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**IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
FIFTH APPELLATE DISTRICT**

THE PEOPLE,

Plaintiff and Respondent,

v.

LENNETT LELA BAKER,

Defendant and Appellant.

F065821

(Super. Ct. No. FP003867A)

OPINION

THE COURT*

APPEAL from a judgment of the Superior Court of Kern County. Eric Bradshaw,
Judge.

Paul Bernstein, under appointment by the Court of Appeal, for Defendant and
Appellant.

Kamala D. Harris, Attorney General, Dane R. Gillette, Chief Assistant Attorney
General, Michael P. Farrell, Assistant Attorney General, Stephen G. Herndon and
Melissa Lipon, Deputy Attorneys General, for Plaintiff and Respondent.

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* Before Levy, Acting P.J., Gomes, J. and Kane, J.

Following a bench trial, the court ordered appellant, Lennett Lela Baker, recommitted to the State Department of Mental Health for one year for treatment as a mentally disordered offender (MDO) pursuant to Penal Code sections 2970 and 2972.¹ On appeal, appellant contends the evidence was insufficient to support the MDO recommitment order and, alternatively, that the court erred in denying her request that she be released on outpatient status pursuant to section 2972, subdivision (d) (section 2972(d)). We affirm.

FACTS

Mubashir Farooqi, M.D., is a staff psychiatrist at Patton State Hospital (PSH), where appellant is a patient.² Prior to testifying at appellant's September 2012 recommitment hearing, he reviewed appellant's hospital records, spoke with members of her clinical treatment team and, in March 2013, conducted two "interviews" of appellant.

Records that Dr. Farooqi reviewed indicated the following: Appellant came to PSH as a result of an act of arson committed in 2003, "where she was accused of starting a fire" in her mother's house. At the time, "she had made statements that would be considered delusional," including that "somebody had bombed her house," "there were demons in the house," and "the demons started the fire."

Appellant's "primary diagnosis," with which Dr. Farooqi concurs, is paranoid schizophrenia. Her "predominant symptoms are paranoid or persecutory delusions," including a belief that there is a "system wide" government conspiracy "to keep her locked up." As a result of her illness, "her thought processes are very unclear when she's not under any treatment," but "[w]hen she's getting treatment, her thought processes are much more clear and coherent."

¹ Except as otherwise indicated, all statutory references are to the Penal Code.

² Except as otherwise indicated, our factual summary is taken from Dr. Farooqi's testimony.

In addition, appellant's illness also affects her "perception of reality" in that "her thought content is still grounded in delusional beliefs." Appellant's mental illness "does not allow her to accept" that she is ill. This lack of "insight" is "part of her illness."

Dr. Farooqi also opined that appellant has a "substance abuse problem."

Appellant, in her March 2013 interviews with Dr. Farooqi, made "quite extraordinary statements" that "would be considered delusional unless proved otherwise" regarding "conspiracy theories" about the CIA and the Bakersfield Police Department, "millions of dollars," and "government agencies monitoring her"; stated she "believed she was cured of [her mental illness]"; and stated "[s]he was ambivalent about her medication use." Dr. Farooqi concluded from these interviews that appellant "lack[ed] clear insight into her mental illness." Appellant "did say that she would take medication," but Dr. Farooqi "was not really convinced about her understanding, at that time, of the importance of the medication." At the time of her interviews, appellant was "voluntarily taking her medication," but "[e]ven with taking the medication, her understanding of the mental illness [was] not very clear."

If a person with a diagnosis of paranoid schizophrenia stopped taking prescribed medication, Dr. Farooqi "would expect to see a relapse or increase in the symptoms of paranoid schizophrenia, mainly delusions, hallucinations, poor insight, poor judgment."

A psychiatric report indicated that in March 2012, appellant stated, "she would not continue psychotropic medications outside of her stay at [PSH]." Dr. Farooqi found this "significant." A January 2012 progress note in appellant's treatment records indicated appellant was willing to participate in the "care program" only because "a judge had ordered her to do so in order for her to get out of [PSH]." This was "significant" because "it indicates a lack of a real insight on her part into her wanting to do the program to keep her safe and sober as part of her relapse prevention plan." Another report in early 2012 indicated that appellant "continued to hold the belief that she does not have a mental illness and doesn't believe she needs medications to control symptoms[.]" Dr. Farooqi

also found this significant because it showed that at that time appellant did not have a “clear understanding of her mental illness.”

