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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT

DIVISION THREE

THE PEOPLE,

Plaintiff and Respondent,

v.

MARIE CHANTAL McDONOUGH,

Defendant and Appellant.

G046021

(Super. Ct. No. 98NF3762)

O P I N I O N

Appeal from an order of the Superior Court of Orange County, M. Marc Kelly, Judge. Affirmed.

Harry Zimmerman, under appointment by the Court of Appeal, for Defendant and Appellant.

Kamala D. Harris, Attorney General, Dane R. Gillette, Chief Assistant Attorney General, Julie L. Garland, Assistant Attorney General, Barry Carlton and Joy Utomi, Deputy Attorneys General, for Plaintiff and Respondent.

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Appellant Marie Chantal McDonough, who had been committed to the state hospital as a result of having been found not guilty by reason of insanity in a felony prosecution. Eight years later, the director of the Metropolitan State Hospital filed a semiannual report recommending appellant be placed in outpatient treatment. (Pen. Code, § 1603, subd. (a)(1); all statutory references are to the Penal Code unless otherwise stated.) The superior court held a hearing on the matter and denied appellant outpatient treatment. In a published opinion we reversed “because the trial court did not find appellant is currently mentally ill *and* dangerous, and denied outpatient status because it did not find the treatment program appropriate.” (*People v. McDonough* (2012) 196 Cal.App.4th 1472, 1493.) We directed the trial court on remand to consider the evidence from the trial, any other relevant evidence the parties may offer, and determine whether appellant carried her burden by a preponderance of the evidence and is entitled to outpatient treatment. (*Ibid.*)

The parties offered no new evidence on remand. The trial court reviewed the evidence from the first hearing and again denied outpatient treatment, finding appellant to be currently dangerous.

I

FACTS

As no new evidence was offered and admitted on remand, we use the facts set forth in our first opinion in this matter. (*People v. McDonough, supra*, 196 Cal.App.4th 1472.)

“The Underlying Offenses and Procedural Setting

“In 1999, an information alleged appellant assaulted her father, Ernest, with a firearm (§ 245, subd. (a)(2)), committed two acts of elder abuse (§ 368, subd. (a)), one count naming her father as the victim and the other naming her mother as the victim, on December 29, 1998. The information also alleged appellant personally used a firearm in

the commission of each of the offenses. (§ 12022.5, subd. (a).) As a result of delusions, appellant purchased a shotgun and went to her parents' residence to protect her mother from her father. During the incident at her parents' home, she chased her father, threatened to assault him, and discharged the weapon, hitting the ceiling. No one was harmed.

“Criminal proceedings were suspended at one point because appellant was not competent to stand trial. (§ 1368.) Once competency was restored, she entered a plea of not guilty by reason of insanity to each charge. After considering the reports of the two doctors who evaluated her, the court found appellant not guilty by reason of insanity and set her maximum term of commitment at 16 years. The court ordered appellant committed to Patton State Hospital on May 10, 2000. She was transferred to MSH on December 5, 2000.

“In August 2002, appellant filed an application for release and outpatient treatment pursuant to section 1026.2. She withdrew the petition a month later. Appellant filed another section 1026.2 application for outpatient treatment in January 2004. That application was also withdrawn. In November 2004, appellant filed a petition for restoration of sanity pursuant to section 1026.2, subdivision (e). That petition was subsequently withdrawn as well. Appellant filed a petition for restoration of sanity and unconditional release in September 2005. The court appointed Drs. Kaushal Sharma, a psychiatrist, and Veronica Thomas, a psychologist, to examine appellant. Up to this point in time, every semiannual report filed by Patton State Hospital and MSH recommended appellant's retention at the hospital because she continued to be mentally ill and a danger to the health and safety of others, even if furnished supervision and treatment in the community.

“The court held a hearing on appellant's petition in October 2006. During the hearing, appellant withdrew the petition for restoration of sanity. The court found appellant had not carried her burden and denied the request for outpatient treatment.

“In April 2008, MSH’s semiannual interval report recommended placing appellant in outpatient treatment. The report stated the consensus of the wellness and recovery treatment team was that appellant was ready for outpatient treatment, appellant had been accepted for community outpatient treatment, and she no longer posed a danger while under supervision in community.

