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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION ONE

THE PEOPLE,

Plaintiff and Respondent,

v.

ABDUL HADI AWAD,

Defendant and Appellant.

A132533

(Napa County Super. Ct.
No. CR-120724)

Defendant Abdul Hadi Awad appeals an order following a jury trial, in which the trial court ordered a two-year extension of his involuntary commitment to Napa State Hospital pursuant to Penal Code section 1026.5, subdivision (b).¹ He contends there was a lack of substantial evidence to support the prerequisite finding that he represented a substantial danger of physical harm to others, or more specifically, that he had “serious difficulty controlling his dangerous behavior.” We affirm the judgment and the trial court’s order.

BACKGROUND

In January 2006, defendant was found not guilty by reason of insanity of assault with a deadly weapon (§ 245, subd. (a)(1)) arising from an incident where he attempted to commit suicide, and seriously injured a bystander, by driving his car into a gas pump and other vehicles at a gas station. Defendant was committed to Napa State Hospital (NSH) in February 2006, and was released on outpatient status in January 2007. The trial

¹ Further statutory references are to the Penal Code.

court revoked defendant's outpatient status at the request of the Napa County Conditional Release Program (CONREP), after his arrest in August 2007 for driving under the influence. We affirmed the revocation order in January 2008. (*People v. Awad* (Jan. 14, 2008, A119302) [nonpub. opn.])

Defendant was released on outpatient status a second time in April 2008, re-admitted to NSH the following June, released on outpatient status again in April 2009, but was again detained the following February at the request of Solano County CONREP. We affirmed the subsequent revocation order in July 2010. (*People v. Awad* (July 30, 2010, A128321) [nonpub. opn.])

In March 2011, the Napa County District Attorney filed a petition under section 1026.5, subdivision (b), to extend defendant's commitment to NSH, which was due to expire the following month. (See § 1026.5, subd. (b)(2).)

Two months later, in May 2011, the trial court—pursuant to an agreement between counsel—requested Solano County CONREP to prepare and submit a report concerning defendant's suitability for outpatient placement. That report, filed the next month, concluded defendant could not, at present, be “safely and effectively treated on an outpatient basis.”

The trial court held a jury trial to determine whether defendant was a person subject to recommitment under section 1026.5, subdivision (b)(1). (See § 1026.5, subd. (b)(4), (8).) The jury's verdict, entered June 28, 2011, found this to be true. On July 6, the trial court filed its order extending defendant's commitment to April 18, 2013. (See § 1026.5, subd. (b)(8).)

Defendant appeals that order. (See § 1237, subd. (b).)

DISCUSSION

“A person may be committed beyond the term prescribed by [section 1026.5] subdivision (a)[,] only . . . if [he or she] has been committed under Section 1026 for a felony and by reason of a mental disease, defect, or disorder represents a substantial danger of physical harm to others.” (§ 1026.5, subd. (b)(1).) To ensure this provision is consistent with constitutional due process, reviewing courts have construed it to require,

in addition, proof that the person’s mental disease, defect, or disorder causes “serious difficulty in controlling dangerous behavior.” (*People v. Galindo* (2006) 142 Cal.App.4th 531, 533 [applying the interpretation given an analogous provision in *In re Howard N.* (2005) 35 Cal.4th 117]; see also *People v. Zapisek* (2007) 147 Cal.App.4th 1151, 1165.)

The jury was properly instructed of the need to find, beyond a reasonable doubt, defendant suffered from a mental disease, defect, or disorder, as a result of which he not only “[p]osed a substantial danger of physical harm to others,” but also had “serious difficulty in controlling his dangerous behavior.” The signed verdict found true these requisite elements.

Defendant contends the evidence was insufficient for the jury to find he lacked “the volitional capacity to control violent behavior.” He reasons that, whereas some of the prosecution’s expert witnesses expressed their *conclusions* to this effect, the conclusions were not supported either by facts or reasoning. Defendant urges that such “conclusory” testimony is not sufficient to support the jury’s finding that he had “serious difficulty controlling his dangerous behavior.”

We review this claim to determine whether any rational trier of fact could have found true the essential elements of section 1026.5, subdivision (b)(1), beyond a reasonable doubt, viewing the evidence in the light most favorable to the order extending defendant’s commitment. (*People v. Zapisek, supra*, 147 Cal.App.4th at p. 1165.)

Dr. Nader Wassef and Dr. Carol Humphreys prepared and submitted to the court—in their capacity as defendant’s treating psychiatrist and psychologist at NSH—a report in which they endorsed the prosecution’s petition. In addition, at the outset of the proceeding, the trial court appointed two psychiatrists, Dr. Gregory Sokolov and Dr. Robbin Broadman, to prepare and submit evaluations and recommendations regarding an extension of defendant’s commitment. (See § 1026.5, subd. (b)(7).) All four individuals testified as expert witnesses at defendant’s trial.

