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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SIXTH APPELLATE DISTRICT

THE PEOPLE,

Plaintiff and Respondent,

v.

JAMES BURNS II,

Defendant and Appellant.

H036202

(Santa Clara County

Super. Ct. No. CC634756)

I. STATEMENT OF THE CASE

Defendant James Burns II appeals from an order extending his outpatient status and supervised treatment under Penal Code section 1606. He claims the extension order is not supported by substantial evidence.¹ He further claims the court erred in failing to advise him of his right to a jury trial and in conducting a court trial without obtaining his personal waiver of that right.

We affirm the order.

II. PROCEDURAL HISTORY

In April 2007, defendant James Burns II was found not guilty by reason of insanity (NGI) of several offenses and committed to a state hospital under the

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All unspecified statutory references are to the Penal Code.

Department of Mental Health until March 2009.² (§§ 1026, 1026.5.) Before the commitment expired, the Santa Clara County District Attorney sought and obtained a two-year extension until March 2011. In August 2009, the court granted defendant outpatient status for one year, and he was released from the state hospital to another facility under the treatment and supervision of the South Bay Conditional Release Program (CONREP). (§§ 1600, 1604.) In July 2010, the district attorney filed a petition under section 1606 seeking to extend defendant's outpatient status. On October 18, 2010, after a hearing, the court granted the petition and extended defendant's outpatient status.

III. SUFFICIENCY OF THE EVIDENCE

Defendant contends there was insufficient evidence to support the extension of his outpatient status.

A. THE EXTENSION HEARING

In support of the petition, the prosecutor alleged, in pertinent part, that defendant “by reason of mental disease, defect or disorder, continues to represent a substantial danger of physical harm to others, if not treated and supervised by CONREP in the community.”

At the extension hearing, Doctor Douglas Johnson, Ph.D, M.A., M.F.T., the community program director at CONREP, testified as an expert in the diagnosis and treatment of mental disorders and risk assessment. He testified that defendant had a diagnosis of paranoid schizophrenia with polysubstance dependence on alcohol and marijuana. According to Doctor Johnson, defendant was friendly, polite, cooperative, and compliant. Since being committed, he had taken his medication, did not act out, and had not exhibited any symptoms of schizophrenia. He also had attended individual

² The underlying NGI verdict and commitment were based on evidence that in 2006, police forcibly subdued defendant and arrested him after he broke into the Adobe Corporation building. At that time, he thought he was President Bush and needed to make love to his wife.

counseling, been clean and sober, regularly participated in 12-step programs for alcohol and drugs a few times per week, and submitted to drug testing four times per month.

Despite defendant's current stable mental status, Doctor Johnson opined that without continued supervision at CONREP, defendant would have problems controlling his behavior and would pose a risk of danger to others due to his disorder.

Doctor Johnson was particularly concerned about defendant's polysubstance abuse. He explained that most patients recognize red flag, high risk situations and develop skills to avoid them. For defendant, being around substance abusers was a high risk situation. However, he noted that defendant did not avoid such situations. For example, defendant told his CONREP group that once, while he was out in the community, he smelled marijuana; he said he could recognize the type of marijuana being smoked; and he wanted to discuss with the group whether marijuana should be legalized. He even said that if he were able to smoke, he would do so. Doctor Johnson opined that defendant's engagement with red-flag situations put him at a high risk of polysubstance abuse relapse without CONREP supervision.

This caused Doctor Johnson further concern because defendant's high risk of relapse increased the risk that defendant would stop taking his medication. Doctor Johnson said that defendant knew he suffered from delusions and needed to take medication for the rest of his life. He also conceded that if defendant was released, he would probably not stop taking his medication. However, Doctor Johnson opined that if he started using drugs or alcohol again, he progressively could end up in situations where he lacked social support and access to treatment, and under such circumstances, he would simply stop taking his medications.

Doctor Johnson also considered defendant at risk because he did not fully grasp the connection between his history and his mental state and the impact of past traumatic experiences, he did not always recognize high risk situations and distortions in his perceptions. He explained that defendant's treatment followed a "relapse prevention

model” that required patients to assemble personal histories detailing all episodes of psychiatric problems and unlawful conduct. The histories help them to understand and recognize the early warning signs of problems and identify high risk situations.

