2013 IL App (2d) 080353-U
No. 2-08-0353
Order filed March 12, 2013

IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

In re COMMITMENT OF DAVID J. BROWN	)	Appeal from the Circuit Court of Winnebago County.
	)	No. 99-MR-245
(The People of the State of Illinois, Petitioner-Appellee, v. David J. Brown, Respondent-Appellant).	)	Honorable Rosemary Collins, Judges, Presiding.

PRESIDING JUSTICE BURKE delivered the judgment of the court.
Justices Jorgensen and Hudson concurred in the judgment.

ORDER

¶ 1 *Held:* The trial court did not abuse its discretion in committing respondent to the Illinois Department of Human Services, and respondent was not denied effective assistance of trial counsel; affirmed.

¶ 2 Following a bench trial, respondent, David J. Brown, appeals the order of the circuit court of Winnebago County committing him to the custody of the Illinois Department of Human Services (DHS) for residential treatment as a sexually violent person. Respondent contends that the trial court abused its discretion in committing him to DHS and he was denied effective assistance of trial counsel. We affirm.

¶ 3 FACTS

¶ 4 On December 20, 1999, the State filed a petition under the Sexually Violent Persons Commitment Act (Act) (725 ILCS 207/1 *et seq.* (West 2010)), alleging that respondent is a sexually violent person and requesting an order committing him to a secure facility for care, control, and treatment. The petition was supported by a psychological evaluation of respondent and alleged that (1) respondent previously was convicted of aggravated criminal sexual abuse, a sexually violent offense; (2) respondent suffers from the mental disorders of pedophilia and personality disorder with narcissistic features; and (3) respondent is dangerous to others because his mental disorders created a substantial probability that he would engage in future acts of sexual violence. The trial court found cause to believe that respondent was eligible for commitment under the Act, entered an order of detention, and set the matter for a probable cause hearing. Respondent was thereafter transferred from an Illinois Department of Corrections (DOC) center to a DHS facility. On January 10, 2000, following a hearing, the court found probable cause to believe that respondent was subject to commitment under the Act and set the matter for further proceedings.

¶ 5 On March 27, 2007, respondent agreed to a stipulated bench trial.[1] Respondent stipulated that he was convicted of aggravated criminal sexual abuse. He also stipulated that Dr. Barry Leavitt, a clinical psychologist who evaluated respondent, would testify that (1) respondent suffers from pedophilia (sexually attracted to males, nonexclusive type) and personality disorder (not otherwise specified, with compulsive, dependent, and avoidant personality traits and self-defeating personality features); (2) these mental disorders are congenital or acquired conditions that seriously affect

[1]The gap in time between hearings resulted from several motions that were filed by respondent.

respondent's emotional or volitional capacity and predispose him to engage in future acts of sexual violence; and (3) respondent is dangerous because his mental disorders make it substantially probable that he will engage in future acts of sexual violence. The court accepted the stipulation and found sufficient evidence to declare respondent a sexually violent person.

¶ 6 On February 11, 2008, the court conducted a dispositional hearing. Dr. Leavitt testified that he first evaluated respondent in early 2000, following the trial court's probable-cause finding. As part of that evaluation, Dr. Leavitt conducted an interview of respondent and reviewed respondent's records, including his DOC master file, prior psychological and treatment records, and police and investigative reports. Dr. Leavitt concluded that respondent suffered from a mental disorder that affects his emotional or volitional capacity and predisposed him to commit future acts of sexual violence. He believed that it was substantially probable that respondent will commit future acts of sexual violence.

¶ 7 Dr. Leavitt evaluated respondent again in 2005. At that time, he interviewed respondent again and reviewed the records of respondent's sex offender treatment at the DHS facility where respondent had resided since the December 1999 detention order. Dr. Leavitt testified that his "opinions remained the same following [the 2005] evaluation."

¶ 8 Dr. Leavitt evaluated respondent a third time in 2007. This evaluation, following the trial court's order declaring respondent a sexually violent person, was for the purpose of ascertaining respondent's treatment needs and identifying the least restrictive setting in which the necessary treatments could safely and effectively be administered. Dr. Leavitt interviewed respondent for this evaluation. Dr. Leavitt supplemented his previous evaluations by reviewing respondent's most recent DHS treatment records through December 2007, including assessments, evaluations, and

progress notes with respect to respondent's treatment in both the comprehensive sex offender treatment program and ancillary treatment groups.