“The Hearing on the Recommendation for Outpatient Treatment: Expert Testimony

“The court held a hearing on the recommendation in September 2009. (§ 1604, subd. (c).) As the Attorney General acknowledges, appellant presented the testimony of a number of mental health professionals, all of whom agreed she could safely be released to an outpatient program. The prosecution did not present any expert testimony.

“Dr. Stephanie Walker has been a staff psychologist at MSH since December 2007 and has treated appellant since that time. Walker is familiar with appellant’s psychiatric history. Appellant started experiencing symptoms, primarily delusions, in her early 20’s and has been hospitalized nine to 11 times. Her initial diagnosis of mental illness occurred around 1986. There have been several diagnoses, including delusional disorder (persecutory type), schizophrenia, and bipolar disorder. Walker said appellant never received stable outpatient treatment and was never stabilized on psychiatric medication until her current hospitalization. Appellant is currently prescribed Abilify, an antipsychotic, and Zoloft, an antidepressant.

“Walker reviewed appellant’s wellness and recovery plan. Appellant is in a maintenance stage. This involves creating a relapse prevention plan. The plan requires appellant to have insight into her diagnosis and to learn coping skills. Insight requires knowledge of her symptoms and the triggers that impact those symptoms. According to Walker, appellant knows both. She knows her biggest coping skill is taking her

medication. She has been taking Abilify since 2005, and would exhibit delusional symptoms if she stopped taking the drug.

“Walker said appellant’s specific relapse prevention plan is ‘very extensive’ and involves knowing what resources she can go to if symptoms appear. Appellant is ‘very familiar’ with the Fresno CONREP facility and whom to contact there. She also knows of groups she can attend there, the hospital, and that she can consult her psychiatrist.

“Walker said appellant is friendly with staff, patients, and has been danger free for the past 18 months. Appellant has been symptom free since Walker has worked with her. Walker concluded appellant is not a danger to herself or others and has benefitted to the maximum extent possible from the groups at the hospital, has ‘exceptional insight,’ and can safely be treated in the community. Appellant is ready to transfer to Fresno CONREP outpatient treatment and the transition would benefit her. In fact, Walker stated it would be detrimental to keep appellant in the hospital, receiving the same treatment she has already received with nothing more to learn there.

“Walker said appellant does not attend group therapy classes that repeat what she has already learned. For example, the medication and wellness class is a 12-week course and the curriculum *never* changes. The doctor compared it to taking the same Algebra I class over and over again. Appellant does, however, consistently attend groups with a curriculum that changes from time to time.

“Dr. Thomas Grayden evaluated appellant at the request of her attorney. Grayden has previously qualified as an expert in forensic psychiatry in Orange County Superior Court. After having reviewed appellant’s record, interviewing appellant, and speaking with a number of staff, his primary diagnosis is that appellant has an unspecified bipolar disorder, characterized by a history of depressive episodes and at least one manic or hypomanic episode historically. The unspecified subtype allows a ‘description to have other co-morbid type of diagnoses in conjunction with it such as a

delusional disorder.’ Grayden said his review of the records indicates appellant has not had any psychotic symptoms for three years. He further testified she does not pose a threat to herself or others and lacks risk factors that would otherwise be cause for concern. He concluded she does not require a locked state hospital setting and outpatient treatment away from her family is appropriate. He recommended placement in a less restrictive setting such as Fresno CONREP, and added that from a safety standpoint, it would give appellant distance from her father and provide a means of lessening her enmeshment with her mother, allowing appellant to get on with her own life.

“The prosecutor asked Walker and Grayden about an April 8, 2008 entry in appellant’s file. That entry noted appellant was lying on the floor during a writing activity and was instructed to get off the floor. According to the note, appellant became hostile, loud, and verbally abusive, telling the staff member who made the entry, ‘you are lying and making this up’ The incident did not change either doctor’s opinion.

“Dr. Inessa Essaian, a psychiatrist at MSH, has treated appellant since August 2007. Appellant’s current diagnosis is delusional disorder, persecutory type. She has also been diagnosed in the past with schizophrenia and bipolar disorder. The doctor stated all three diagnoses ‘overlap at some point,’ but believes appellant’s main problem is the persecutory delusions. Bipolar disorder and delusional disorder overlap as well when one has a special manic episode with delusional beliefs. However, bipolar disorder requires a history of at least one manic episode and there are no such documented episodes in appellant’s history.