Doctor Johnson opined that defendant did not accept that there was a relationship between his history and his disorder. Thus, he could not use an understanding of the relationship as a way to identify certain behaviors as warning signals and red flags of relapse; rather, he tended to normalize those signals and flags. Defendant also rationalized and discounted the import of previous events and episodes as well as his symptoms and did not fully understand that the signs of his schizophrenia—odd thinking, religiosity, reclusive behavior—had started to appear when he was in his 20’s.

Defendant lacked specific insight into how troubling experiences in his life had affected and continued to affect him and also how they relate to the warning signs of behavioral problems. He noted, for example, that when defendant was young, his father would orally copulate him. Doctor Johnson opined that this traumatic experience later manifested itself in defendant’s distorted thinking. Thus, in the incident at Adobe, defendant talked about feeling that his semen was being stolen. Doctor Johnson explained that defendant’s past traumatic experiences were a major focus of concern because patients must learn to recognize distorted thinking as a warning sign of potential behavioral problems. Defendant, however, minimized the significance of his past sexual abuse and denied that it had any impact on him. Indeed, he said that in some ways it had been pleasurable. For this reason, Doctor Johnson found that defendant had a limited ability to recognize warning signs of behavioral problems like distorted thinking. He further found that defendant similarly failed to recognize the impact of religiosity on his behavior, which had at times caused defendant to preach to others.

Doctor Johnson testified that defendant also had limited insight into the nature of his mental disorder. Most patients focus on their histories, develop coping skills, and know when they are hallucinating or displaying other symptoms. Defendant did not

consistently acknowledge that he had a serious mental disorder and at times viewed the Adobe incident to simply a psychotic episode in which he lost touch with reality. Thus, defendant did not fully grasp that his schizophrenia is a chronic disorder that does not come and go.

In sum, Doctor Johnson believed that because defendant was unable to see the connection between his history and behavioral problems, he lacked good coping skills to avoid red-flag, high risk situations that he would inevitably encounter in the community and was at high-risk of relapse. This together with the limited grasp of his disorder could result in a failure to take his medication and difficulty controlling his behavior, which posed a risk of danger to others.³ Doctor Johnson believed that defendant needed to work on reviewing his life history for traumatic events and patterns of behavior and thinking of the sort that had led to the underlying incident. He also needed to address those events and patterns, such as his sexual trauma, in depth and not disavow them.⁴ And defendant needed to develop a better ability to recognize early warning signs and high risk situations.

Defendant testified that in his view, he had completed his treatment and was ready for release into the community without supervision. He acknowledged that CONREP had five levels of programming—intensive, intermediate, supportive, transitional, and aftercare—and the program was designed to guide patients through these levels, which can take up to five years. However, defendant felt that the program was too limiting, and

³ On cross-examination, Doctor Johnson agreed that there was no evidence that prior to the Adobe incident, defendant had been hospitalized for psychiatric problems or dangerous behavior or engaged in criminal activity directly related to his psychiatric problems.

⁴ Doctor Johnson conceded that there were two schools of thought concerning whether it was appropriate for a patient to delve into delusions, hallucinations, and psychotic processes.

if released, he would be able to exercise more freedom in the community and do things like getting employment and housing.

Defendant did not think he was suffering from a mental disorder at the moment because he was symptom free. He acknowledged that he had a mental condition—paranoid schizophrenia—and needed to take medication to control hallucinations, delusional thinking, and behavior patterns like those he was experiencing during the Adobe incident. He said he knew that if he stopped taking his medication, those symptoms of his schizophrenia would return. However, he said he would continue to take his medication if released and would do so for the rest of his life because it allowed him to remain stable and symptom free.

Defendant acknowledged that his father orally copulated him and that at times in his life he had hallucinations that his genitalia were being attacked and his semen was being stolen. However, he disagreed with Doctor Johnson's view that the sexual abuse was related to those particular delusions. According to defendant, those delusions were religious-based and related to feelings of being spiritually attacked by Satan. Defendant did not consider himself an alcoholic but acknowledged having a problem with marijuana. However, he regularly attended separate drug and alcohol 12-step programs in San Jose, where he has had a sponsor for several months. He said he was currently working on his fourth step. He said he knew about programs directed at marijuana use, but his curfew limited him to the other programs. He said that he no longer had any urge to drink or use marijuana. Although in the past, he had engaged people whom he saw using drugs and alcohol, he now realized that he needed to avoid them and those situations.