Dr. Farooqi opined that “the biggest problem” for persons suffering from mental illness who “[do not] have a really clear idea of their mental illness” is that “they stop taking their medication,” and “[t]hat leads to decompensation,” i.e., an “increase or relapse of psychiatric symptoms.” Under these circumstances, these persons “go back to the same mental status where they were, which got them in trouble.”

Dr. Farooqi further opined that appellant, as of the time he interviewed her, had a “severe mental disorder” that was not in remission, and that, based on the following, she “represent[ed] a substantial danger to others”: “She was suffering from delusions at the time she committed her crime,” “she’s still suffering from delusions,” she “did not understand her mental illness clearly or the need for treatment,” and her “treatment team” had “mentioned that there is an active resistance on her part to psychotropic medication.”

Appellant testified to the following: She was diagnosed with paranoid schizophrenia and she accepts that the diagnosis is correct. In the past, she had the delusional belief that “the government was trying to lock [her] away” but that was her only delusion, and it was neither dangerous nor “threatening.” She now takes medication that makes the delusions “go away.” If she was released on the Conditional Release Program, she would continue to take her medication and cooperate in all ways with her treatment. She did not tell Dr. Farooqi that she was cured of her mental illness, only that she was symptom-free. Although “someone put in [her] chart” that she said she “didn’t want to take medications,” she “never said that.”

DISCUSSION

I. Extension of MDO Commitment

Appellant contends the evidence was insufficient to support a finding that she currently represents a substantial danger of physical harm to others, and therefore the

court's order extending her MDO commitment for one year must be reversed. We disagree.

Legal Background

“The Mentally Disordered Offender Act (MDO Act), enacted in 1985, requires that offenders who have been convicted of violent crimes related to their mental disorders, and who continue to pose a danger to society, receive mental health treatment ... until their mental disorder can be kept in remission. [Citation.]’ [Citation.]” (*Lopez v. Superior Court* (2010) 50 Cal.4th 1055, 1061, disapproved on another point in *People v. Harrison* (2013) 57 Cal.4th 1211.) “Commitment as an MDO is not indefinite; instead, ‘[a]n MDO is committed for ... one-year period[s] and thereafter has the right to be released unless the People prove beyond a reasonable doubt that he or she should be recommitted for another year.’ [Citation.]” (*Id.* at p. 1063.) “A recommitment under the [MDO] law requires proof beyond a reasonable doubt that (1) the patient has a severe mental disorder; (2) the disorder ‘is not in remission or cannot be kept in remission without treatment’; and (3) by reason of that disorder, the patient represents a substantial danger of physical harm to others. (Pen. Code, § 2970.)” (*People v. Burroughs* (2005) 131 Cal.App.4th 1401, 1404.)

On appeal, we assess the sufficiency of the evidence to support an MDO commitment under the substantial evidence standard. (*People v. Clark* (2000) 82 Cal.App.4th 1072, 1082-1083.) This requires us to determine “whether, on the whole record, a rational trier of fact could have found that defendant is an MDO beyond a reasonable doubt, considering all the evidence in the light which is most favorable to the People, and drawing all inferences the trier could reasonably have made to support the finding. [Citation.] ““Although we must ensure the evidence is reasonable, credible, and of solid value, nonetheless it is the exclusive province of the trial judge or jury to determine the credibility of a witness and the truth or falsity of the facts on which that determination depends....’ [Citation.]” [Citations.]” (*Ibid.*)

A single opinion by a psychiatric expert that a person is currently dangerous due to a severe mental disorder can constitute substantial evidence to support the extension of a commitment. (Cf. *People v. Zapisek* (2007) 147 Cal.App.4th 1151, 1165 [section 1026.5 commitment.]) However, “expert medical opinion evidence that is based upon a “guess, surmise or conjecture, rather than relevant, probative facts, cannot constitute substantial evidence.” [Citations.]” (*In re Anthony C.* (2006) 138 Cal.App.4th 1493, 1504 (*Anthony C.*.)

Contentions and Analysis

Appellant does not claim the evidence was insufficient to establish that she has a severe mental disorder that is not in remission. Rather, as indicated above, she contends the evidence was insufficient to support the conclusion that by reason of that disorder, she represents a substantial danger of physical harm to others. We disagree. As also indicated above, Dr. Farooqi testified that in his opinion, appellant, by reason of her severe mental disorder, represents a substantial danger to others. Dr. Farooqi’s expert opinion testimony, in our view, constitutes substantial evidence on this point.

