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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION THREE

THE PEOPLE, Plaintiff and Respondent, v. TIMOTHY B. MCWHORTER, Defendant and Appellant.	A104036 (Contra Costa County Super. Ct. No. 942077-9)

Timothy B. McWhorter appeals from an order revoking his outpatient status. He contends that he was denied his constitutional right to due process because the trial court fundamentally misunderstood the nature of the proceeding to revoke his outpatient status under Penal Code section 1608,[1] and erroneously applied the different standards and burdens of proof applicable to a proceeding on a request for release under section 1026.2. In the alternative, he argues that even if the trial court applied the proper standards in making its determination under section 1608, its decision should be reversed because it relied on wrongly admitted hearsay evidence. We affirm the trial court's order.

FACTUAL AND PROCEDURAL BACKGROUND

By information filed November 22, 1994, appellant was charged with assault with a deadly weapon (§ 245, subd. (a)(1)), with enhancing allegations that he had suffered three prior strike convictions (§ 667, subd. (d), (e)), three prior serious felony

[1] Unless otherwise indicated, all further statutory references are to the Penal Code.

convictions (§§ 667, subd. (a), 1192.7, subd. (c)), had served two prior prison terms (§ 667.5, subd. (b)), and was ineligible for probation (§ 1203, subd. (e)(4).). On May 12, 1995, appellant withdrew his original plea of not guilty and entered a plea of not guilty by reason of insanity. Based on the submissions, the trial court found appellant not guilty by reason of insanity, and ordered that he be referred for evaluation and a recommendation as to treatment. On June 9, 1995, the trial court ordered appellant committed to the state hospital system for a maximum term of 25 years to life plus 16 years.

On May 1, 2001, appellant filed a motion and petition in propria persona requesting transfer to an outpatient treatment facility, pursuant to sections 1026 and 1026.2. On May 6, 2002, and without objection by the People, the trial court granted appellant's petition for transfer to outpatient treatment. By orders filed on June 5 and June 10, 2002, the trial court directed that appellant be placed in outpatient treatment under the supervision of the Contra Costa Conditional Release Program (the Conditional Release Program),[2] as soon as "a suitable placement" could be arranged. However, on June 14, 2002, Health Services sent the trial court a written request for revocation of appellant's outpatient status pursuant to sections 1608 and 1609. On August 27, 2002, after the district attorney declined to pursue the incident that led to the request for revocation of outpatient status, the trial court denied the request without prejudice.

Sometime in late October, appellant was sent back to Napa State Hospital, based on perceived threats he had made to treatment staff, pending resolution of a written request by the outpatient treatment facility that the trial court revoke appellant's outpatient status. The request stated that appellant "appears to require more intensive treatment than [the outpatient facility] can provide and it does not seem prudent to risk reoffense by maintaining him in the community at the present time. In view of the above, it is apparent [appellant] can no longer be safely or effectively

[2] The Conditional Release Program is part of the Contra Costa Health Services Department (Health Services), Mental Health Division.

treated in an outpatient setting. We strongly recommend revocation of his outpatient status until he can be treated sufficiently to ensure a safe return to the community."

On November 13, 2002, Health Services again requested that the trial court revoke appellant's outpatient status pursuant to section 1608, based on appellant's "threatening behavior" at the outpatient treatment facility and the "ongoing, serious concerns about [appellant]'s potential for danger in the community." Health Services specifically asked that a hearing be set within 15 days on its request for revocation. Appellant remained at Napa State Hospital.

On December 26, 2002, the parties, including appellant, met with the trial court. The history of appellant's case was reviewed, and argument was presented on the request to revoke his outpatient status. Defense counsel argued that appellant's diagnosis of antisocial personality disorder did not qualify as a mental illness for which he could continue to be confined. In response, the prosecutor argued that appellant suffered from a mental disease and had a documented history of violence justifying his confinement. After being informed that appellant had been returned to Napa State Hospital, the trial court took the matter of revocation of outpatient status under submission. On December 31, 2002, the trial court ordered the matter continued to February 2003 for an evidentiary hearing on whether appellant's outpatient status should be revoked on the grounds he suffered from an "antisocial personality disorder which might render him to be a danger to himself or to others." The court denied appellant's request for a release on his own recognizance, and directed him to be returned "forthwith" to Napa State Hospital.