According to Dr. Wassef, defendant’s initial diagnosis was “schizoaffective disorder,” which he described to include both psychotic symptoms and extreme mood

states of depression, mania, or both. The report he helped prepare regarding the prosecution's petition revised defendant's diagnosis to include not only "schizoaffective disorder," but also "alcohol dependency," "cannabis dependence," and "substance induced psychosis disorder." Dr. Wassef noted that about 60 percent of patients with schizoaffective or bipolar disorder had such dual diagnoses.

From Dr. Wassef's testimony, it is evident the more recent inclusion of substance-induced psychosis in defendant's diagnosis arose from an ongoing concern during the preceding months—that defendant had been using drugs both while on outpatient status and within NSH.² This raised the question whether defendant's psychotic symptoms arose from an organic mental illness—such as schizoaffective disorder—or from drug abuse. In October 2010, Dr. Wassef proposed discontinuing defendant's psychotropic medications, to determine whether organic mental illness could be ruled in or out. Defendant was tapered off psychotropic medications and remained off of them between November 2010 and March 2011.

Dr. Wassef stated, during this period, beginning with an incident in November 2010, defendant began to exhibit behavior that was "very irritable," "confused," and "paranoid." Defendant also became more "intrusive" with peers, and in March 2011 staff intervened in a "significant fight" between defendant and another patient. Dr. Wassef and others suspected defendant was continuing to use contraband drugs, but defendant eluded, and hospital staff could not compel, the collection of a reliable urine sample for testing.

Defendant's psychotic behavior continued, and Dr. Wassef decided to resume defendant's psychotropic medications in March 2011. Afterwards, defendant's symptoms lessened.

Dr. Wassef concluded defendant needed long-term, regular, psychotropic medication in order to be released safely into the community. Regardless of the cause of the psychotic symptoms, whether from organic mental illness, drug-induced psychosis, or

² At one point, Dr. Humphreys admitted that, "[s]adly," it was possible for NSH patients to obtain contraband drugs.

both, the medication was effective to manage them. If defendant were to be released into the community and did *not* take his medication, he would, according to Dr. Wassef, develop psychotic symptoms again “that will endanger himself and others in the community.”

Dr. Wassef said he advised defendant, after the resumption of psychotropic medications, to take them at greater intervals by injection. He explained that, not only would defendant experience fewer side effects, but this would also increase the likelihood of a CONREP outpatient placement, given the greater certainty that defendant, on outpatient status, would be receiving his prescribed medication. As Dr. Wassef put it, defendant would have been unable “to spit . . . out” injected medication. Defendant, however, refused injections, and according to Dr. Wassef was “basically trying to find any reason not to be on it.” To Dr. Wassef, defendant’s stance was a “major concern,” given his past history of not taking his medication when released into the community.

Dr. Wassef also related an incident at NSH that had occurred only a few weeks before the trial, in which defendant had temporarily refused to return a plastic knife to the dining hall in violation of a hospital rule. While this was not a psychotic symptom, it was a “character issue” that Dr. Wassef deemed significant to his assessment of defendant’s suitability for release. In his view, it was critical to defendant’s safe release into the community, that he complies with the rules of that conditional release, particularly those requiring him to keep his treatment appointments and to take his prescribed medications as directed. Dr. Wassef said he and several other NSH clinicians began to sense, from defendant’s conduct, that he was far more motivated to “outsmart the system” than to comply with its rules. This concern was exacerbated by defendant’s recent insistence that he did not have a mental illness. In Dr. Wassef’s opinion, defendant would have no incentive to take his medication once he was released into the community, so long as he persisted in a belief that he had no mental illness requiring such treatment.

Dr. Wassef further reported defendant had not fulfilled NSH recommendations regarding attendance in substance abuse recovery programs—evidently intended to address defendant’s diagnoses of alcohol and cannabis dependence. He explained that

these programs required a patient's participation for some six to 10 months in order to properly develop a plan to avoid "significant relapse" following conditional release into the community. Defendant, he said, had only been participating in the programs for about five weeks.

When asked specifically his opinion as to whether defendant had "serious difficulty controlling his behavior," Dr. Wassef first responded that he felt defendant had the capacity, tools and skills to "work the program once he decides he wants to do it." He concluded, however, that defendant did not presently "qualify . . . for release" because he had not yet learned the skills he needed to acquire by completing the wellness recovery programs. More importantly, it was a "major risk factor" that defendant continued to believe he did not have a mental illness, and hence had no incentive to take his medications independently. During cross-examination, Dr. Wassef defended his opinion, stating further that if defendant was moved into the community at the present time—without assurance that he would properly take his medications—"he [would] be at [a] very high risk of assaultiveness."

