudden decline is being claimed . . . . [¶] . . . [¶] My sister is not perfect, but her mental state at this moment as has been reflected in the medical reports written by her counseling team do not substantiate her needing to be in Metropolitan State Hospital at this time. There is nothing that she actually did within the community to have her community status revoked."

Defendant testified that she never called another individual a homosexual and never asked for money on the street. She said she did ask another individual at the board-and-care for bus tokens because she had been denied additional bus tokens by her resource social worker. Defendant admitted she had three cell phones in her possession, but denied ever selling a phone. Defendant said both the program and the board-and-care had each of her cell phone numbers.

Defendant said she was required to attend two or three Narcotics Anonymous/Alcoholics Anonymous (NA/AA) meetings a week; she generally attended eight to ten. She was required to drug test regularly and never had a dirty test. She was in

regular contact with her NA sponsor. She never missed a counseling session; if she had, she would immediately have been rehospitalized.

Defendant said she did not have a great relationship with Dr. Barrett, but was always honest and forthcoming with her. Defendant does not believe she was decompensating in any manner. She experienced a lot of anxiety about the bed bugs, which were a problem at each of the outpatient facilities where she lived. Defendant agreed she had had three different roommates at her last placement, but said two of the three had had their outpatient status revoked. She also agreed she had a friendship with a homeless man, but said Dr. Barrett had never instructed her to stop communicating with him.

Defendant agreed that she had thrown feces at someone after she was rehospitalized. She said her action was unacceptable and degrading.

Defendant addressed the court with regard to CONREP as follows: "I love CONREP for what it did for me, the learning experiences I had. I don't appreciate the bed bugs. But overall, sometimes we are placed in places to learn things, and I always keep an open mind about learning. I have grown [out of] being . . . in CONREP. I got to work for awesome volunteer places. . . . I got to spend time with my family. . . .

". . . I want to grow. I don't lie. And for those things that were said by Dr. Barrett, she would never have known about them if I wasn't forthcoming [about] telling her about those things."

C. Trial Court's Findings

At the conclusion of the hearing, the court sustained the revocation of defendant's outpatient status. It explained as follows:

"Whether [defendant] is housed at outpatient treatment facility or at [DSH Metropolitan], the purpose of her being there is so that she could get treatment. In order to be placed in an outpatient facility, she has to demonstrate that she can be responsible and she [can] follow orders. [¶] In this instance, Dr. Barrett testified that . . . based on a number of factors she was not able to follow orders and that she had a pattern of misbehaving. That includes testimony about going through numerous roommates because she couldn't get along with them, allegation[s] of compulsive behavior relating to bed bugs, allegation[s] of owning multiple phones, and so forth.

"But there [are] two things that the court will consider that [are] really important in this case. One is, only one expert testified in this case. That is, Dr. Barrett is the one that has training, expertise in this field. She testified that Ms. Moore should not be in an outpatient status. And then all of her testimony was corroborated by what happened once she was placed at D.S.H., and that is, even though that did not happen until her outpatient status was revoked, it is an important consideration because it just corroborates Dr. Barrett's finding that she . . . is unable to follow orders and that she does present a danger. [¶] It is not normal for somebody to throw feces at people, especially at staff members. That clearly indicates to me that the order to revoke her outpatient status had grounds. And therefore, I will sustain that revocation."

Defendant timely appealed from the April 6, 2016 revocation order.

DISCUSSION

I.

The Revocation of Defendant's Outpatient Status Was Supported by Substantial Evidence

A. Statutory Overview: Not Guilty by Reason of Insanity Plea, State Hospital Commitment, and Conditional Release to Outpatient Status

" 'Insanity, under California law, means that at the time the offense was committed, the defendant was incapable of knowing or understanding the nature of his act or of distinguishing right from wrong. [Citations.]'. . . .

"If the jury finds the defendant was insane at the time of the offense, the trial court shall commit the defendant to a state hospital or other appropriate public or private facility for the care and treatment of the mentally disordered, or place the defendant on outpatient status pursuant to section 1600 et seq. [Citations.] Upon a commitment to a state hospital, the medical director of the facility submits semiannual reports to the court as to the person's status and progress. [Citation.] [¶] . . . [¶]

"A successful insanity plea relieves the defendant of all criminal responsibility. [Citation.] The commitment of the defendant to a state hospital 'is in lieu of criminal punishment and is for the purpose of treatment, not punishment. [Citation.]' [Citation.] 'The purpose of committing an insanity acquittee is two-fold: to treat his mental illness and to protect him and society from his potential dangerousness. [Citation.]' [Citation.]" (*People v. Dobson* (2008) 161 Cal.App.4th 1422, 1431–1432.)