The evidentiary hearing was not conducted until April 28, 2003. At a prehearing conference held several days previously to discuss the evidentiary hearing and appellant's request that he be permitted to waive a personal appearance, defense counsel told the trial court that the issues before it were (a) whether appellant had an antisocial personality disorder that was "sufficient to keep him locked up" and thus justified his continued confinement ; and (b) "whether [appellant's] activities when he

was on outpatient were sufficient to have his outpatient status revoked." In this connection, defense counsel appeared to indicate to the court that appellant's outpatient status *had already been* "revoked" by the treatment facility to which he had been assigned, and that appellant then "went back" to the state hospital.[3] The trial court expressed some concern at the fact the petition to revoke appellant's outpatient status had been "filed quite some time ago," and inquired whether appellant was "just being housed [at Napa State Hospital] pending a hearing here or whether he was being actually treated." Defense counsel indicated that "they are not quite sure what to do with [appellant]." Defense counsel again indicated that, from his perspective, the issue before the court was whether appellant's condition could legally justify keeping him "locked up in a mental hospital," or whether "almost by operation of law" he had "to be released back to outpatient."

The evidentiary hearing commenced on April 28, 2003, and continued on June 13 and July 11, 2003. Appellant waived his right to be present, and was not at the hearing on any of these dates. Dr. Alexandra Cons, a clinical psychologist employed by the Conditional Release Program, testified on behalf of the People that she had done a three hour evaluation of appellant on October 24, 2002, soon after he had gone on outpatient status. Dr. Cons administered several psychological tests on appellant.

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[3] The following colloquy took place: "MR. CLARK [defense counsel]: . . . I think we've got a couple of issues to resolve, Judge. Number one, I think first and foremost is whether, in fact, [appellant] has an antisocial personality disorder. And then concomitant to that, is that sufficient to keep him locked up . . . .

"THE COURT: Yeah.

"MR. CLARK: Then secondarily -- and this actually may take a little more time because it will involve other witnesses -- the issue of whether his activities when he was on outpatient were sufficient to have his outpatient status revoked. [¶] To remind you what happened, [appellant] was placed on outpatient. He was put in a [treatment facility] in Stockton called Northstar. He had some problems with Northstar. They then revoked his outpatient status [¶] So I think --

"THE COURT: And he went back to the State Hospital.

"MR. CLARK: I'm sorry?

"THE COURT: And he went back to the State Hospital.

"MR. CLARK: Yes, sir."

She testified that appellant attempted "to present himself in sort of an overly virtuous way," and as "a victim of the system." He was "not exactly candid and forthcoming in how he presents himself," and "[t]here was no indication of a cooperative endeavor [on his part] in terms of [his] treatment."

Dr. Cons diagnosed appellant as suffering from a narcissistic personality disorder with tendencies to grandiosity and no real capacity for empathy with others; antisocial personality disorder; and polysubstance dependence in partial remission as long as he remained in an institutional setting. In Dr. Cons's opinion, appellant appeared to be a person who needed an external environment to exert the controls that he lacked internally. She concluded that he was "a fairly severe psychopath." Dr. Cons further testified that psychopathy was a very infrequent disorder; that psychopaths like appellant do *not* tend to become less dangerous with age; and that it was unlikely that appellant would grow out of his psychopathy. Moreover, because of his tendency to see himself as a victim of circumstances or of the system, appellant did not really acknowledge or accept the fact he suffered from substance abuse problems and mental illness. Unlike a simple diagnosis of antisocial personality disorder, appellant's identification as a psychopath was substantive evidence of a mental disorder or defect. Based on this diagnosis, and his history of aggressive behavior and serious conflicts with authority figures, Dr. Cons opined that appellant needed to be in an extremely supervised, secure setting, would not be able to manage successfully in anything but an inpatient program, and was "not ready to be treated in the community on outpatient status."