Defendant believed that if released from CONREP, his greatest sources of stress would be homelessness and poverty. However, he thought he could find a job and housing. He thought it possible that he could get his old job back at a ranch. However,

he acknowledged that there was no job opening there, and the ranch was isolated, which would make it difficult for him to get ongoing therapy.

At the conclusion of the hearing the court found that due to his mental condition, defendant would represent a danger without continued supervision and treatment by CONREP.

B. DISCUSSION

A single psychiatric opinion that an individual on outpatient status would be dangerous because of a mental disorder without continued supervision can constitute substantial evidence to support an extension of outpatient status. (See *People v. Bowers* (2006) 145 Cal.App.4th 870, 879 [one expert opinion sufficient to support psychiatric recommitment]; accord *People v. Zapisek* (2007) 147 Cal.App.4th 1151, 1165.)

Doctor Johnson's conclusions that defendant would pose a danger without continued supervision and that because of his schizophrenia, he would have serious difficulty controlling his behavior support the court's findings on those issues and the extension of defendant's outpatient status. However, as defendant correctly notes, Doctor Johnson's expert opinion does not automatically constitute substantial evidence. Rather, the value of an expert's opinion on a given matter rests not on the ultimate conclusion but rather on the material from which that opinion is fashioned and the expert's reasoning from the material to the conclusion. In other words, " ' Expert evidence is really an argument of an expert to the court, and is valuable only in regard to the proof of the *facts* and the validity of the *reasons* advanced to the conclusions. ' " (*People v. Bassett* (1969) 69 Cal.2d 122, 141; *People v. Coogler* (1969) 71 Cal.2d 153, 167.) Accordingly, " '[w]here an expert bases his conclusion upon assumptions which are not supported by the record, upon matters which are not reasonably relied upon by other experts, or upon factors which are speculative, remote or conjectural, then his conclusion has no evidentiary value. [Citations.] In those circumstances the expert's opinion cannot rise to the dignity of substantial evidence. [Citation.]' [Citation.]" (*Borger v. Department of*

Motor Vehicles (2011) 192 Cal.App.4th 1118, 1122, quoting *Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1135; *Lockheed Martin Corp. v. Superior Court* (2003) 29 Cal.4th 1096, 1110; *Place v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 372, 378.)

Defendant points out that there is no evidence that prior to the underlying incident he ever posed a risk or danger to anyone. He notes that the incident was the result of *untreated* schizophrenia. Now, however, he was clean and sober and being successfully treated with medication that stopped his hallucinations and delusional thinking. Moreover, he notes that Doctor Johnson did not believe that he would immediately stop taking his medication if released from CONREP. Doctor Johnson also acknowledged that defendant knew he needed to take medication to control the symptoms of his schizophrenia, and defendant testified that he knew his symptoms would return if he stopped taking his medication.

Defendant asserts that instead of providing factually-based reasons why defendant was dangerous, Doctor Johnson offered only an opinion of potential future dangerousness based on a hypothetical scenario in which sometime after being released, defendant started using alcohol and marijuana again and stopped taking his medication, which in turn would render him susceptible to his schizophrenia and the sort of hallucinations, delusional thinking, and lack of behavioral control he manifested in the underlying incident. Defendant argues that although it was reasonable for Doctor Johnson to be concerned about what would happen *if* he started using alcohol and marijuana and also stopped taking his medication, his opinion was based on the speculative assumption that he would, in fact, do so. Such speculation, he claims, does not constitute substantial evidence that he was dangerous and had serious difficulty controlling his behavior.

We do not agree that Doctor Johnson's opinion that he would have trouble controlling his behavior and pose a risk of danger was pure and unfounded speculation.

Doctor Johnson testified that defendant had not succeeded in his relapse prevention plan. Defendant's understanding of his mental illness was limited and inconsistent, in that at times, he believed that when taking his medication and symptom-free, he did not have a mental disorder. However, his schizophrenia was a constant, chronic condition that did not appear one day and disappear depending on whether he took his medication.

Doctor Johnson also found that defendant did not understand his history in a therapeutically significant way that would help him recognize that mental distortions and perceptions were the warning signs of high risk situations. Moreover, in minimizing or disavowing past events, defendant failed to grasp how they informed the delusional and distorted thinking and perceptions he had experienced in the past.