“A hospital report dated July 9, 2009, indicates appellant has met all objectives and discharge criteria of the hospital. Essaian agrees with the report’s recommendation for CONREP placement. In the two years she has worked with appellant, Essaian has not observed any behavior that would lead her to conclude appellant would be a danger to anyone. She added that appellant has been asymptomatic

for two years, has good coping skills, and has developed good insight into her mental illness.

“The facts surrounding the crime that resulted in appellant’s commitment offense and a prior incident, where appellant purportedly poured gasoline on her father and tried to light a match, would not change the doctor’s opinion. Those incidents occurred because appellant was having intense delusions and had been drinking and using drugs around that time. Essaian said appellant is ‘very stable right now’ and it is important to transition her to outpatient treatment at this time. Appellant has met all the goals in the hospital, developed good insight into her illness, and has a viable relapse prevention plan. The different diagnoses do not affect Essaian’s opinion. The treatments for bipolar disorder and delusional disorder are the same and appellant has a good history of medication compliance.

“Mark Duarte is a licensed clinical social worker and the director of Central California’s CONREP since 1987. He has testified as an expert on the subject of whether an individual can be treated safely while under the care of CONREP and whether the person poses a danger to self or others. He knows appellant. He said appellant started experiencing depressive episodes in college and experimented with drugs that would exacerbate a mental illness and create a thought disorder. She was in ‘full-blown psychosis for a lot of that time.’ She was committed temporarily pursuant to Welfare and Institutions Code section 5150, medicated, stabilized, and released. Once released, she stopped taking her medication, did not keep her appointments with mental health professionals, and relapsed. Duarte said appellant had been committed 12 times.

“Appellant’s hospital records contain a report by Dr. Burchuk stating appellant stated the television, radios, and birds were sending messages to her. Duarte said those are common psychotic symptoms. Appellant also thought red cars meant her mother was going to be killed by the devil.

“Duarte submitted a report to the court in May 2008, after meeting with clinical staff and reviewing appellant’s medical and clinical records at MSH. He also met appellant’s parents. His report recommended outpatient treatment and supervision in CONREP.

“Fresno CONREP has a one-to-10 staff-to-client ratio and presently has 74 clients, each with a mental disease or defect that cannot be cured. CONREP’s purpose is to provide enhanced protection to the community through a standardized system of treatment and supervision. Individual therapy and group therapy are provided and CONREP performs home visits, toxicology screening, collateral contacts, and annual assessments. During the first year, home visits might occur every other week, but daily visits are made as needed.

“When one is admitted to CONREP, CONREP usually picks the patient up at the hospital. CONREP provides five levels of treatment: intensive, intermediate, supportive, transitional, and aftercare. For those in need of ‘decompression from the hospital,’ CONREP has a 90-day transitional residential program. CONREP also furnishes shared living apartments or houses. Duarte does not feel appellant needs a 90-day transitional setting. Rather, he intends to place her in an intensive setting in an unsecured two-bedroom apartment with other peers in CONREP. No mental health professionals live in the apartment, but the apartment is within walking distance of the program. The residential setting is supervised by staff.

“Duarte described the setting as follows: ‘There are two female clients in the conditional release program that each have primary clinicians, that each have access to clinical staff 24 hours a day, seven days a week via telephone after hours or emergency home visits that we do after hours. She’ll check in daily with us. We will make home visits. We will see her daily for at least the first 90 days that she is out in the program and we will get her a bus pass and we will get her clothes and we will get her medical attention and we will get her registered for school if that is what she wanted to do. We

will find out by talking with [appellant] everyday what she is capable of doing, what she is motivated to do, and what is the best activity schedule for her’

“The clients who do not go to school or have a job check in with CONREP by 9:30 a.m. each day. If the person is late or nonresponsive, a home visit is immediately made. CONREP has the key to every client’s residence. The clients are subject to search and seizure and Duarte stated CONREP is ‘very intrusive.’ CONREP corroborates everything the clients do, including what groceries they have, what their activities are, and whom they associate with. CONREP is involved in ‘a very intense and direct way’ with each client and seeks to be aware of all the client’s major life decisions. Clients are not permitted to travel out of the county without written permission.