Patrick Dwyer, a mental health clinical specialist employed for 15 years by the Conditional Release Program, testified regarding a number of incidents that occurred while appellant was confined in a state hospital, and when he was on outpatient status. Dwyer had worked with appellant for approximately one year, both in the hospital and while he was in outpatient status, and had reviewed his conduct and behavior in the state hospital system and in the Conditional Release Program. In 1997, while confined

at a state hospital, appellant and another patient had beaten a psychiatrist "quite severely," resulting in his conviction of criminal charges arising therefrom. Appellant had tested positive for illegal drug use on several occasions, was caught at least twice with "pruno," and had bragged about using heroin, all while confined on inpatient status at state hospitals between 1996 and 2001. In an incident during group therapy while on placement at an outpatient treatment facility, appellant had justified his violent attack on the psychiatrist by claiming the doctor had "called him a con man"; and when the group facilitator asked what he would do if he called him a con man, dared him to "[t]ry it and see." On another occasion, appellant became agitated and loud, standing and waving his hands about and intimidating other group members, and making remarks that the facilitator viewed as a threat.[4]

Dwyer concurred in diagnosing appellant as suffering from a current antisocial personality disorder. The most recent reports from the state hospital where appellant was then confined showed that he had not met the first criteria for discharge—namely, an ability to take responsibility for his crimes or to demonstrate remorse—and showed no progress in substance abuse treatment or anger management. Based on appellant's history and behavior, diagnosed antisocial personality disorder with psychopathy, demonstrated impulsivity, lengthy history of drug abuse and continued drug abuse even while on inpatient status, sense of self-justification and denial, lack of insight, and failure to respond to or actively participate in treatment, Dwyer opined that there was only "an extremely low probability that [appellant] could succeed" in a community outpatient program, even if highly structured, and that he should instead remain in a state hospital on inpatient status.

Appellant offered two witnesses. Dr. Paul Good, a clinical and forensic psychologist, opined that appellant had "significant risk factors that make him dangerous," including an addictive dependency on drugs and poor anger control.

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[4] Dwyer testified that appellant told the facilitator: " 'And by the way, I'm a violent sleepwalker. So if you ever see me sleepwalking, don't touch me or I'll take your head off."

However, these were "partially mitigate[d]" by certain "protective factors" that reduced the likelihood of future violence, including appellant's "advanced age" (47), "average intelligence," "some interpersonal skills," "reasonably good work history," and "the fact that he comes from an intact family." Based on an interview with appellant and two tests he administered, a conversation he had with appellant's mother, and his review of written reports by others on appellant's condition, Dr. Good concluded that appellant did not meet the criteria for an antisocial personality disorder because he did not appear to have had a conduct disorder before the age of 15; and in any event, there is a tendency for persons to "outgrow their antisocial personality" after the age of 40. On the other hand, however, Dr. Good testified that appellant did qualify for diagnosis as a psychopathic personality, which he defined as "a malignant variant of antisocial personality in which a person has a cold, callous, nonempathic, parasitic aggressive streak in them that makes them do bad things." Dr. Good estimated that appellant had a 44 percent probability of engaging in a violent incident within seven years. He recommended that appellant be placed in an "intensive two-year residential drug treatment program and an ongoing anger management program."

Finally, the defense offered the testimony of Leo Archer, a Conditional Release Program patient assigned to the same outpatient treatment where appellant was placed between October and December 2002. Archer described the program as consisting of approximately 11 patients, all of whom lived in the same house and attended group therapy sessions together there. He testified that he was present at the group therapy sessions in which the incidents described by Dwyer had occurred. According to Archer, appellant was at most "being a smart aleck," and his behavior and statements were not actually threatening or intended as such.

In closing argument, the prosecutor argued the witnesses had established that appellant suffered from both antisocial personality disorder and psychopathy; and that as a result of these diagnoses, and his demonstrated propensity for violence, appellant should not be continued on outpatient status. In response, defense counsel argued that

the prosecution had not "met their burden here even of preponderance of the evidence" in establishing that appellant suffered from the kind of unmitigated serious mental disease or defect that required him to be committed to inpatient status; and he recommended that appellant be transferred to a different outpatient program, preferably in a different county. The trial court took the matter under submission.

On August 20, 2003, the trial court issued its decision. In reviewing the procedural posture of the case before it, the trial court framed it not as a proceeding on a petition for revocation of outpatient status, but instead as one on *appellant's* "petition requesting that he be released from the State Hospital."[5] The court concluded that "(1) The revocation of [appellant's] out-patient status was in all respects legal and proper. [¶] (2) There was good cause, therefore, to return [appellant] to the State Hospital. [¶] (3) While the exact diagnosis is not in all respects clear, nevertheless, it is the ruling of the Court that [appellant] is a danger to himself and others, that [appellant] is not at the present time an appropriate candidate for reinstatement and placement on the out-patient status under the Conditional Release Program, and he should, therefore, continue to be confined and undergo treatment in an appropriate facility in the California Department of Mental Health." The trial court further ordered that if there had been no change in appellant's placement after the second quarterly report in 2004, "then the case should be reviewed, if either counsel so requests."