A defendant committed to a state hospital or treatment facility after having been found not guilty by reason of insanity may be placed on outpatient status subject to the procedures of section 1600 et seq. Those sections provide that if the director of the treatment facility to which the defendant has been committed recommends that the defendant be placed on outpatient status, the community program director shall submit to the court a recommendation regarding defendant's eligibility for outpatient status and the recommended plan for outpatient supervision and treatment. The plan shall set forth specific terms and conditions to be followed during outpatient status. (§ 1604, subds. (a)–(c).)

Upon receiving the community program director's report, the court shall calendar the matter for a hearing, at which time "[t]he court shall . . . either approve or disapprove the recommendation for outpatient status. If the approval of the court is given, the defendant shall be placed on outpatient status subject to the terms and conditions specified in the supervision and treatment plan." (§ 1604, subd. (d).)

Outpatient status "shall be for a period not to exceed one year. At the end of the period of outpatient status approved by the court, the court shall, after actual notice to the prosecutor, the defense counsel, and the community program director, and after a hearing in court, either discharge the person from commitment under appropriate provisions of the law, order the person confined to a treatment facility, or renew its approval of outpatient status." (§ 1606.)

B. Standards Governing Revocation of Outpatient Status

If the treatment supervisor of a person granted outpatient status believes that he or she either (1) requires extended inpatient treatment, or (2) refuses to accept further outpatient treatment and supervision, the community program director shall inform the court and request revocation of outpatient status. Thereafter, the court "shall hold a hearing and shall either approve or disapprove the request for revocation of outpatient status." (§ 1608; see also *People v. DeGuzman* (1995) 33 Cal.App.4th 414, 419.) The People bear the burden of establishing the need for revocation by a preponderance of the evidence. (*DeGuzman*, at p. 419.)

" 'Outpatient status is not a privilege given the [offender] to finish out his sentence in a less restricted setting; rather it is a discretionary form of treatment to be ordered by the committing court only if the medical experts who plan and provide treatment conclude that such treatment would benefit the [offender] and cause no undue hazard to the community.' [Citation.]" (*People v. Sword* (1994) 29 Cal.App.4th 614, 620; see also *People v. Cross* (2005) 127 Cal.App.4th 63, 72 [same].)

An order denying outpatient status is reviewed for abuse of discretion. (*People v. McDonough* (2011) 196 Cal.App.4th 1472, 1489; *People v. Henderson* (1986) 187 Cal.App.3d 1263, 1267–1268 (*Henderson*).) "The abuse of discretion standard is not a unified standard; the deference it calls for varies according to the aspect of a trial court's ruling under review. The trial court's findings of fact are reviewed for substantial evidence, its conclusions of law are reviewed de novo, and its application of the law to the facts is reversible only if arbitrary and capricious." (*Haraguchi v. Superior Court* (2008) 43 Cal.4th 706, 711–712,

fns. omitted.) Because defendant challenges the sufficiency of the evidence to support revocation, our review is for substantial evidence.

C. The Trial Court Was Permitted to Consider Evidence of Defendant's Behavior Both Before Her Outpatient Status Was Renewed and After She Was Rehospitalized

Defendant asserts that at an outpatient revocation hearing, only evidence related to changes in circumstances since the last outpatient status hearing should be admissible. She thus suggests that the court abused its discretion by considering evidence of her conduct before September 2015, when her outpatient status was renewed, and after November 2015, when she was rehospitalized.

We disagree. As the court noted in analogous circumstances in *Turner v. Superior Court* (2003) 105 Cal.App.4th 1046, 1058, a finding regarding a defendant's mental health at one point in time is not dispositive of his or her mental health at a subsequent point in time "because an individual's mental health and potential dangerousness can, and frequently does, change." (*Id.* at pp. 1058–1059.) Thus, "an adjudication of status or mental health issues is not conclusive as to the same status on a later date." (*Ibid.*)