“By the time a patient is placed with CONREP, CONREP will have made an assessment of the community resources and benefits the person will need, and CONREP will walk the person ‘through every day until they can navigate pretty much on their own.’ Upon release to the program, appellant would be assigned a primary clinician who would arrange for individual sessions, daily at first, and perform certain case management functions such as helping to establish eligibility for Social Security benefits. Arrangements for food, clothing, and shelter would be made, and necessary medical attention is provided. Duarte stated that ‘as long as the person follows their regimen[,] they do very well.’

“If it appears a client has not been taking prescribed medications, the client is immediately remanded into custody to await transfer to the state hospital. If the client is not from Fresno County, a section 1610 hold is placed on the client and the committing court is notified. The section 1610 hold may be for up to 180 days if medication reevaluation is needed and a return to the community is anticipated. In the past when a client has absconded from CONREP, CONREP went to court, obtained a bench warrant for the client’s arrest, and filed a section 1610 petition for remanding the client into custody. CONREP has a zero tolerance policy for unlawful drug use and would petition

the court to revoke outpatient status if a client uses unlawful drugs. If granted outpatient treatment with CONREP, appellant would not be permitted to stop treatment.

“Whether diagnosed as bipolar or with delusional disorder makes no difference in appellant’s treatment plan because she must comply with her medication regimen, which at present includes Abilify and Zoloft. Appellant is currently ‘quite stable’ on those medications. Fresno CONREP would assure medication compliance by observing appellant take medications. Duarte will also watch a client take his or her medication if there are concerns about medication compliance. Appellant would have routine lab work performed and see CONREP’s psychiatrist once a month. Her behavior would be noted daily.

“Appellant signed the terms and conditions of outpatient treatment. The terms and conditions ‘are guidelines that are required by [Duarte’s] conditional release program and have been standardized with the Department of Mental Health throughout the state of family conditional release programs.’ Fresno CONREP’s plan for appellant’s treatment was filed in the court in May 2008. Appellant’s treatment goal is to ‘do good and avoid evil.’

“Duarte said appellant will not pose a danger to the health and safety of others if she is released in a court-ordered outpatient treatment program. He has not spoken with appellant’s siblings, but said he would if appellant is released to CONREP. He did interview appellant’s parents. They are eager to have appellant released.

“CONREP requires a client’s list of collateral contacts before being placed in the community. One of the purposes of the contact list is to check and corroborate a client’s activities and statements. It aids in making CONREP aware of whether the client is associating with people who might encourage her to consume alcohol or illegal drugs. In other words, the contact list is a means of determining whether the client’s stability may be affected by the associations. The only contacts appellant disclosed were her parents. Appellant knows she is to have no contact whatsoever with her sister Michele

and her brother Dennis. Duarte said appellant's brother and sister are free to contact him about any concerns or questions.

“Duarte knew ‘there have been several instances of infractions on the units’ after his initial report, but was not aware appellant’s grounds privileges had been ‘pulled.’ He said that if the grounds privileges were pulled because she did not comply with unit routine, that would not affect his opinion. He looks for six months of infraction-free conduct, but what is important is whether the infraction was serious or minor.

“HCR-201¹ is a standardized test sometimes used to assess the risk of individuals to be released into the community. The test has not been given to appellant and would be administered once she is transferred to CONREP.

“The parties stipulated Dr. Jody Ward is qualified to testify as an expert in the field of forensic psychology. Ward was appointed by the court to evaluate appellant at the request of the district attorney, and to give an opinion as to appellant’s readiness for outpatient treatment. Ward has performed at least 100 evaluations to determine whether a patient in a secure hospital should be transitioned into the community. Most of her appointments have come at the request of the district attorney. The vast majority of the time (75 to 80 percent), Ward concludes the patient is not ready to leave the secure hospital setting. She described herself as very conservative in this regard, having worked at Napa State Hospital and MSH.

“The doctor met with appellant in April 2009. Appellant told Ward that she had been ‘a party animal’ in college. She said she used marijuana, alcohol, and tried cocaine and mushrooms. Appellant also told the doctor she felt the drugs ‘tipped off’ her mental illness. She then started having vivid dreams, became more delusional over time, and began to believe her father was hurting her mother. She got a gun and tried to shoot him.