This appeal timely followed.

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[5] The court stated as follows: "On May 12, 1995, [appellant] was found Not Guilty by Reason of Insanity for the crime of assault with a deadly weapon. Since that date, [appellant] has been continuously under the custody and control of the California Department of Mental Health, with the exception of a relatively brief period of time when he was released to the Conditional Release Program of the Contra Costa County Health Department. Shortly thereafter [appellant's] out-patient status was revoked and he was returned to the Napa State Hospital, where he is presently a patient. [¶] On December 31, 2002, [appellant] filed a petition requesting that he be released from the State Hospital. Numerous hearings were thereafter held with several witnesses being presented by each side."

DISCUSSION

Appellant urges that the trial court erroneously treated the extended hearing as though it was being held to determine whether he was suitable for conditional release to an outpatient program under section 1026.2, rather than being what in fact it was: a hearing held under section 1608 on the requests for revocation of appellant's outpatient status submitted by Health Services, the treatment facility to which he had been assigned, and the Conditional Release Program itself. In so doing, appellant argues, the trial court fundamentally misunderstood the nature of the outpatient revocation proceeding before it, and denied him his constitutional rights to due process as a result. We conclude on the basis of the record that, to the extent there was confusion on the part of the trial court and counsel about the precise nature of the proceeding, the trial court's decision upholding revocation of appellant's outpatient status was nonetheless made in accordance with the proper evidentiary standards and burdens of proof applicable under section 1608, and was supported by substantial evidence. There was consequently no prejudice to appellant.

At issue is the distinction between a proceeding on a request for *revocation* of outpatient status by a treatment supervisor, pursuant to section 1608, and one for conditional release and transfer *to* outpatient status under section 1026.2. Under section 1603, any person found not guilty by reason of insanity of a violent felony may be placed on outpatient status if the director of the state hospital or other treatment facility "advises the committing court that the defendant would no longer be a danger to the health and safety of others, including himself or herself, while under supervision and treatment in the community, and will benefit from that status"; and "[t]he community program director advises the court that the defendant will benefit from that status, and identifies an appropriate program of supervision and treatment." (§ 1603, subd. (a)(1), (2).) Section 1608 in turn provides for revocation of outpatient status upon the request of a community program director, based on the opinion of the outpatient treatment supervisor that the individual (1) requires extended inpatient

treatment or (2) refuses to accept further outpatient treatment and supervision, and a trial court decision approving revocation after a hearing to be held "[w]ithin 15 judicial days" of the request.[6]

"Like revocation of probation, revocation of outpatient status under [section 1608] does not deprive a person of absolute liberty but rather deprives him of a conditional liberty to which he is entitled only if he observes special restrictions. Although revocation of outpatient status requires due process, it is not part of a criminal prosecution requiring the higher standard of proof. [Citation.] If the outpatient community program director requests revocation of outpatient status under section 1608, the court must hold a de novo hearing which includes 'the constitutional requirements of confrontation, cross-examination, and a fact-finding hearing by a neutral body applying a preponderance of the evidence standard of proof.' [Citation.]" (*People v. DeGuzman* (1995) 33 Cal.App.4th 414, 419-420.)

In contrast, the ultimate focus of a proceeding under section 1026.2 for conditional release to outpatient status from inpatient confinement in a state hospital is the adjudication of the issue of restoration to sanity, usually upon the application for release of the concerned defendant who has been committed to a state hospital or other

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[6] Section 1608 provides in pertinent part: "If at any time during the outpatient period, the outpatient treatment supervisor is of the opinion that the person requires extended inpatient treatment or refuses to accept further outpatient treatment and supervision, the community program director shall notify the superior court . . . of such opinion by means of a written request for revocation of outpatient status. The community program director shall furnish a copy of this request to the defense counsel and to the prosecutor . . . .

"Within 15 judicial days, the court where the request was filed shall hold a hearing and shall either approve or disapprove the request for revocation of outpatient status. If the court approves the request for revocation, the court shall order that the person be confined in a state hospital or other treatment facility approved by the community program director."