Although defendant was able to remain clean and sober under the close supervision of CONREP and participated in 12-step programs, Doctor Johnson noted that he had shown a lack of insight concerning red-flag situations and the skills necessary to avoid them, especially involving marijuana. As a result, defendant was at high risk of relapse. This evaluation was supported by evidence that defendant had engaged in, rather than avoided, situations involving marijuana. Defendant's statement that he would smoke if he were free to do so was particularly relevant and supported Doctor Johnson's view that defendant was at high risk, especially when he was no longer subject to regular CONREP drug testing. Doctor Johnson's assessment was also supported by defendant's potential homelessness and lack of a local support group that, like CONREP, could help him cope with and avoid red flag situations.

Defendant's testimony indirectly supported aspects of Doctor Johnson's testimony conclusions. Defendant denied any connection between his history as a victim of sexual abuse and the underlying incident, and this confirmed Doctor Johnson's opinion that defendant did not grasp the relationship between his history and the delusional thinking. Moreover, to the degree that defendant disagreed with or contradicted Doctor Johnson's

testimony about specifics concerning the impact of past trauma on defendant's delusional thinking or its relationship to the underlying incident, the trial court resolved the debate in Doctor Johnson's favor; and under the substantial evidence test, we are obliged to accept the court's credibility determination. (*People v. Ochoa* (1993) 6 Cal.4th 1199, 1206.)

We note that defendant was participating in a 12-step program for alcohol abuse, but denied that he was an alcoholic. Moreover, he admitted engaging in, rather than avoiding, situations and discussions involving marijuana. Finally, defendant acknowledged that CONREP offered a structured model in which a defendant proceeds through various stages and ended in reintegration into the community, and CONREP provided support for each stage. Nevertheless, defendant felt it was unnecessary for him to complete the process and sought immediate release even though homelessness, lack of money, lack of a support group, and lack of realistic employment and housing plans would be stressors.

In our view, the factors cited by Doctor Johnson concerning the limitations on defendant's understanding of his mental disorder, his lack of a fully realized relapse prevention plan, his inability to grasp the historical components of his delusional thinking and its warning signals, a lingering interest in marijuana, his high risk of relapse, and his lack of a social network to replace CONREP reasonably support his view that defendant was likely to relapse and stop taking his medication and that without CONREP supervision, defendant, as a result of his schizophrenia, would pose a danger to others and have serious difficulty controlling his behavior. Although defendant sought to rebut Doctor Johnson's view that he might relapse and stop taking his medication, the court, having observed him testify, was entitled to determine his credibility and implicitly found Doctor Johnson's view to be more persuasive and credible.

Under the circumstances, we conclude that there was sufficient evidence to support the court's finding that defendant would pose a danger without continued supervision and treatment on outpatient status.

IV. FAILURE TO COMPLY WITH SECTION 1026.5

Defendant contends that the court violated the procedural requirements set forth in section 1026.5, subdivision (b) in failing to advise him of his right to a jury trial and in conducting a court trial without obtaining his express personal jury waiver.

Initially, the record did not reveal either an advisement or an express waiver. In our original opinion, however, we concluded that defense counsel had authority to waive a jury trial on defendant's behalf and implicitly did so by proceeding with a court trial. Given counsel's waiver, we found the court's apparent failure to advise harmless. We later granted rehearing on our own motion and directed the trial court to prepare a settled statement concerning whether there was an *express* advisement and waiver. (See Cal. Rules of Court, rule 8.137.) The court's statement revealed that it did not advise defendant, but that counsel had expressly waived a jury trial at an unreported, in chambers conference. Thereafter, we requested further briefing on a number of issues including whether the procedures set forth in section 1026.5, subdivision (b)—in particular a jury advisement and waiver—apply at a hearing on a petition under section 1606 to extend outpatient treatment. We now conclude that these procedures do not apply. Thus, we reject defendant's claims.