Nor does the law prohibit a court from considering prior circumstances in light of subsequent events. To the contrary, a court considering revocation of outpatient status may consider a defendant's complete records. Thus, in *People v. McDonough*, *supra*, 196 Cal.App.4th 1472, the Court of Appeal rejected the defendant's contention that the trial court erred in admitting testimony about statements the defendant allegedly made to a

third party several years earlier. The court explained: "In determining whether outpatient status treatment is appropriate, the court considers the crime that resulted in the patient's commitment. [Citations.] The offense in this case occurred more than six years *before* the alleged 'stale' statements were made. In deciding whether a hospitalized patient should be granted outpatient status (and on what conditions), the court must take into consideration the patient's underlying offense and the progress made throughout the hospitalization. The fact that appellant may or may not have suffered delusions three years before the outpatient hearing is no less relevant than the fact that she suffered delusions 10 years before the hearing when, as a result of those delusions, she committed the acts that resulted in her commitment. By all accounts the [at-issue statements to a third party] were made years before the director of the state hospital and CONREP found appellant . . . had reached the point in her treatment where she should leave the hospital and rejoin society through outpatient treatment. But again, that goes to the weight to be given the evidence, not its admissibility." (*Id*. at p. 1489.)

Accordingly, the trial court did not err in considering defendant's conduct before the September 2015 hearing in light of her conduct after that hearing.

The trial court similarly did not err in considering defendant's conduct after she was rehospitalized in November 2015. As the court observed in *People v. Sword*, *supra*, 29 Cal.App.4th at p. 635, 636, italics added, "Issues which relate to the questions of whether defendant continues to have a mental illness, and whether defendant continues to be dangerous, can only be fully explored if the trial court is presented with

defendant's *complete* medical records." To the extent that defendant's conduct, as described in those records, reflects on her mental status, such conduct is relevant and was properly considered by the trial court.

D. The Trial Court Did Not Err in Permitting Dr. Barrett to Testify About Hearsay Statements Made to Her by Other Patients

Defendant contends that the trial court violated her right to confront and cross-examine witnesses when it allowed Dr. Barrett to testify to "case-specific facts beyond her personal knowledge"—namely, that defendant called one patient a homosexual, told another she smelled like urine, and told another that she was bald—in violation of *People v. Sanchez* (2016) 63 Cal.4th 665 (*Sanchez*). For the reasons that follow, we disagree.

"[R]eliable hearsay evidence may properly be considered in outpatient status hearings, just as it is in parole revocation proceedings. [¶] ' "[T]he revocation of parole is not part of a criminal prosecution and thus the full panoply of rights due a defendant in such a proceeding does not apply to parole revocations." [Citation.] Despite the relaxed rules of evidence governing probation revocation proceedings, a court is not permitted " 'to admit unsubstantiated or unreliable evidence as substantive evidence . . . .' " [Citations.] [¶] As long as hearsay testimony bears a substantial degree of trustworthiness it may legitimately be used at a probation revocation proceeding. [Citations.] In general, the court will find hearsay evidence trustworthy when there are sufficient "indicia of reliability." [Citation.] Such a determination rests within the discretion of the trial court and will not be disturbed on appeal absent an

abuse of discretion.' (*People v. Brown* (1989) 215 Cal.App.3d 452, 454–455.)" (*People v. Sword*, *supra*, 29 Cal.App.4th at p. 635.)

Applying these standards, the Court of Appeal in *People v. Sword*, *supra*, 29 Cal.App.4th 614 held that the trial court did not abuse its discretion in admitting defendant's hospital records at an outpatient status hearing, even though those records described hearsay conversations with third parties. The court explained: "Issues which relate to the questions of whether defendant continues to have a mental illness, and whether defendant continues to be dangerous, can only be fully explored if the trial court is presented with defendant's complete medical records. Even if such records were not technically within the business records exception or state of mind exceptions to the hearsay rule, they are usable at an outpatient status hearing if the trial court finds that they are reliable. Here, the notes of the [psychiatric hospital] staff were reliable because they were contemporaneous records kept by the staff in the regular performance of their duties. . . .

"Under the outpatient status procedure, the state hospital and the community program director must submit to the court an evaluation and recommendation for the treatment of the defendant on outpatient status, and the trial court must evaluate the recommendation in order to approve or disapprove it. (§§ 1602, 1604.) In order to carry out its function, we think the trial court must have available any and all reliable information that the hospital possesses relating to the patient. While some of the material is hearsay, the trial court's use of the notes to evaluate the recommendation given to it is necessary and proper, just as it is in a probation or parole revocation hearing." (*People v. Sword*, *supra*, 29 Cal.App.4th at pp. 635–636.)