¹ Historical-clinical risk-management-20 test.

“Ward also considered writings attributed to appellant predating the commitment offense by a year or more. Those had to do with appellant wanting to kill a college professor she believed was a rapist. Ward said the writings were clearly written by someone who was not of a sound mind.

“Ward made a June 2009 followup report at the request of the prosecutor, who asked Ward to review transcripts of the deputy’s interviews of appellant’s brother and sister. Ward considered the transcripts.

“The doctor concluded appellant ‘is ready for CONREP.’ The doctor said appellant made the effort to change her release from Orange County to Fresno as a concession to her family, which the doctor thought was noteworthy and a ‘very positive thing,’ because appellant did not have to do that.

“In reaching her conclusion, Ward considered the committing offense, appellant’s mental illness at the time of the offense, the hospital records indicating appellant ‘has not shown any persecutory delusions for the last three years,’ and her interview with appellant. The interview was important to determine appellant’s insight into her mental illness and her plan for treating the illness once she was released from the hospital. Ward said appellant has insight into the mental illness, knows the delusions are false, and knows how the delusions developed through vivid dreams and her prior thinking that the dreams were special and significant. Appellant knows dreams are triggers and that she has to pay close attention to that fact. Appellant also acknowledged that she was not going to spend too much time alone, because she felt that was a trigger as well.

“Ward and appellant discussed stressors appellant is likely to encounter in a conditional release program. Appellant said she would let those around her know that she has been mentally ill before so that they can call CONREP or intervene if the need arises. Ward concluded appellant would pose no danger to herself or others. The fact that Fresno CONREP does not plan to have appellant spend the first 90 days in a secure

location does not change Ward's opinion. Neither does the fact that appellant has expressed a plan to get married.

“Ward said that while she is not a medical doctor, she does not believe medications affect delusional disorders. In her opinion, the therapeutic environment in the hospital heals the patients with delusional disorders. Having said that, she is of the opinion that the antipsychotic and antidepressant medications appellant takes are important to her treatment. Ward's opinion about the role of medications is different if a patient has a bipolar disorder as opposed to a delusional disorder. The chemical imbalance present in patients with a bipolar disorder needs to be controlled by medication. Ward was unaware that a doctor opined appellant suffers from a bipolar disorder and not a delusional disorder, but she disagrees that appellant has a bipolar disorder.

“Prosecution Evidence

“The prosecution presented one witness, Dr. Stacey Berardino, a forensic psychologist. Berardino did not testify as an expert. Rather, she testified only to statements appellant made to her when she evaluated appellant in 2005 and 2006. The court overruled appellant's objections to Berardino's testimony.

“Berardino spoke with appellant about posttraumatic stress disorder on November 6, 2006. During that conversation, appellant said she had been French-kissed by her father when she was 11 years old. Appellant said she had negative thoughts about the incident and that she worried about it. She said she thinks about the incident every two to three weeks when her parents visit and her father kisses her. Berardino asked how the family dynamics played into the underlying commitment offense and appellant responded, ‘I haven't worked on this,’ but that anger at her father may have been involved in the commitment offense. Appellant also made statements about having nightmares.

“Berardino asked appellant about medication and appellant stated the medication helps her think more clearly and that she liked the medication, but that she went off the medication for two years when she suffered a side effect from the medication. Appellant said being off the medication did not adversely affect her. When Berardino interviewed appellant in 2005, appellant said the medication does not do anything and that there is nothing for the medication to do. She said talking is everything and medication does not change who you are. She added that she would have hurt her father even if she had been on medication and that talk therapy is the key for her. Berardino asked her why she needed medications and appellant answered that everybody in the hospital has to take medications and she needs to take medicine to get on CONREP. She further stated she takes the medication because her doctor thinks she should, and added that she had not suffered any delusions since she has been in the hospital.

“Berardino admitted on cross-examination that a patient’s understanding of the need to take medication can change over time. She was not able to state how quickly such a view may occur.