A. THE STATUTORY FRAMEWORK

Under section 1026, subdivision (a), when a defendant is found not guilty of criminal charges by reason of insanity, the court must commit the defendant to a state hospital for care and treatment of the mental disorder unless it appears that the defendant has recovered his or her sanity. Thereafter, the NGI defendant may not be kept in actual custody longer than the maximum state prison term to which he or she could have been sentenced for the underlying offense. (§ 1026.5, subd. (a)(1).) Before the expiration of

the commitment, the district attorney may file a petition to extend or recommit the defendant for two years based on allegation that the defendant presents a substantial danger of physical harm to others because of a mental disease, defect, or disorder. (§ 1026.5, subs. (b)(1), (b)(2), & (b)(10).) Under section 1026.5, subdivisions (b)(3) and (b)(4), the defendant has the right to a jury trial on a petition to extend a state hospital commitment; and when such a petition is filed, the court must advise the defendant of his right to a jury trial and conduct a jury trial unless it is waived by both the parties.⁵

Once an NGI defendant is committed to a state hospital, section 1026.1 provides that he or she may be released in only one of three ways: (1) when the defendant or the director of the defendant's state hospital or outpatient treatment facility formally applies for release under section 1026.2 on the ground that the defendant's sanity has been restored; (2) where the maximum time of the NGI commitment has expired and not been extended under section 1026.5, subdivision (b); or (3) when the defendant has been granted outpatient status under the provisions of section 1600 et seq. (See *People v. Soiu* (2003) 106 Cal.App.4th 1191, 1194-1195.)

⁵ Section 1026.5, subdivision (b)(1) provides: "A person may be committed beyond the term prescribed by subdivision (a) only under the procedure set forth in this subdivision and only if the person 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."

Section 1026.5, subdivision (b)(3) provides: "When the petition is filed, the court shall advise the person named in the petition of the right to be represented by an attorney and of the right to a jury trial. The rules of discovery in criminal cases shall apply. If the person is being treated in a state hospital when the petition is filed, the court shall notify the community program director of the petition and the hearing date."

Section 1026.5, subdivision (b)(4) provides: "The court shall conduct a hearing on the petition for extended commitment. The trial shall be by jury unless waived by both the person and the prosecuting attorney. The trial shall commence no later than 30 calendar days prior to the time the person would otherwise have been released, unless that time is waived by the person or unless good cause is shown."

B. DISCUSSION

This case involves the third option for release. The court granted a recommendation by CONREP and the medical group that defendant be placed in an outpatient treatment program, and he was released from state hospital. (See §§ 1026.1, subd. (c), 1600, 1603, & 1604.) Before the expiration of the one-year of outpatient treatment, the prosecutor filed a petition under section 1606 to extend it.

Section 1606 provides, in relevant part; “Outpatient status shall be for a period not to exceed one year. At the end of the period of outpatient status approved by the court, the *court* shall, after actual notice to the prosecutor, the defense counsel, and the community program director, and after a hearing in court, either discharge the person from commitment under appropriate provisions of the law, order the person confined to a treatment facility, or renew its approval of outpatient status. Prior to such hearing, the community program director shall furnish a report and recommendation to the medical director of the state hospital, where appropriate, and to the court, which the court shall make available to the prosecutor and defense counsel. The person shall remain on outpatient status until the *court* renders its decision unless hospitalized under other provision of the law. The hearing pursuant to the provisions of this section shall be held no later than 30 days after the end of the one-year period of outpatient status unless good cause exists. The court shall transmit a copy of its order to the community program director or a designee.” (Italics added.)

The terms of section 1606 expressly provide for the *court* to make the determination of whether to extend previously granted outpatient status. Section 1026.5, subdivision (b), on the other hand, provides the right to a jury trial on a petition to extend a custodial commitment in a state hospital. That section illustrates that if and when the Legislature intends to establish a statutory right to a jury trial, it knows how to do so clearly and explicitly. (Cf. § 2972, subd. (a) [expressly providing right to jury trial on petition to extend hospital commitment as a mentally disordered offender]; see *People v.*

Cole (2006) 38 Cal.4th 964, 980 [express statutory exceptions show that when Legislature wants to create them, it knows how].)