Appellant argues it does not, claiming that Dr. Farooqi’s opinion on the question of appellant’s current dangerousness was without “adequate factual basis.” In support of this claim she argues as follows: “Much” of Dr. Farooqi’s testimony—e.g., his testimony that a person who was diagnosed with paranoid schizophrenia would decompensate if he or she stopped taking prescribed medication—was about mentally ill persons in general but “not about [appellant] specifically”; Dr. Farooqi did not make explicit that there exists a causal link between failure to take medication and dangerousness; and he similarly did not testify as to any causal link between delusions and dangerousness. Therefore, appellant argues, Dr. Farooqi’s testimony established at most a correlation between appellant’s mental illness and dangerous behavior, but not a causal connection. These points are not well taken.

Dr. Farooqi opined that because appellant suffered from paranoid schizophrenia she represented a substantial danger to others. His reasoning was as follows: Persons who are mentally ill and who lack insight into their illness, including failing to appreciate the need for medication, stop taking their medication. Given evidence of which he was aware, including evidence that in March 2012 appellant stated she was cured and would stop taking her medication if released from PSH, Dr. Farooqi believed appellant lacked insight into her mental illness and would, as her records indicated she had said, stop taking her medication if released from PSH. When persons who, like appellant, suffer from paranoid schizophrenia stop taking their medication they decompensate, i.e., they experience the symptoms of their illness, including delusions. Thus, if appellant, who had suffered delusions in the past, stopped taking her medication, those delusions would return. And because appellant was in a delusional state when she committed arson in 2003, there existed the danger that appellant would commit similar dangerous acts if her delusions returned.

The foregoing demonstrates that Dr. Farooqi based his opinion not on conjecture and surmise, but on “relevant, probative facts” (*Anthony C.*, *supra*, 138 Cal.App.4th at p. 1504), i.e., appellant’s mental illness, how persons with mental illness behave, and how appellant has behaved.

Appellant finds Dr. Farooqi’s testimony wanting because he based his opinion in part on his knowledge of how persons suffering from the same mental disorder as appellant behave. However, an expert may properly render an opinion, as Dr. Farooqi did, that because appellant suffers from paranoid schizophrenia, it is likely she will behave like other persons who have the same disorder. Appellant’s criticism that Dr. Farooqi failed to explicitly testify that there exists a causal connection between (1) the failure to take psychotropic medication and dangerous conduct and (2) delusions and dangerous conduct also misses the mark. Dr. Farooqi testified that a mentally ill person’s failure to take medication can lead to a relapse of the illness, including delusions, and it is

reasonably inferable from Dr. Farooqi's reference to appellant's commission of arson while in a delusional state that it was his opinion that a causal link exists between such a mental state and the likelihood of conduct that could harm others. This too is proper expert opinion. As stated earlier, such opinion constitutes substantial evidence that appellant is currently dangerous.

Appellant also seeks reversal of the recommitment order on the ground that there is no substantial evidence that she "lacked the volitional capacity to control dangerous behavior." (Unnecessary capitalization and emphasis omitted.)

Appellant bases this contention on the following principle: "[T]he safeguards of personal liberty embodied in the due process guaranty of the federal Constitution prohibit the involuntary confinement of persons on the basis that they are dangerously disordered without 'proof [that they have] serious difficulty in controlling [their dangerous] behavior.' [Citation.]" (*People v. Williams* (2003) 31 Cal.4th 757, 759 (*Williams*), quoting *Kansas v. Crane* (2002) 534 U.S. 407, 413 (*Crane*).) Appellant argues that because Dr. Farooqi did not specifically testify that she has serious difficulty controlling her behavior, the evidence was insufficient to establish that she has such difficulty. We disagree.

Appellant likens the instant case to *In re Howard N.* (2005) 35 Cal.4th 117 (*Howard N.*). In that case, which dealt with the statutory scheme providing for the extended detention of dangerous juveniles (Welf. & Inst. Code, § 1800 et seq.), our Supreme Court held that to maintain its constitutionality under United States Supreme Court and California Supreme Court authority, that scheme should be interpreted to contain a requirement that the person's mental deficiency, disorder, or abnormality caused serious difficulty in controlling his or her behavior. (*Howard N.*, at pp. 122-132.) The court further held that the absence of an instruction on the question of volitional control could not be considered harmless because the evidence adduced was not such that no rational jury could have found the lack of serious control element. The court based

this holding in part on the fact that although a psychiatric expert testified that the defendant was dangerous “due to an untreated sexual disorder,” there was “no testimony that defendant’s mental abnormality caused him serious difficulty controlling his sexually deviant behavior.” (*Id.* at p. 138.)