“In 1997, appellant’s sister, Michele, found documents written by appellant inside appellant’s car. She asked appellant about the documents during a telephone conversation a day or two before the commitment offense. Appellant said the documents were her private journal and nobody else’s business. The writings were admitted into evidence and contained appellant’s plans to kill Michele and her children, other family members, and appellant’s former math professor.

“Michele said she is skeptical appellant will comply with her medication regimen, based upon what she perceives as appellant’s ‘long-standing pattern’ of agreeing to take medications and not following through. She was also skeptical because she had a telephone conversation with appellant 10 years earlier, before the commitment offense, and appellant said similar things about doing better. During that conversation,

appellant attempted to set up a face-to-face meeting with their brother and the rest of the family. Appellant ‘clearly indicated that she would not hurt anybody.’

“Michele has not had any conversations with appellant since 1999.”

(*People v. McDonough, supra*, 197 Cal.App.4th at pp. 1476-1485.)

Rulings Denying Outpatient Treatment

The trial court denied appellant outpatient status (§ 1604, subd. (d)) after the first trial. We reversed and remanded the matter “because the trial court placed an undue burden on appellant, denying outpatient status not because she would not benefit from outpatient treatment, but rather because the court was not satisfied with the day-to-day details of the proposed outpatient treatment program.” (*People v. McDonough, supra*, 197 Cal.App.4th at p. 1475.)

The parties did not introduce any additional evidence on remand. Appellant’s counsel took the position that as the trial court did not make a finding as to dangerousness at the conclusion of the first trial, appellant was entitled to outpatient status. The People asserted the court had made a determination of dangerousness in the first trial. The trial court read the transcripts from the first trial and denied appellant outpatient status, finding appellant did not carry her burden of proving by a preponderance of the evidence that she is not dangerous. This appeal ensued.

II

DISCUSSION

“Appellant was committed to the state hospital because she had been found not guilty by reason of insanity. (§ 1026, subd. (a).) An insanity acquittee committed to a state hospital may be released from the hospital as provided by section 1600 et seq. (*People v. Soiu* (2003) 106 Cal.App.4th 1191, 1194-1195; §§ 1026.1, 1600.) Pursuant to section 1600 et seq. ‘a defendant may be placed on outpatient status if the director of the state hospital and the community program director so recommend, and the trial court

approves the recommendation after hearing. [Citation.]’ [Citation.]” (*People v. McDonough, supra*, 196 Cal.App.4th at p. 1490.)

“We review the court’s decision denying outpatient status for an abuse of discretion. [Citation.]” (*People v. McDonough, supra*, 196 Cal.App.4th at p. 1489.) In determining whether the court abused its discretion in this matter, “we ‘consider whether the record demonstrates reasons for the trial court’s disregard of the opinion of the treating doctors and other specialists who [all] testified that defendant is no longer dangerous.’ [Citation.]” (*Ibid.*) The mere fact that all the experts testified in appellant’s favor does not necessarily mean a court errs in finding an individual does not qualify for outpatient treatment because he or she remains a danger. A trial court does not act as a rubber stamp that merely approves the experts’ recommendation to place an insanity committee on outpatient status. (*People v. Sword* (1994) 29 Cal.App.4th 614, 628.)

The discretion to be exercised by the trial court “is neither arbitrary nor capricious, but is an impartial discretion, guided and controlled by fixed legal principles, to be exercised in conformity with the spirit of the law, and in a manner to subserve and not to impede or defeat the ends of substantial justice. [Citations.]’ [Citation.] ‘Obviously the term is a broad and elastic one [citation] which we have equated with “the sound judgment of the court, to be exercised according to the rules of law.” [Citation.]’ [Citation.] Thus, ‘[t]he courts have never ascribed to judicial discretion a potential without restraint.’ [Citation.] ‘Discretion is compatible only with decisions “controlled by sound principles of law, . . . free from partiality, not swayed by sympathy or warped by prejudice” [Citation.]’ [Citation.] ‘[A]ll exercises of legal discretion must be grounded in reasoned judgment and guided by legal principles and policies appropriate to the particular matter at issue.’ [Citation.]” (*People v. Superior Court (Alvarez)* (1997) 14 Cal.4th 968, 977.)