We note that appellant does not raise the issue of the tardiness of the hearing on the request for revocation of his outpatient status, or otherwise contend that the trial court's decision upholding revocation of his outpatient status was vitiated or voided by the fact the hearing on the request was not held "[w]ithin 15 judicial days." That issue is therefore not before us.

treatment facility. (§ 1026.2, subd. (a).) As part of this procedure, section 1026.2 requires that a court hold a hearing at which the *applicant* bears the burden of showing, by a preponderance of the evidence, that he or she "will *not* be a danger to the health and safety of others, due to mental defect, disease, or disorder, if under supervision and treatment in the community." (§ 1062.2, subd. (e), (k), italics added; *People v. Sword* (1994) 29 Cal.App.4th 614, 621.) If the court determines that the applicant has successfully made this showing, it must order the applicant placed with a conditional release outpatient program for one year, at the end of which time a trial is held to determine if the applicant's sanity has been restored, defined as meaning that "the applicant is no longer a danger to the health and safety of others, due to mental defect, disease, or disorder." (§ 1062.2, subd. (e).)[7]

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[7] Section 1026.2 provides in pertinent part as follows: "(e) The court shall hold a hearing to determine whether the person applying for restoration of sanity would be a danger to the health and safety of others, due to mental defect, disease, or disorder, if under supervision and treatment in the community. If the court at the hearing determines the applicant will not be a danger to the health and safety of others, due to mental defect, disease, or disorder, while under supervision and treatment in the community, the court shall order the applicant placed with an appropriate forensic conditional release program for one year. All or a substantial portion of the program shall include outpatient supervision and treatment. The court shall retain jurisdiction. The court at the end of the one year, shall have a trial to determine if sanity has been restored, which means the applicant is no longer a danger to the health and safety of others, due to mental defect, disease, or disorder. The court shall not determine whether the applicant has been restored to sanity until the applicant has completed the one year in the appropriate forensic conditional release program, unless the community program director sooner makes a recommendation for restoration of sanity and unconditional release as described in subdivision (h). . . . [¶] . . . [¶]

"(h) If the court determines that the person should be transferred to an appropriate forensic conditional release program, the community program director or a designee shall make the necessary placement arrangements, and, within 21 days after receiving notice of the court finding, the person shall be placed in the community in accordance with the treatment and supervision plan, unless good cause for not doing so is made known to the court. . . .

"(i) If at the trial for restoration of sanity the court rules adversely to the applicant, the court may place the applicant on outpatient status, . . . unless the applicant does not meet all of the requirements of Section 1603.

Thus, a proceeding upon a request for revocation of outpatient status under section 1608 differs fundamentally from one upon an application pursuant to section 1026.2 for release from commitment upon restoration of sanity. In the former, the defendant may be *deprived of* a conditional liberty interest upon a showing by the prosecution that he or she requires extended inpatient treatment or refuses to accept further outpatient treatment and supervision; in the latter, the defendant may be *granted* a conditional liberty interest upon a showing by the applicant (usually the defendant him or herself) that the defendant will *not* be a danger to the health and safety of others, due to mental defect, disease, or disorder, if under outpatient supervision and treatment in the community.

The record shows a certain degree of confusion on the part of both court and counsel as to the nature of the proceeding before the trial court. Several months before the commencement of the hearing, the trial court specifically asked defense counsel to confirm that the matter before it was on a request for revocation of outpatient status. Although defense counsel did confirm this,[8] he then promptly attempted to steer the entire focus of the proceeding toward the contention that appellant was improperly diagnosed as having an antisocial personality disorder—and by extension, that he did not suffer from *any* mental defect, disease or disorder that would justify his continued inpatient confinement in the state hospital. In other words, defense counsel was essentially attempting to make the case required on an application for release from

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"(j) If the court denies the application to place the person in an appropriate forensic conditional release program or if restoration of sanity is denied, no new application may be filed by the person until one year has elapsed from the date of the denial.

"(k) In any hearing authorized by this section, the applicant shall have the burden of proof by a preponderance of the evidence."

[8] "THE COURT: Do I understand that what really is before the Court at this time is a request to revoke outpatient status?

"MR. CLARK [deputy public defender]: Yes.