The court, however, distinguished *Williams*, where it was held the lack of a volitional control instruction was harmless, on the ground that in that case, “the mental abnormality with which defendant was diagnosed[] was ‘a mental disorder characterized by intense and recurrent fantasies, urges, and behaviors about sex with nonconsenting persons, which symptoms persist for six months or more and cause significant dysfunction or personal distress,’” (*Howard N.*, *supra*, 35 Cal.4th at p. 138.) Had such evidence been presented, the court suggested, a rational jury could have found that the defendant was volitionally impaired. The psychiatric evidence in the instant case that appellant’s mental illness caused her to suffer from delusions which affected her behavior was similar to evidence that the defendant in *Williams* had intense and recurrent fantasies which caused significant dysfunction. Such evidence was sufficient to establish that appellant had serious difficulty in controlling her behavior.

We find instructive *People v. Putnam* (2004) 115 Cal.App.4th 575 (*Putnam*). In that case, the patient challenged his MDO recommitment on the basis that the jury was not adequately instructed on the requirement that the prosecution establish he had serious difficulty in controlling his behavior. (*Id.* at p. 579.) Instructions given informed the jury of the following: “[I]n order to find that appellant had a severe mental disorder, it had to find that he had ‘an illness or disease or condition that substantially impair[ed] [his] thoughts, perception of reality, emotional process, or judgment, or which grossly impair[ed] [his] behavior.’” (*Id.* at p. 582.) “[I]n order to find that the disorder was not in remission, the jury had to find that ‘the overt signs and symptoms of the severe mental disorder’ were not under control.” (*Ibid.*) And the jury “had to find that ‘by reason of such severe mental disorder, [appellant] represents a substantial danger [of] physical

harm to others.” (*Ibid.*) The court held there was no instructional failure because “the instructions given . . . , which tracked the language of the MDO statute, necessarily encompassed a determination that appellant had serious difficulty in controlling his violent criminal behavior.” (*Ibid.*)

Here, as demonstrated above, substantial evidence supported each of the points covered in the jury instructions given in *Putnam*. And, as *Putnam* explains, these points “necessarily encompass[]” (*Putnam, supra*, 115 Cal.App.4th at p. 582) the showing required to establish serious difficulty in controlling behavior. Therefore, appellant’s challenge to the sufficiency of the evidence that she had serious difficulty controlling her behavior fails.

II. Release to Outpatient Status

Appellant requested that she be released on outpatient status pursuant to section 2972(d). The court denied this request.

Section 2972(d) provides an opportunity for continued MDO treatment on outpatient status where, as here, a court sustains a section 2970, subdivision (e) petition for recommitment. “[T]he court has the authority to release the MDO for outpatient treatment so long as it finds ‘there is reasonable cause to believe that the committed person can be safely and effectively treated on an outpatient basis. (§ 2972, subd. (d).)’” (*People v. May* (2007) 155 Cal.App.4th 350; see also *People v. Rish* (2008) 163 Cal.App.4th 1370, 1382 (*Rish*) [section 2972(d) “describes an alternative disposition that is available to the court” upon sustaining a section 2970 petition].)

Appellant first argues that the trial court improperly delegated its duty to determine whether appellant should be granted outpatient release under section 2972(d) by deferring to the judgment of the Conditional Release Program (CONREP) rather than making its own independent determination as to whether appellant could be safely and effectively treated on an outpatient basis. We disagree.

We begin by summarizing the relevant testimony. Dr. Farooqi testified to the following: CONREP is a “county-run program.” It is “a step down from the structure of the state hospital to a community outpatient treatment.” CONREP likes “to see people [who are] psychiatrically stable,” and it “appear[ed]” to Dr. Farooqi from talking to her for “a few minutes” on the day he testified that she was psychiatrically stable, although he “[could not] make that assessment in a minute or two.” Programs similar to those available to appellant in PSH would be available on CONREP release, and CONREP would “monitor” appellant and “make sure she does take her medication.” Dr. Farooqi “will be very happy if [appellant is] accepted by the Conditional Release Program.” He testified, “I cannot give an opinion on whether she’s ready for a conditional release program, at this time [T]hat is a decision for the treatment team to make. [¶] My opinion is restricted to the criteria about her severe mental disorder or remission status and her dangerousness.”