The insanity committee (patient) must bear the burden in the trial court of proving by a preponderance of evidence that he or she should be granted outpatient

status. (*People v. Cross* (2005) 127 Cal.App.4th 63, 72.) To qualify for outpatient treatment, the court must find the patient is no longer mentally ill or no longer dangerous. (*People v. McDonough, supra*, 196 Cal.App.4th at p. 1492.) Had the court granted appellant outpatient status in this matter there certainly would have been sufficient evidence to support the decision. All the experts testified in favor of placing appellant in outpatient treatment, even the expert appointed at the prosecutor's request. The court, however, denied outpatient status and found appellant was still dangerous.

In 2000, appellant was found not guilty by reason of insanity in a prosecution for assault with a firearm and elder abuse. In the incident underlying the prosecution, appellant assaulted her father with a shotgun, discharging it once, and placed both her mother and father in a situation where their health was endangered. Appellant attacked her father because “[s]he had the idea that she needed to protect her mother from her father, which actually had been a common thread through many of her delusional episodes.” She was thereafter committed to the state hospital under Penal Code section 1026, subdivision (a).

In finding appellant to be presently dangerous, the court considered the evidence previously presented and stated it had “problems with a lot of the expert testimony presented by the defense.” It appears the problem consisted of the failure of experts to perform “a complete analysis with respect to the patient’s history and with respect to her medications and noncompliance, [and] with respect to changing diagnoses in terms of her mental disease, disorders or defects.”

While the testimony of the witnesses seems quite credible on the cold record we review, it is the trial court that observed the appearance and demeanor of the witnesses and determines their credibility. (*In re Shiela B.* (1993) 19 Cal.App.4th 187, 199-200.) The issue of witness credibility and the weight to be given a witness’s testimony is for the trier of fact to determine. (*People v. Voice* (1945) 68 Cal.App.2d 610, 614.) In this matter, the trial court stated it did not accept as true all the evidence

presented. Addressing the expert testimony, the trial court stated, “Some of it also appeared *unbelievable, unreasonable, or unsupported by the evidence.*” (Italics added.) Specifically, the court pointed to Dr. Stephanie Walker’s testimony about conflicting diagnoses and the apparent bias in the testimony of the experts.

The original trial on appellant’s petition for outpatient treatment took place in 2009. Dr. Walker, one of appellant’s treating psychologists, stated appellant was aware of her disorder, can identify its symptoms, and that appellant has “exceptional insight” into her diagnosis and what circumstances trigger her symptoms. The doctor said appellant would again become delusional if she stopped taking her medication, and added she was not aware of any occasion of appellant refusing medication. Clare Domingo, a clinical social worker who has worked with appellant at the hospital since 2007, however, acknowledged there was a time prior to 2007 when appellant had been noncompliant with her medication regime.

Walker was also asked about an interdisciplinary note from 2008 in appellant’s file. Appellant had been lying on the floor and was told to return to her room. The note stated appellant became hostile and verbally abusive to the person who prepared the note, stating, “You are lying and making this up, asshole.” There was another note from 2008 indicating appellant continues to test the limits with staff, particularly male staff.

People’s witness, Dr. Bernardino, spoke with appellant in 2005. She did not offer an opinion on appellant’s suitability for outpatient treatment. Appellant told Bernardino the medication she was taking did nothing for her, medication does not change who one is, and that even if she had been on medications at the time of the underlying incident she would still have tried to hurt her father. Appellant stated her belief that she had to be on medication to be placed in outpatient treatment, but that *she would not have any symptoms even if she stopped taking the medication.* Appellant said everyone in the hospital must take medication to get outpatient treatment through

CONRP. She said she does not have symptoms when she does not take medication, and the medication is given as a prophylactic. According to appellant, the key to her treatment is talk therapy. Appellant's statements concerning taking medication to remain in remission — that the symptoms would not return if she stopped taking the medication — is contradicted by expert testimony and relates to whether she is dangerous. Wells testified appellant would become delusional again if she stopped taking her medication.

As the evidence makes evident, appellant is dangerous when she is delusional. Not only was there the episode with the shotgun when she was delusional, there were other instances demonstrating appellant's dangerousness when delusional. In 1997, two years before appellant's attack on her father, appellant's sister Michelle found notebooks in appellant's car. The notes were in appellant's handwriting and revealed her plans to kill Michelle, Michelle's child and other family members, as well as a math professor from college. In December 1998, Michelle spoke with appellant on the telephone about the writings. Appellant said the journal was her private business and none of Michelle's business.