"THE COURT: That's really what it amounts to.

"MR. CLARK: That's what it amounts to."

commitment upon the ground of restoration of sanity under section 1026.2. Later, at a brief hearing some days before the commencement of the evidentiary hearing, defense counsel "remind[ed]" the trial court that appellant had been placed on outpatient status at the Northstar facility, and that "[t]hey then revoked his outpatient status" and he was sent back to the state hospital when he had "some problems" there. The trial court continued to focus on the fact that the proceeding arose from a petition to revoke appellant's outpatient status. However, because of the fact that appellant had already been returned to Napa State Hospital after his brief conditional release on outpatient status, the entire posture of the proceeding was necessarily different from one in which the defendant was still conditionally released on outpatient status and not yet returned to the state hospital. Confusion was further encouraged by defense counsel's insistence that the proper issue before the court was whether appellant suffered from any diagnosed mental disease that would legally justify keeping him "locked up in a mental hospital" rather than being released "by operation of law."

At the extended hearing held on April 28, June 13 and July 11, 2003, the parties offered considerable evidence appropriate to a section 1026.2 proceeding on whether appellant represented a danger to the health and safety of others, based on their conflicting respective diagnoses of his mental condition. In offering this evidence, however, the focus of the People's case was clearly on demonstrating that appellant required extended inpatient treatment and supervision and could not benefit from less structured outpatient treatment. Contrary to appellant's assertions on this appeal, the prosecution's evidence and argument at the contested hearing was in complete accordance with the requirements under section 1608 for revocation of outpatient status. Thus, both of the People's expert witnesses specifically testified—based on appellant's diagnosed antisocial personality disorder and psychopathy, history and behavior during the period of his conditional release on outpatient status, continued drug abuse, and failure to respond to or actively participate in treatment—that appellant definitely required extended, highly structured inpatient treatment in a state

hospital, and would not benefit from outpatient treatment and supervision in the community. Even appellant's own expert witness confirmed that appellant qualified for diagnosis as a psychopath, and that his history and personality manifested "significant risk factors that make him dangerous," and that were only partially mitigated by such factors as his age and family history. Moreover, the record shows both parties and the trial court itself correctly placed the burden of proof on the *prosecution* to establish by a preponderance of the evidence that appellant's behavior and condition required his commitment to extended inpatient treatment. In sum, the record contains ample substantial evidence to support a decision under section 1608 revoking appellant's outpatient status. (Cf. *People v. DeGuzman, supra,* 33 Cal.App.4th at p. 420.)

Appellant contends that a contrary conclusion is compelled by the language of the trial court's decision, stating that revocation of appellant's outpatient status "*was* in all respects legal and proper," "[t]here *was* good cause . . . to return [appellant] to the State Hospital," appellant "is not at the present time an appropriate candidate for *reinstatement* and placement" on outpatient status, and that he should therefore "*continue*" to be confined in a state hospital. (Italics added.) We disagree. Read in context, it is clear from the trial court's decision it was simply ruling that the request for revocation of outpatient status was fully justified by the evidence that appellant was not benefiting from outpatient placement, and he needed to be returned to extended inpatient treatment. To the extent the trial court phrased its findings in the past tense, this was the understandable result of the factual context in which it was required to make its determination. Appellant was already residing at the state hospital following the *de facto* cancellation of his outpatient status, and pending the outcome of the evidentiary hearing. Regardless of the terminology employed by the trial court, the record clearly shows that it properly considered the relevant factors under section 1608 regarding appellant's requirements with respect to inpatient treatment versus outpatient placement.

Appellant nevertheless insists that the emphasis at the evidentiary hearing and in the trial court's decision on whether he presented a danger to the health and safety of himself and others was an irrelevant and improper criterion for revocation of outpatient status under section 1608, and was only relevant to a determination whether to release him from the state hospital because of restoration to sanity under section 1026.2. The contention is meritless. Appellant's level of dangerousness to himself and others was highly relevant to whether he should remain in outpatient status or instead be returned to the state hospital for extended inpatient treatment. Indeed, sections 1602 and 1603 specifically provide that a person found not guilty by reason of insanity—such as appellant—may only be placed on outpatient status if the director of the state hospital or other treatment facility to which the defendant has been committed informs the court that he or she will not pose a danger to the community. Although section 1608 does not *require* a finding that the defendant is a danger to the health and safety of others, neither does it *bar* a trial court from considering this factor in determining whether to revoke outpatient status. Indeed, in making its determination whether to return a defendant to extended inpatient treatment a trial court is fully justified in considering the possible danger to the public that might result from continuing the defendant in an outpatient placement. (*People v. DeGuzman, supra,* 33 Cal.App.4th at pp. 420-421; cf. *In re McPherson* (1985) 176 Cal.App.3d 332, 339-340 [in making determination on request for revocation under section 1608, trial court was not *required* to make finding that defendant was a danger to himself and others, but only that he required extended inpatient treatment or refused to accept further outpatient treatment and supervision].)[9] There was no error.