Dr. Humphreys, defendant's treating psychologist, described a number of incidents involving defendant at NSH between November 2010 and June 2011—at which times defendant had exhibited paranoia, confused and illogical thoughts, agitation, and intrusive behavior. These included the incidents mentioned by Dr. Wassef. Dr. Humphreys stated there had been "some improvement" in these symptoms since defendant's medications were resumed. When asked specifically whether she believed defendant had "serious difficulty controlling his behavior," Dr. Humphreys responded, "Yes, I do." In her opinion, it would be safe "at some point" to release defendant, but he was "not there yet." Although his symptoms had improved after the resumption of his medication, she did not believe defendant would take his medication consistently once released from hospital supervision.

Dr. Broadman's evaluation was based on a review of defendant's medical records, a discussion with defendant's treatment team at the hospital, and a two-hour interview with defendant. In her subsequent testimony at trial, Dr. Broadman noted that defendant,

at the time of his interview, presented as inappropriate at times, but not psychotic. On the other hand, defendant denied “flat out” having any substance abuse problems. He denied having a mental illness, stating there was no need for him to take psychotropic medication. He “glossed over” his past psychiatric history. He minimized his reported behavior at NSH during the preceding months, telling Dr. Broadman that hospital staff had been “overreacting.” Defendant also dismissed his failed outpatient placements as nothing more than “misunderstanding[s]” on the part of CONREP staff.

Dr. Broadman expressed the opinion defendant still posed a substantial danger of physical harm to others, based on the behavior resulting in his initial commitment, as well as his subsequent behavior at NSH. His history indicated to her he suffered from an organic mental illness, most likely schizoaffective disorder, as well as “substance abuse disorder,” yet there was no consistent, long-term treatment plan in place to ensure his own and the community’s safety in the event of his release. She observed he had the ability to “clear up enough to be discharged,” but, once given an outpatient placement, showed a tendency not to follow the CONREP rules, which are “proven [to] keep the community safe.” Dr. Broadman said, “when someone chooses to disregard those rules they put themselves and the community at risk.” In this context, she opined that defendant did, in fact, have “serious difficulty controlling his behavior.”

Dr. Sokolov similarly based his evaluation on a review of defendant’s medical records and a two-hour interview. He diagnosed defendant as suffering from a “psychotic disorder not otherwise specified,” which includes symptoms of delusions, paranoid thoughts, and disorganized thinking. In his view, this was the better diagnosis since there was still some uncertainty about whether defendant’s symptoms arose from organic mental illness or were drug induced.

Defendant had reported to Dr. Sokolov he was “completely fine.” Defendant’s medical records, however, reported defendant was still having paranoid thoughts. This led Dr. Sokolov to conclude defendant had “poor insight into the severity of his mental illness” and how that illness could “contribute to future dangerous behavior.” Thus, Dr.

Sokolov, too, expressed the opinion that defendant still “represente[d] a substantial risk of harm to others if released.”

When asked his opinion whether defendant had “serious difficulty controlling his dangerous behavior,” Dr. Sokolov replied that he did have concerns defendant would be unable to control such behavior “[w]hen he’s in a paranoid psychotic state.” In his opinion, “that risk [was] significantly lessened” if defendant remained “medicated and compliant and [was] regularly monitored for worsening of symptoms.” Based on his prior behaviors, however, Dr. Sokolov believed defendant was at risk of not taking his medication independently.

Viewing the foregoing evidence in the light most favorable to the trial court’s order, we conclude it provides substantial support for a rational trier of fact to find, beyond a reasonable doubt, that defendant not only suffered from a mental disease that posed a present danger of physical harm to others, but most particularly that defendant had serious difficulty controlling his dangerous behavior. Substantial evidence on this issue may be established by a single psychiatric opinion. (*People v. Zapisek, supra*, 147 Cal.App.4th at p. 1165.)

Defendant concedes there may have been evidence that he did not control his dangerous behavior, but insists the evidence never addressed whether he ever *attempted* to control his behavior, and had serious difficulty, because of his mental illness, *succeeding* in an attempt to control his behavior. We disagree. The foregoing evidence showed that defendant had a mental illness—schizoaffective disorder, substance induced psychosis, or both. It showed that, if he did not take prescribed psychotropic medication, he would develop psychotic symptoms resulting in dangerous behavior. He became paranoid, agitated, intrusive, even assaultive, and gave no indication he could control that behavior while in that psychotic state. While medication lessened the risk of symptoms leading to dangerous behavior, defendant failed to take his medication independently on prior occasions when given conditional release into the community, and he presently persisted in the belief that he had no mental illness and did not require psychotropic medication, and also refused to take his medication by injection. We are satisfied

substantial evidence supports defendant had serious difficulty controlling his dangerous behavior.

DISPOSITION

The order filed July 6, 2011, is affirmed.

Marchiano, P.J.

We concur:

Margulies, J.

Banke, J.