Michelle was skeptical of appellant's claim that she will continue to take her medication. She said appellant has "a long-standing pattern" of saying she will comply with a medication regimen and saying what she needs to say to be released. A few days before the shooting incident that caused her to be committed to the state hospital system, appellant talked to Michelle, represented she was doing better, and made promises (apparently of compliance with medications). In that conversation, appellant said she wanted to have a face-to-face meeting with Michelle, their brother Dennis, and the rest of the family. Appellant said she would not hurt anyone.

Appellant's sister also said appellant has been hospitalized 13 times, and while she always promised to comply with her medication regimen, she never followed through once released. She said appellant has a history of running away, as well. The shooting incident with her father occurred within a year of appellant's release from a

hospital. In 2006, when Michelle visited appellant in the hospital, appellant said it was Michelle's fault she had been hospitalized so often.

Appellant spoke with Dennis in 2006. When they spoke, he got the impression she was hiding something. She told him Michelle, a mental healthcare worker, attempted to murder her three times. According to appellant, Michelle was responsible for appellant's institutionalization and as a result, responsible for the three times the drugs appellant was prescribed at the hospital nearly killed her.

During the same conversation, appellant went off on a tangent about the presence of so many red cars on the road and the fact that factories could not be making that many. Dennis said appellant "had this thing about the color red at least as far [back] as 1998." Hospital records indicate appellant thought red cars meant her mother was going to be killed by the devil and that televisions, radios, and birds were sending messages to her.

As to her taking her medication, appellant told Dennis, "I'm on record as saying that the drugs I am currently being given are not appropriate for my condition" and "I take them because it's expected of me and they give them to me because it's their job to drug people."

Dennis said in the decades of his observing appellant's behavior, he has been constantly reminded of the "cyclical nature of her improvement and subsequent collapse" that have followed healthcare professionals saying appellant has improved. He also related her statement that before going to shoot their father, she had gone to a shooting range to practice. When confronted about her writing about killing their sister and her baby, appellant said only that she wrote "kill all the disgusting snots," meaning *all* the family members, and that she was sorry he read that.

The evidence concerning appellant's particular mental illness was in conflict as well. Walker said appellant suffers from a delusional disorder and was prescribed Abilify to control delusions and Zoloft, an antidepressant. Dr. Thomas

Grayden diagnosed appellant as suffering from a bipolar disorder. He said appellant's symptoms and history are *inconsistent* with the hospital's diagnosis of a long-term delusional disorder. Appellant had also been diagnosed in the past with schizophrenia.

Berardino also spoke to appellant in 2006 about a recent posttraumatic stress syndrome diagnosis. In response to questioning about the diagnosis, appellant stated her father had French-kissed her when she was 11 years old. Appellant said she had negative thoughts about the incident and thought about it every two or three weeks. In response to being asked whether that incident played into the shotgun attack on her father, appellant said, "I haven't worked on this." The court concluded this issue was never addressed by the experts. "There is also evidence that there was a sexual molestation by her father; that she was still angry at her father and still harbored resentment concerning that. To me, in analyzing all the testimony, that really was never addressed. And the fact that there still may be some anger issues there indicates that the defendant is still a danger . . . if she's released into the outpatient setting."

Six months before she attacked her father with a shotgun, appellant poured gasoline on him and attempted to set him aflame. The existence of the gasoline incident caused the trial court to discredit Dr. Grayden's opinion that appellant was not dangerous. Grayden based his conclusion that appellant was not dangerous, in part, on appellant not any history of fire setting and no other violent behaviors other than the offense that lead to her commitment.

Notwithstanding the fact that there would have been substantial evidence justifying an order granting appellant outpatient status, the above evidence demonstrates certain of the trial court's reasons for discrediting the experts support a conclusion the court did not act arbitrarily or capriciously, and did not abuse its discretion in finding appellant did not carry her burden of proving by a preponderance of the evidence she is not dangerous.

III
DISPOSITION

The order denying appellant outpatient status is affirmed.

MOORE, J.

WE CONCUR:

O'LEARY, P. J.

THOMPSON, J.