¶ 9 Dr. Leavitt testified to the following. Respondent had been convicted of aggravated criminal sexual abuse and was incarcerated on that charge when the petition to commit him was filed in December 1999. That conviction arose from respondent's attempt to insert his hand into the shorts of a 12-year-old acquaintance named Ben in an attempt to fondle the child's genitals. Ben resisted, and respondent then became obsessed and preoccupied with Ben. He confronted Ben at a bus stop and attempted to talk to him. When Ben attempted to leave, respondent struck Ben in the face and restrained him.

¶ 10 Respondent admitted to Dr. Leavitt to having 11 sexual abuse victims (10 boys and 1 female). One was a 10-year-old boy whom respondent befriended. Respondent told Dr. Leavitt that, over a three-year-period, he fondled the boy's buttocks and genitals, engaged in acts of mutual masturbation with the boy, and on at least one occasion performed oral sex on the boy. Although never charged with sexual abuse, respondent was convicted of destruction of property and assault for cutting the telephone wires at the boy's home to prevent him from calling the police.

¶ 11 Dr. Leavitt opined that respondent experienced a "growing interest and preoccupation with younger male children," which began in respondent's mid-to late-adolescent years and extended into his early adulthood and which included "extensive and *** ongoing sexual fantasies and urges." Respondent became obsessed with these fantasies and urges and displayed a "clear inability to adequately control his sexual impulses." Dr. Leavitt explained that these past acts of abuse demonstrate "a serious level and chronicity and persistence to [respondent's] sexually deviant interests [in] behavior," including "the use of extensive manipulation, grooming, and at some point

in time excessive aggression and/or physical force." Dr. Leavitt stated that respondent's past actions displayed an inability or refusal to control his impulses.

¶ 12 Dr. Leavitt concluded that respondent continues to suffer from pedophilia, sexually attracted to males, nonexclusive type; dysthymic disorder in at least partial remission; and a personality disorder not otherwise specified with dependent, compulsive, and avoidant traits, as well as self-defeating personality features. He explained that a pedophilia diagnosis requires "a history of recurrent *** sexual urges, impulses, and/or behaviors involving pre-pubescent children that extends over at least a six-month period of time" and "cause a disruption to [one's] social or adaptive functioning." Dr. Leavitt believed that respondent had suffered from recurrent urges and fantasies or behaviors involving children dating back to his mid-adolescence, which involved serious disruption to his social and overall adaptive function. Dr. Leavitt noted that pedophilia is a mental disorder affecting volitional control and predisposes respondent to commit future acts of sexual violence.

¶ 13 Dr. Leavitt explained that the dysthymic disorder is a form of depression. It does not predispose respondent to commit future acts of sexual violence, but is "an additional risk consideration and treatment issue." Similarly, Dr. Leavitt did not believe that respondent's personality disorder predisposes respondent to commit future acts of sexual violence. Rather, Dr. Leavitt believed that it was a complicating risk factor that might undermine respondent's ability to make effective and meaningful use of available treatment. However, Dr. Leavitt explained that the combination of these three mental disorders created a "complexity of concerns" that were crucial to the issue of whether respondent should be treated in the community or in a secure facility. Dr. Leavitt believed that, when dealing with an individual who suffers from a serious predisposing

mental disorder of a long-standing nature and has the additional disorders that respondent suffers from, there are other problems that may undermine the individual's ability to make effective use of the treatments that would be available.

¶ 14 As to respondent's future risk, Dr. Leavitt employed the Static-99 actuarial risk assessment instrument. This assessment places an individual in a particular risk-of-reoffense category based on the individual's static (or "unchangeable") risk factors. It provides "a baseline or starting off point in terms of understanding an individual's sexually violent reoffense risk," and it has been shown to be reliable and valid in assessing the risk for future sexual reoffenses among the sex offender population.

¶ 15 Respondent scored a five on the Static-99, placing him in the "moderate high category of reoffense risk." While the Static-99 is a starting point for assessing an individual's risk level, Dr. Leavitt also considered the presence of various "dynamic risk factors" that "would potentially elevate [respondent's] level of risk to a higher threshold." Dr. Leavitt concluded, having considered respondent's static and dynamic risk factors, that respondent's "risk level was high, and that there was a continued substantial probability of [respondent] reoffending at some time in the future."