Applying the principles articulated in *Sword* to the present case, we conclude that Dr. Barrett's testimony about her conversations with other patients—although hearsay—was admissible. Dr. Barrett had been treating defendant for fourteen months prior to her rehospitalization, and thus she was well equipped to evaluate the likely veracity of the reports of defendant's behavior made by other patients. Indeed, Dr. Barrett testified that she credited the reports, at least in part, because they were consistent with defendant's past conduct: "If you look at Ms. Moore's trajectory while she was at Patton State Hospital . . . when she becomes stressed and anxious and paranoid, she tends to become verbally and physically aggressive. [S]ometimes it will start with just verbal assaults. Saying things to peers, threatening them, saying things that are degrading, demoralizing. . . . [¶] So what we were noticing was, as she was starting to feel as though her needs were not getting met, her anxiety was heightening. We're also starting to see some of these clients come forward and say, 'I was . . . a victim of her bullying.' "

Further, the reports from other patients were consistent with one another. According to Dr. Barrett, three of defendant's recent roommates had reported bullying behavior by defendant.

Under these circumstances, therefore, Dr. Barrett's testimony regarding her conversations with other patients was admissible at defendant's outpatient revocation hearing.

E. Dr. Barrett's Testimony Was Substantial Evidence That Defendant Required Extended Inpatient Treatment

Defendant asserts that the decision to revoke her outpatient status was based entirely on "uncorroborated" reports

of other patients, which she claims do not rise to the level of substantial evidence. According to defendant, "no context or details were provided, including when [the alleged incidents] occurred. Under these circumstances, uncorroborated reports by other patients in the program can hardly be considered reasonable, credible, and of solid value."

As discussed in the prior section, we believe that the reports of other patients, although uncorroborated, were relevant to the issue before the trial court and were properly credited. But even were we to conclude otherwise, we still would find that the decision to revoke defendant's outpatient status was supported by substantial evidence. Indeed, most of the behavior Dr. Barrett said she relied on in deciding to rehospitalize defendant—namely, defendant's difficulty regulating her emotions, her increasing anxiety, and her unwillingness to follow the conditions of her release—was not based on the reports of other patients, but rather was behavior that Dr. Barrett herself observed. That evidence included the following:

Difficulty with emotional regulation: Dr. Barrett testified that in outpatient treatment, defendant demonstrated difficulty with emotional regulation, as evidenced by defendant's increasing preoccupation with her physical health. This preoccupation with physical health "bec[ame] an obsession and compulsion." As such, it interfered with defendant's treatment: Dr. Barrett said defendant missed more sessions than most patients due to illness, and when she came in, she often complained that she was not feeling well and thus did not engage with the group. As a result, much of defendant's treatment became what Dr. Barrett characterized as crisis management, rather than productive mental health treatment.

Increasing anxiety: Dr. Barrett testified that defendant exhibited increasing anxiety while in outpatient treatment, as demonstrated by her extreme response to the presence of bed bugs at her board-and-care facility. Defendant's anxiety did not respond to medication, and it was of great concern to the treatment staff because anxiety historically had been a precursor to defendant decompensating.

Failure to follow the terms of her conditional release: Dr. Barrett testified that in the months leading up to her rehospitalization, defendant exhibited an increasing unwillingness or inability to comply with the terms of her conditional release. Dr. Barrett gave several examples of defendant's noncompliance, including having undisclosed contacts with people not approved by her treatment team, asking for money, and having undisclosed cell phones. Dr. Barrett testified that this behavior was of concern to defendant's treatment team because "it [is] really difficult to manage someone in the community when they are not being forthcoming about their whereabouts, who they are talking to, things like that."

Defendant also suggests that even if the events described by Dr. Barrett occurred, "they are not probative on the issue of whether the appellant was amenable to treatment in the outpatient setting." We do not agree. Dr. Barrett testified that being treated on an outpatient basis caused defendant to experience increasing anxiety and emotional dysregulation, which "was obviously causing a lot of distress for [defendant]." Further, Dr. Barrett said that defendant's emotional dysregulation was causing her to behave in ways that were problematic for other patients and destabilizing for the program

in general. Both of these factors—the effect that the outpatient setting was having on defendant's mental health, and the effect of defendant's behavior on the mental health of others—are highly relevant to defendant's amenability to treatment in the outpatient setting.