Appellant points to several statements by the court at the close of the trial which, she asserts, support her claim that the court abdicated its responsibility to make an independent determination of whether appellant was entitled to release on outpatient status under section 2972(d). Representative of those statements are the following:

“So if I say: Yeah, release to the community program, are we not stepping over one of the parts of the process that would allow the community program to make that evaluation themselves? [¶] Why should I do that? [¶] It seems like they’re in the best position to evaluate what they evaluate”

“I can make this thing happen by myself.... [Dr. Farooqi] wants [release on CONREP] for her. I want it for her. But should I substitute my judgment for the very people who need to make the final decision, really, about whether it should happen? I’m just very uncomfortable with that. I think that those are the mental health professionals, not me. And I just -- that’s the part that’s hanging me up here.”

However, the court concluded with the following:

“I think that I found Dr. Farooqi’s testimony very []credible and insightful. And obviously, he thinks a lot of [appellant] in terms of her

potential, but [he] ... just would not go so far as to -- as to substitute his judgment.

“It seems that -- had he been acting in a different capacity, he might very well have. But that’s speculation on my part. He did not do this here in this proceeding. And it’s because of that that I do not feel that the statements of [appellant] give me *enough information to make the type of finding I would have to make* under [section 2972(d)], that there’s reasonable cause to believe that she can be safely and efficiently [*sic*]³ treated on an outpatient basis. I would want to hear that opinion from Dr. Farooqi or some other person with an M.D. or a Ph.D. or some credential after their name. And I don’t have it. You know, I’ve walked right up to the point where I think Dr. Farooqi has. But I’m not going to take it any further than that.” (Italics added.)

In our view, the court’s statement about “substitut[ing] [its] judgment,” when viewed in the context of its closing remarks does not mean the court believed it lacked the power to order outpatient treatment absent the recommendation of mental health professionals. Rather, the court’s remarks, particularly its closing remarks, indicate that there was no expert testimony that appellant could be safely and effectively treated on an outpatient basis and that therefore the evidence was simply insufficient to establish that she satisfied the criteria for section 2972(d) outpatient release. The record does not establish that the court failed to make an independent determination.

Appellant also argues the evidence was insufficient to establish she could not be released on outpatient status under section 2792(d) because, she asserts, “There was no evidence that the medication that was demonstrating success for [her] could not be administered to her and monitored in the outpatient program.” We disagree.

Under section 2792(d), the patient “shoulders the burden of showing his [or her] suitability for outpatient treatment.” (*People v. Gregerson* (2011) 202 Cal.App.4th 306, 316.) Thus, “[t]he patient must demonstrate ‘reasonable cause to believe that [he or she]

³ In that the court appeared to be quoting section 2972(d), we assume that either the court misspoke or that the court reporter misheard and substituted “efficiently” for “effectively.”

can be safely treated on an outpatient basis.’ (§ 2972, subd. (d).)” (*Id.* at p. 317.) To meet this burden, “the patient must raise a strong suspicion in a person of ordinary prudence that outpatient treatment would be safe and effective.” (*Id.* at p. 319, fn. omitted.) A trial court’s denial of a patient’s request for outpatient treatment under section 2972(d) must be upheld if supported by substantial evidence. (*Id.* at p. 320; accord, *Rish, supra*, 163 Cal.App.4th at pp. 1384-1385.)

We recognize, as appellant points out, that some evidence militated in favor of a finding that appellant could be safely and effectively treated on an outpatient basis. Dr. Farooqi testified, “Initially, [CONREP placement] is very structured, very supervised.” He answered, “Yes,” when asked if CONREP would “monitor” appellant and “make sure she does take her medication.”

On the other hand, as indicated earlier, there was also evidence that appellant had stated she viewed herself as “cured” and that if released from PSH she would not take her medication. And although appellant requested release on outpatient status and testified that she would promise to take her medication if released to CONREP, Dr. Farooqi testified that PSH records indicated that at some point appellant was not “interested” in CONREP release, and that such lack of interest “may be the biggest barrier” to appellant being accepted into a CONREP program.

Thus, there was some conflict in the evidence as to whether appellant could be safely and effectively treated on an outpatient basis, and, as indicated earlier, we resolve such conflicts in favor of the court’s order. On this record, we conclude the court could reasonably find that appellant had not met her burden of showing that she was entitled to outpatient release under section 2972(d).

DISPOSITION

The judgment is affirmed.