¶ 16 Dr. Leavitt testified that the best way to treat respondent is through intensive sex offender specific treatment, which serves to address specific dynamic risk factors and treatment needs and then to address, through other types of ancillary or other relevant treatments, any additional factors that might serve to support or undermine the ability of an individual (like respondent) to make meaningful and good use of treatment. Dr. Leavitt believed that the DHS facility in Rushville, Illinois, provides that type of comprehensive sex offender treatment, as its "core sex offense treatment program is *** a comprehensive program that is designed to address sex offender specific

treatment risk factors and treatment needs." Dr. Leavitt opined that no other sex offender treatment program of similar intensity is available outside of the DHS secure care facility.

¶ 17 When asked about the various outpatient sex offender programs in Winnebago County, Dr. Leavitt testified that those programs were "limited in scope" and were not comparable to the DHS secure care treatment facility. Dr. Leavitt testified that there was no method of treatment, other than the program offered at DHS, that would adequately and safely meet respondent's treatment and security needs. Dr. Leavitt opined that "the least restrictive and appropriately available treatment setting would be the secure care treatment available to him through the [DHS] at Rushville."

¶ 18 Dr. Leavitt stated that respondent was not currently participating in the core sex offender treatment program, despite being housed at DHS. He had participated in the core sex offender treatment program for about three and one half years but quit the program in June 2004, and has since refused to return. Respondent was participating only in some of the facility's "ancillary or supportive groups secondary to the core sex offender specific program." Although the ancillary groups are additional important tools, they are not substitutes for core treatment, which is the major treatment vehicle for sex offenders and is essential for reducing their risk of reoffense.

¶ 19 At the time respondent quit the program in June 2004, respondent had progressed only to the second phase of the five-phase program. Dr. Leavitt explained that respondent had not been able to come to terms with understanding the full extent of his pattern of sexual deviance; a key component of respondent's being able to put together an adequate relapse prevention plan that would allow him to function safely in the community. Neither has respondent "develop[ed] the kinds of interpersonal *** adequate coping skills that would allow him to deal with frustration [and] disappointments, without just externalizing blame onto others."

¶ 20 Dr. Luis Rosell, a clinical and forensic psychologist, testified for respondent. He evaluated respondent for the purpose of determining whether respondent could be treated in the community. Dr. Rosell interviewed respondent in October 2007 and reviewed prior evaluations of respondent and "some other types of records." Dr. Rosell did not perform any actuarial tests on respondent, review any of respondent's treatment records, or speak with any of respondent's treatment providers at DHS.

¶ 21 Dr. Rosell acknowledged that Dr. Leavitt properly scored the Static-99 test and that respondent's score of five on the test indicates a 40% chance of reoffense within 15 years and a 30% chance within 10 years.

¶ 22 Although respondent did not complete the core sex offender treatment program, Dr. Rosell believed that the fact that respondent had been in treatment for three years was a factor to consider. Dr. Rosell also emphasized that the fact that respondent has acknowledged his victims, "more than we knew about" demonstrated "his honesty, his desire *** to confess his past and to move on."

¶ 23 Dr. Rosell concluded that enough conditions could be offered to allow respondent to be released into the community for treatment. These conditions include appropriate housing, employment, and treatment. He noted two outpatient programs in Winnebago County that would provide appropriate treatment and "keep him safe," one of which offered a fairly comprehensive program, where the groups meet between one and three times a week, and the other offering individual therapy.

¶ 24 Respondent testified that he participated in the core sex offender treatment program at DHS for three years but quit in 2004 because "roadblocks were being placed in front of [him]." He explained that the roadblocks were the treatment providers told him that he needed to be in tactics group, which is a program for people who are blocking change and helps them to not be so defensive

when they are a focus in core group. Respondent did not believe that he was blocking change and that, "to a degree," he knew more about his psychological problems and needs for treatment than his treatment providers did.

¶ 25 Respondent testified that he left the program because of "disingenuous assessments" of him by his providers, particularly a report that he "had challenged staff when it came to following the rules." Respondent talked to various staff and told them that they were lying about this and that this was damaging his treatment progress. When the matter was not resolved to respondent's satisfaction, he quit the core group. Respondent stated that, if he were released into the community, he would attend sex offender treatment if that was a condition of his release. He did not know whether he would return to treatment in the core sex offender program if he was not given conditional release.