III.
The Timing of Defendant's Revocation Hearing Was Consistent with Her Right to Due Process

Defendant urges finally that even if her revocation was supported by substantial evidence, her right to due process was violated because her revocation hearing was not timely held. Specifically, she contends that CONREP did not request revocation of her outpatient status within a reasonable time after she was rehospitalized, and the trial court did not hold a hearing within the time required by statute. Defendant therefore requests that we reverse the trial court's order revoking her outpatient status and order her reinstated in a suitable outpatient program.

As we now discuss, defendant is correct that the revocation hearing was not held within the statutory timeframe. However, because the statutory provisions are directory, not mandatory, and the untimely revocation hearing did not prejudice defendant, she is not entitled to have her outpatient status reinstated.

A. Defendant's Hearing Was Not Held Within the 15 Days Specified by Statute

Section 1608 provides that if a defendant's outpatient treatment supervisor believes the defendant requires extended inpatient treatment, the community program director "shall notify the superior court . . . of such opinion by means of a written

request for revocation of outpatient status." The court shall hold a revocation hearing "[w]ithin 15 judicial days" of the filing of the request for revocation. (§ 1608.)

Section 1610 provides that "[u]pon the filing of a request for revocation under Section 1608 . . . and pending the court's decision on revocation, the person subject to revocation may be confined in" an inpatient facility if it is the opinion of that director that the person will "be a danger to self or to another while on outpatient status and that to delay confinement until the revocation hearing would pose an imminent risk of harm to the person or to another." (§ 1610, subd. (a).)

In the present case, there is no dispute that defendant was rehospitalized on November 13, 2015; notice of revocation was provided to the court on December 7, 2015; a request for revocation of defendant's outpatient status was filed on January 15, 2016, and the court commenced the evidentiary hearing on March 3, 2016. Accordingly, defendant's hospitalization and revocation hearing violated the express terms of sections 1608 and 1610—that is, defendant was rehospitalized *prior to* the filing of the request for revocation, rather than "*[u]pon the filing of*" the request for revocation, and the revocation hearing was commenced more than 15 court days after the filing of the revocation request.

Having concluded that the timing of defendant's revocation hearing violated the terms of the statue, we now turn to the question of remedy.

B. People v. Lara

In *People v. Lara* (2010) 48 Cal.4th 216 (*Lara*), defendant Lara was found not guilty by reason of insanity and committed to a state psychiatric hospital. Less than 30 days before Lara's

scheduled release date, the People petitioned to extend Lara's commitment under section 1026.5, subdivision (b)(1). That section provided that Lara's commitment could be extended if a court found him to represent a substantial danger of physical harm to others due to a mental disease, defect, or disorder, but required that a petition to extend the commitment be filed at least 90 days before the commitment was set to expire in the absence of good cause. (*Lara*, *supra*, at p. 222.)

Lara's counsel moved to dismiss the petition because it was not timely filed. The prosecutor conceded that the delay was not excused by good cause, but nonetheless opposed the motion. The trial court denied the dismissal motion; subsequently, almost seven months after Lara's original commitment ended, a jury found Lara represented a danger of harm to others, and the trial court extended his commitment for two years. (*Lara*, *supra*, 48 Cal.4th at pp. 222–223.) Lara appealed, and the Court of Appeal directed the trial court to grant Lara's motion to dismiss because it concluded that the untimely extension proceedings had denied him due process.

The Supreme Court granted review and reversed the judgment of the Court of Appeal. (*Lara*, *supra*, 48 Cal.4th at pp. 223–224.) The court began by rejecting Lara's contention that the statutory deadline was mandatory and thus that the People's failure to comply with the statute denied the trial court jurisdiction to extend Lara's commitment. The court explained: "Whether the failure to follow a statute makes subsequent action void or merely voidable ' "has been characterized as a question of whether the statute should be accorded 'mandatory' or 'directory' effect. If the failure is determined to have an invalidating effect, the statute is said to be mandatory; if the failure is determined

not to invalidate subsequent action, the statute is said to be directory." ' " (*Id.* at p. 225.) In the case before it, although section 1026.5 used the term "shall" to describe statutory time limits (i.e., "[t]he petition *shall* be filed no later than 90 days before the expiration of the original commitment"], the court held that the Legislature's omission of a penalty for noncompliance with the statutory procedures suggested that the timing requirements were "directory" (nonjurisdictional) rather than "mandatory" (jurisdictional). It explained: "Section 1026.5 does not say that [an extension] trial is precluded if the statutory time limits are not met. Indeed, the statute itself provides that the time limits are not binding if good cause is shown for not having met them, and also provides that a defendant may waive time to allow proceedings beyond the timeframes set out." (*Lara*, *supra*, at p. 227.) Further, the court said, finding the filing deadlines to be mandatory would mean that a court faced with a missed filing deadline would be powerless to extend treatment under the statute no matter how great the defendant's need or the danger release might pose to the public. Such an interpretation "would run counter to the very purposes of the [not guilty by reason of insanity] statutes and the provision for extension of commitment" and "would elevate the secondary benefit to the defendant derived from the time limit over the fundamental purposes of the NGI provisions, to ensure that needed treatment is provided and the public protected." (*Id.* at p. 228.)[2]