The Supreme Court made this very point in *People v. Tilbury* (1991) 54 Cal.3d 56 (*Tilbury*). There, the court construed similar statutory language in section 1026.2, which, as noted, governs one of three ways in which an NGI defendant may be released from a custodial commitment in a state hospital, namely, upon restoration of sanity. (§ 1026.1, subd. (a).) At that time section 1026.2, subdivision (e) provided, in relevant part: “The *court* shall hold a hearing to determine if the person applying for restoration of sanity would no longer be a danger to the health and safety of others, including himself or herself, 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, including himself or herself, while under supervision and treatment in the community, the *court* shall order the applicant placed with an appropriate local mental health 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, including himself or herself. The court shall not determine whether the applicant has been restored to sanity until the applicant has completed the one year in the appropriate local mental health program. . . .” (Italics added.)⁶

⁶ Section 1026.2, subdivision (e) now provides, in relevant part, “*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

In *Tilbury*, the defendant initiated the process for his release based on the restoration of sanity by applying for release from state hospital on outpatient status under section 1026.2. He requested a jury trial, but it was denied. On appeal, he claimed he was entitled to a jury trial on his outpatient placement. In rejecting this claim, the Supreme Court acknowledged that upon completion of the required one-year of supervised outpatient treatment, a defendant has a right to a jury trial concerning whether his or her sanity has been restored. (*Tilbury, supra*, 54 Cal.3d at p. 60; *In re Franklin* (1972) 7 Cal.3d 126, 148-149 [equal protection entitles defendant to jury at sanity-restoration trial].) However, the issue before it was whether a defendant was entitled to a jury trial at the initial “hearing” on whether he or she should be released for outpatient treatment. Considering the issue as a matter of statutory construction, the court observed that “[t]he relevant statute does not purport to give a committed person the right to a jury at the hearing on outpatient placement.” Noting that the statute specifically provided that “ ‘[t]he court shall hold a hearing’ ” to determine whether the person would pose a danger if released for supervised treatment, and that if “ ‘the court’ ” so finds, then “ ‘the court’ ” shall order the defendant to an outpatient program, the Supreme Court opined that “[i]f the Legislature had intended to require juries at placement hearings, it knew how to say so clearly.” (*Tilbury, supra*, 54 Cal.3d at pp. 60-61, italics in *Tilbury*.) Indeed, the court noted that “[i]n the same statutory scheme the Legislature expressly provided for juries at the sanity phase of criminal trials . . . and at hearings to recommit at the end of the maximum term” (*Ibid.*, fns. omitted.) The court further rejected 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” (Italics added.)

Although the current version differs from the former version in some respects, the difference does not undermine the analysis in *Tilbury*; nor is it relevant to our analysis in this case.

defendant's claim that the term "hearing" actually meant and had to be interpreted to mean a jury trial because that is what the Legislature intended. The court could find no "good reason to believe that the Legislature actually intended to require jury trials on the issue of outpatient placement" and concluded that such a requirement was inconsistent with the purpose of section 1026.2, subdivision (e) and the reason for imposing a period of outpatient treatment as a prerequisite to release. (*Id.* at pp. 61-63.)⁷

We recognize that *Tilbury* involved the right to a jury trial at the hearing on an *initial* outpatient placement, and this case involves the right to a jury trial on the extension of such a placement. In our view, however, this is a distinction without a difference. In both situations, the primary concern is the safety of others in the community, and the determination hinges on the status of a defendant's mental disease, defect, or disorder and defendant's dangerousness due to his or her mental status. Moreover, whether a defendant is released from a hospital or from an outpatient treatment program, the question is whether a supervised treatment program is necessary to protect others while the defendant is in the community. Under the circumstances, therefore, we fail to see why the Legislature would provide for a jury trial in one situation but not the other.

In short, if the Legislature had intended to provide the right to a jury trial on a petition under section 1606 to extend outpatient status, we believe it would have done so clearly, if not expressly. In construing a statute, a court's responsibility "is simply to ascertain and declare what is in terms or in substance contained therein, not to insert what has been omitted" (Code Civ. Proc., § 1858.) Courts may not, under the guise of interpretation add language or insert provisions to accomplish a purpose that does not appear in the language of the statute itself. (*People v. Morris* (1988) 46 Cal.3d 1, 15,

⁷ The court also rejected the defendant's claims that principles of equal protection and his right to due process required a jury trial on the issue of outpatient placement. (*Tilbury, supra*, 54 Cal.3d at pp. 63-70.)

disapproved on other grounds in *In re Sassounian* (1995) 9 Cal.4th 535, 543-544, fn. 5; *Bank of America v. Salinas Nissan, Inc.* (1989) 207 Cal.App.3d 260, 270; see Code Civ. Proc. §§ 1858 & 1859.) Where, as here, the statute expressly provide that the court shall decide whether to extend outpatient status, we decline judicially amend it to provide the defendant with a statutory right to a jury trial on that issue.