¶ 26 Respondent believed that his likelihood of reoffending was minimal, that he has accepted responsibility for his actions, and has accepted his "sexuality." Respondent stated that he is now "able to be up front with [his] parents, which [he] felt [he] couldn't do before," and that he is no longer the person that he was in 1998 when he was convicted of aggravated criminal sexual abuse.

¶ 27 The trial court rendered its decision on March 25, 2008. The court concluded that Dr. Leavitt's testimony was "more compelling" than Dr. Rosell's testimony, noting that Dr. Leavitt "had a better grasp of what the appropriate treatment would be." The court noted the importance of respondent's long-standing refusal to participate in the core sex offender treatment program after having completed just the first phase of the five-phase program. Because of that refusal, the court concluded that respondent had not come to terms with accepting the full extent of his behavior and "his sexually deviant arousal." The court noted that respondent did participate in several ancillary

treatment groups, but these groups, while helpful, were not a substitute for the core treatment program that is not available anywhere else. The court further observed that the available outpatient options are not in a secure facility that would "not only protect the community but also protect the respondent." Accordingly, the court concluded that "the least restrictive and most beneficial placement for treatment" for respondent was to be committed to the secure care and the custody of the DHS at the Rushville Treatment and Detention Facility. Respondent timely appeals.

¶ 28 ANALYSIS

¶ 29 Committing Respondent to Institutional Care

¶ 30 Respondent first contends that the trial court abused its discretion in committing him to the secure care and custody of DHS. Respondent's argument is premised on the belief that the trial court reviewed only the reports submitted at the dispositional hearing and that the State failed to present live medical testimony to establish respondent's current mental state. Because the court's decision was not based on live medical testimony, respondent argues that its decision to commit him to the secure care and custody of DHS was an abuse of discretion.

¶ 31 The appellate record prepared by the clerk of the circuit court initially did not contain the transcript of the evidentiary hearing that took place on February 11, 2008. It is respondent's burden, as appellant, to provide this court with an adequate record on appeal to support his claim. Ordinarily, the absence of such evidence in the record is construed against the appellant, which is respondent. See *Foutch v. O'Bryant*, 99 Ill. 2d 389, 391-92 (1984) (explaining that any doubts that might arise from the incompleteness of the record will be resolved against the appellant). In this case, even though it was not the State's burden to do so, it supplemented the record on appeal with the transcript of the evidentiary hearing, and the record of the dispositional hearing clearly shows that

the State as well as respondent presented live expert testimony. Moreover, the trial court, in rendering its decision, specifically referred to "the testimony of the doctors." Accordingly, respondent's argument lacks merit.

¶ 32 The State argues that, because respondent makes no argument that, in light of the experts' live testimony, the trial court abused its discretion in committing respondent to secure care, any such argument is forfeited and should be rejected on that ground. Regardless of whether respondent has forfeited the argument, we find that the trial court properly exercised its discretion in committing respondent to secure care rather than conditionally releasing him.

¶ 33 "In determining whether commitment shall be for institutional care in a secure facility or for conditional release, the court shall consider the nature and circumstances of the behavior that was the basis of the allegation in the petition, *** the person's mental history and present mental condition, and what arrangements are available to ensure that the person has access to and will participate in necessary treatment." 725 ILCS 207/40(b)(2) (West 2010). A trial court's decision to commit a respondent to secure care is reviewed only for abuse of discretion. See *In re Detention of Lieberman*, 379 Ill. App. 3d 585, 609 (2007). An abuse of discretion will be found only where the trial court's ruling is arbitrary, fanciful, unreasonable, or where no reasonable person would take the view adopted by the trial court." *Id.*

¶ 34 The substantial evidence presented by the State through Dr. Leavitt's testimony supports the trial court's decision to commit respondent to secure care. Such evidence includes (1) respondent's conviction of aggravated criminal sexual abuse; (2) respondent's admission to abusing a boy in Virginia; (3) respondent's extensive history of sexually abusing 10 other young children; (4) respondent's diagnosis of pedophilia; (5) the actuarial risk assessment of respondent placing him at

a moderate high risk to reoffend; (6) respondent's dropping out of core sex offender treatment in 2004; (7) respondent's completing only level one of five in core treatment; and (8) the treatment options in the community did not compare to those offered by DHS.