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[2] The *Lara* court also noted that section 1026.5 expressly provided that " '[t]he time limits *of this section* are not jurisdictional.' " (*Lara*, *supra*, 48 Cal.4th at p. 225.) However, in *People v. Cobb* (2010) 48 Cal.4th 243, decided the following day, the court noted that section 2972, subdivision (a) did not contain

Having concluded that a failure to comply with section 1026.5's time limits did not deprive the trial court of "fundamental jurisdiction," the court then considered the question of remedy. It explained that if a petition is filed too late to allow the defendant a reasonable time for trial preparation or if the balance of the equities otherwise so requires, a defendant should be released pending trial on the extension petition if he or she so moves. However, if defendant does not suffer any prejudice from the delay, "*no remedial action* need be taken." (*People v. Lara*, *supra*, 48 Cal.4th at p. 235, italics added.) Likewise, "if the defendant does not object, waives time, or consents to a trial date beyond the expiration of the commitment, the defendant may remain confined and the court may go forward with trial on the petition." (*Ibid.*)

Applying these standards to the case before it, the court concluded that Lara was not entitled to any relief. It explained: "In the future, those in defendant's circumstances [i.e., defendants who do not have adequate time to prepare for trial before the expiration of their current terms of commitment] will be entitled to release at the end of their then current terms . . .

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comparable language, but that the absence of such language was not dispositive. It explained: "One of the grounds for our conclusion [in *Lara*] was that section 1026.5, subdivision (a)(2) expressly states the time limits set out in that section 'are not jurisdictional.' The statute setting out the time limit for commencing a [mentally disordered offender] recommitment trial does not have a similar disclaimer. (See § 2972.) However, this difference does not necessarily indicate the Legislature intended this deadline to be mandatory. *Unless the Legislature clearly expresses a contrary intent, time limits are typically deemed directory*." (*People v. Cobb*, *supra*, at p. 249, italics added.)

pending trial on their extension petitions. *However, no relief is appropriate in this case*. The court retained jurisdiction to try the petition. The trial, while untimely, was ultimately fair. Therefore, violation of the statutory timelines does not warrant reversal." (*Lara*, *supra*, 48 Cal.4th at p. 236, italics added, fns. omitted.)

C. The Statutory Violation Does Not Entitle Defendant to Have Her Outpatient Status Restored

Applying the Supreme Court's analysis in *Lara* to the present case, we conclude that the statutory violations present here do not entitle defendant to release from inpatient confinement.

First, we conclude that as in *Lara*, the statutory deadlines relevant here are directory, not mandatory. Although section 1608 directs that the court "shall" hold a hearing within 15 days of filing a revocation request, there is no statutory penalty for noncompliance. (§ 1608.)

Second, as in *Lara*, the purposes of the statute would be defeated by holding the time limit to be mandatory. Indeed, such an interpretation of the statute would mean that a court would be powerless to order inpatient treatment, even if it were necessary to safeguard the defendant or members of the public. (See *Lara*, *supra*, 48 Cal.4th at p. 250.)

Third, the People's failure to comply with the statutory timeframes did not prejudice defendant. Defendant urges that she suffered prejudice because after being rehospitalized, she "refused to participate with CONREP representatives, presumably from a lack of trust." But that asserted prejudice flowed from defendant's rehospitalization, *not* the People's failure

to comply with the statutory timeframes, and thus is not relevant to our analysis.

Finally, as in *Lara*, defendant did not object in the trial court to the People's failure to follow the statutory timeframes. Accordingly, as in *Lara*, there was no legal barrier to defendant's confinement.

DISPOSITION

The order revoking defendant's outpatient status pursuant to section 1608 is affirmed.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

EDMON, P. J.

We concur:

LAVIN, J.

DHANIDINA, J.*

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* Judge of the Los Angeles Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.