Defendant's reliance on *People v. Superior Court (Almond)* (1990) 219 Cal.App.3d 607 (*Almond*) is misplaced.

In *Almond*, an NGI defendant was committed to a state hospital and later granted outpatient status. While an outpatient, he sought unconditional release by filing a petition under section 1026.2, subdivision (a) based on the restoration of sanity. Although defendant had the right to a jury trial (*In re Franklin, supra*, 7 Cal.3d at pp. 148-149), he waived it. But when the trial court proposed to proceed without a jury, the People asserted their right to a jury trial, and the court scheduled a jury trial. Before the trial, the defendant's outpatient program recommended his release from outpatient status under section 1607. The defendant then argued that this changed the nature of the proceedings, and the People no longer had the right to a jury trial because section 1607 did not provide for a jury trial. The superior court agreed. The People then sought a writ to compel a jury trial. (*Almond, supra*, 219 Cal.App.3d at pp. 609-610.)

The issue before the court was whether the People have the same right to a jury trial when an outpatient program requests release under section 1607 as when an NGI defendant applies for restoration under section 1026.2, subdivision (a). The court noted that section 1607 states: “ ‘If the outpatient supervisor is of the opinion that the [NGI defendant] . . . is no longer insane, . . . the community program director shall submit such opinion to the medical director of the state hospital, where appropriate, and to the court which shall calendar the case for further proceedings under the provisions of Section . . . 1026.2 of this code’ ” (*Almond, supra*, 219 Cal.App.3d at p. 611.) The defendant noted that section 1606 provided for only a “hearing” and not a jury trial and

argued that the “further proceedings” referred to in section 1607 similarly referred to only a hearing and not a jury trial. In rejecting this argument, the court pointed out that “it overlooks the fact that section 1607 meshes with section 1026.2 by requiring proceedings under section 1026.2 when an outpatient program recommends sanity be restored.” (*Id.* at p. 612, italics added.) Accordingly, the court held that the People are entitled to a jury trial under section 1026.2 regardless of whether the NGI defendant applies for release directly under section 1026.2 or the outpatient program does to indirectly by filing a request under section 1607. (*Ibid.*)

In this case, defendant did not file a petition under section 1026.2, subdivision (a) for release due to the restoration of his sanity. Nor did defendant’s outpatient program do so under section 1607 for release from outpatient status. On the contrary, defendant’s treatment director at CONREP, in essence, recommended that his outpatient status be extended. Moreover, here the district attorney filed a petition under section 1606 seeking to extend outpatient status on the ground that defendant would pose a danger to others in the community without continued supervision and treatment. We note that despite their statutory proximity and their relationship to the same subject, sections 1606 and 1607 differ in a pertinent respect: section 1607 expressly requires further proceedings under section 1026.2, whereas section 1606 does not even refer to that statute. For these reasons, *Almond* is distinguishable and does not convince us that defendant was entitled to a jury trial.

Defendant notes that under section 1606, the court is authorized to “either discharge the person from commitment under appropriate provisions of the law, order the person confined to a treatment facility, or renew its approval of outpatient status.” (§ 1606.) According to defendant, the possibility that the court could discharge an outpatient NGI defendant renders the “hearing” on a section 1606 petition “the functional equivalent of a restoration of sanity determination,” and concerning that determination, a defendant is entitled to a jury trial.

Although there is some logic to defendant’s argument, it is not sufficiently compelling for us first to ignore express language in section 1606 providing for *the court* to decide whether to extend outpatient status and then to legislate judicially a statutory right to a jury trial.

In sum, at the hearing on the petition under section 1606 to extend his outpatient status, defendant did not enjoy the same right to a jury trial he would have enjoyed at a restoration of sanity trial under section 1026.2. For this reason, we conclude that the procedures set forth in an altogether different statute —section 1026.5, subdivision (b)— did not apply.

V. DISPOSITION

The order extending defendant’s outpatient status is affirmed.

RUSHING, P.J.

WE CONCUR:

PREMO, J.

ELIA, J.