¶ 35 Although Dr. Rosell did disagree with the recommendation made by Dr. Leavitt to commit respondent to secure care at DHS, believing that there were adequate treatment options available in the community, Dr. Rosell formed his opinion without reviewing respondent's past treatment records and did not interview respondent's DHS providers. The trial court acted well within its discretion in discounting Dr. Rosell's testimony and crediting Dr. Leavitt's testimony, and it is not the function of this court to reweigh the evidence, make credibility determinations, or resolve conflicting evidence. See *In re Detention of Ehrlich*, 2012 IL App (1st) 102300, ¶ 76; *In re Detention of Welsh*, 393 Ill. App. 3d 431, 457 (2009). We find that the trial court's decision to commit respondent to secure care was not arbitrary, fanciful, or unreasonable. Thus, based on the evidence presented, we cannot say that the trial court's decision was an abuse of discretion.

¶ 36 Ineffective Assistance

¶ 37 Respondent next contends that he was provided ineffective assistance of trial counsel. To prevail on an ineffective assistance claim, respondent must show that counsel's performance was deficient, and that the deficiency prejudiced his defense. *Strickland v. Washington*, 466 U.S. 668, 687 (1984). To establish deficiency, respondent must show that counsel's performance "fell below an objective standard of reasonableness." *Id.* at 688. To demonstrate prejudice, respondent "must show that there is a reasonable probability that, but for counsel's unprofessional errors, the result of the proceeding would have been different." *Id.* at 694.

¶ 38 We initially question whether a respondent in a commitment proceeding is entitled to ineffective assistance claims under *Strickland*. While the Act affords respondents the right to counsel (see 725 ILCS 207/25(c)(1) (West 2010)), that right is statutory in nature and not tied by statute to the constitutional right to counsel in criminal proceedings. Thus, whether the right to effective assistance of counsel under the Act should be determined by the *Strickland* standard remains an open question. We need not decide this issue, however, because even applying the *Strickland* standard results in an affirmance.

¶ 39 Respondent raises three arguments in support of his ineffective assistance claim. First, he maintains that his attorney was ineffective for failing to object to the lack of personal jurisdiction because he was not properly served with a summons. The Act does not require service of a summons or service of process. Rather, it provides that "[a]ny person who is the subject of a petition filed under [the] Act shall be served with a copy of the petition in accordance with the Civil Practice Law." 270 ILCS 270/25(a) (West 2010). The record demonstrates that respondent was served with a copy of the petition in the probable cause proceedings.

¶ 40 Moreover, even if the Act required the State to serve a respondent not only with a copy of the petition but also with a summons, the trial court would respond to an objection by serving respondent immediately. *In re Detention of Erbe*, 344 Ill. App. 3d 350, 362-63 (2003). Therefore, there is no reasonable probability that a motion to dismiss for lack of personal jurisdiction based on the State's failure to serve a summons would have succeeded or that the result of the proceedings would have been different. Counsel performing in an objectively reasonable manner would have known that objecting to service would have gained respondent nothing.

¶ 41 Second, respondent asserts that his attorney was ineffective for failing to present live testimony at the dispositional hearing and for failing to file any motion *in limine* to prevent the State from introducing only the written report of Dr. Leavitt. In addition, respondent blames his counsel for "fail[ing] to cross-examine Dr. Leavitt, who was not personally present and did not testify for the People during the Dispositional Hearing," and for failing to "bring Dr. Luis Rosell to appear and testify in person." These claims are affirmatively refuted by the record. As pointed out above, the record clearly shows that both the State and respondent presented live expert testimony, including Drs. Leavitt and Rosell, at the dispositional hearing. Accordingly, this argument simply has no factual basis.

¶ 42 Respondent's last contention is that his counsel was ineffective for failing to file a posttrial motion to preserve issues for appeal. Respondent does not state what issues in particular he believes were forfeited by counsel's failure to file a posttrial motion. Regardless, counsel's failure to file a posttrial motion cannot forfeit issues for appeal because, under Supreme Court Rule 366(b)(3)(ii) (eff. Feb. 1, 1994), "[n]either the filing of nor the failure to file a post judgment motion limits the scope of review" after a non-jury proceeding. In sum, we find that respondent's trial counsel did not provide ineffective assistance of counsel.

¶ 43 The judgment of the circuit court of Winnebago County is affirmed.

¶ 44 Affirmed.