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[9] "DeGuzman also contends the trial court erred in basing revocation under section 1608 on concerns for public safety. Section 1608 requires a finding that the patient needs extended inpatient treatment or refuses to accept further outpatient treatment. It does not require the court to find that the patient is a danger to the health and safety of others. [¶] . . . [¶]

"If a court determines to return a patient to extended inpatient treatment because of a finding of a need for such treatment, we see no error or prejudice in the judge's also considering the possible danger to the public which might result from continued

Finally, appellant contends that the trial court's decision must be reversed because it was based on hearsay evidence. The contention is meritless. A witness testifying in the form of an opinion may state on direct examination the reasons for his or her opinion and the matter upon which the opinion is based, unless otherwise precluded by law from using such reasons or matter as the basis for the opinion. (Evid. Code, § 802.) Moreover, an expert witness may rely on competent hearsay as the basis for an opinion, so long as it is "of a type that reasonably may be relied upon by an expert in forming an opinion upon the subject to which his [or her] testimony relates." (Evid. Code, § 801, subd. (b); *People v. Arias* (1996) 13 Cal.4th 92, 184.) Thus, there is no error in permitting an expert to describe the basis for his or her opinion, even if it entails placing otherwise inadmissible hearsay on the record. (*People v. Gardeley* (1996) 14 Cal.4th 605, 617-619; *People v. Arias, supra,* 13 Cal.4th at p. 184.)[10]

Here, both of the People's expert witnesses had the opportunity to interact with and evaluate appellant personally. Dr. Cons testified that she had tested appellant with a battery of psychological evaluations, the results of which supported her diagnosis

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outpatient treatment. . . . A person such as DeGuzman who is found because of delusional tendencies to be a danger to the public rather obviously is in need of extended inpatient treatment. Consideration of public safety will always be, we believe, an integral part of placement or continuance of a patient in outpatient status. The court therefore did not err in considering the question of public safety when it decided to revoke DeGuzman's outpatient status." (*People v. DeGuzman, supra,* 33 Cal.App.4th at pp. 420-421, fn. omitted.)

[10] "Expert testimony may . . . be premised on material that is not admitted into evidence so long as it is material of a type that is reasonably relied upon by experts in the particular field in forming their opinions. [Citations.] . . . [¶] So long as [the] threshold requirement of reliability is satisfied, even matter that is ordinarily *inadmissible* can form the proper basis for an expert's opinion testimony. [Citations.] And because Evidence Code section 802 allows an expert witness to 'state on direct examination the reasons for his [or her] opinion and the matter . . . upon which it is based,' an expert witness whose opinion is based on such inadmissible matter can,

and conclusion that appellant was a psychopath in need of extended inpatient treatment. Dwyer testified that he had worked with appellant for at least a year, and was very familiar with his case history and record. This is not a case where the experts on whose testimony the trial court based its determination had no personal knowledge of the defendant's behavior, history and condition. (Cf. *In re McPherson, supra,* 176 Cal.App.3d at pp. 340-341 [outpatient revocation order reversed, where trial court wrongly failed to conduct de novo hearing and relied on hearsay testimony of doctor who had virtually no personal knowledge of defendant's behavior in applying abuse of discretion standard to outpatient supervisor's opinion regarding defendant's treatment needs].) Once again, there was no error.

DISPOSITION

The trial court's decision revoking appellant's outpatient status is affirmed.

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McGuiness, P.J.

We concur:

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Parrilli, J.

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Pollak, J.

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when testifying, describe the material that forms the basis of the opinion. [Citations.]" (*People v. Gardeley, supra,* 14 Cal.4th at pp. 618-619.)