2016 IL App (2d) 140984-U
No. 2-14-0984
Order filed August 3, 2016

IN THE

APPELLATE COURT OF ILLINOIS

SECOND DISTRICT

In re COMMITMENT OF JOHN L. BIRCH	)	Appeal from the Circuit Court
	)	of DeKalb County.
	)	
	)	
	)	
(The People of the State of Illinois,	)	No. 05-MR-152
Petitioner-Appellee v. John L. Birch	)	
Respondent-Appellee).	)	Honorable
	)	Robbin J. Stuckert,
	)	Judge, Presiding.

JUSTICE McLAREN delivered the judgment of the court.
Justices Jorgensen and Birkett concurred in the judgment.

ORDER

¶ 1 *Held*: To prove that respondent was a sexually violent person, the lack of volitional control was not a separate element that the State had to prove; nothing in the language of section 30(c) or any other section of the Sexually Violent Persons Commitment Act prohibited the State from obtaining more than two evaluations of respondent; where the State presented evidence that respondent would be a danger to the community, the trial court did not abuse its discretion by ordering respondent committed to a secure treatment facility; trial court affirmed.

¶ 2 In 2013, a jury found respondent, John L. Birch, to be a sexually violent person under the Sexually Violent Persons Commitment Act (Act) (725 ILCS 207/1 *et seq.* (West 2012)). Following a subsequent dispositional hearing, the trial court ordered respondent committed to the

Illinois Department of Human Services (DHS) for institutional care in a secure facility. Respondent appeals, arguing that: (1) the evidence was insufficient to support the jury's verdict that he is a sexually dangerous person because there was no current evidence that he lacked volitional control; (2) the trial court erred by allowing the testimony of two additional experts because their testimony exceeded the number of authorized evaluations under the Act; and (3) the trial court erred by ordering him confined for institutional care in an institutional setting. We affirm.

¶ 3 I. BACKGROUND

¶ 4 In 1991, respondent was convicted of attempted aggravated criminal sexual assault, aggravated criminal sexual abuse, unlawful restraint, and resisting a peace officer and was sentenced to 30 years in prison. Respondent was scheduled to be released into mandatory supervised release (MSR) on December 6, 2005.

¶ 5 A. Petition For Adjudication

¶ 6 On December 5, 2005, the day prior to respondent's scheduled release, the Attorney General and the DeKalb County State's Attorney jointly petitioned to have respondent adjudicated a sexually violent person pursuant to the Act (725 ILCS 207/1 *et seq.* (West 2004)). The petition alleged that, in 1991, respondent was convicted of attempt criminal sexual assault, aggravated criminal sexual abuse, unlawful restraint, and resisting a peace officer. The petition further alleged:

> "The Respondent, who was 29 years of age, grabbed a 19 year old woman as she was about to enter her apartment building in DeKalb, Illinois and held a knife to her throat. He took her into some bushes and placed tape over her eyes and mouth. He then removed her shirt and fondled her breasts. He attempted to remove her pants when he heard people

in the area. As he was carrying her across the street, she began to scream. He threw her to the ground and ran away.

* * *

In 1993 the Respondent pled guilty to Home Invasion ***. [The Respondent] entered a woman's home. He forced her to perform oral sex on him."

¶ 7 The petition also alleged that respondent had been diagnosed by Dr. Michael H. Fogel with "Paraphilia, Not Otherwise Specified, Nonconsent," as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association, fourth edition (DSM–IV). We note that the petition states that Dr. Fogel's "Sexually Violent Persons Commitment Act Evaluation" of respondent was attached as an exhibit to the petition. However, Dr. Fogel's evaluation is not included in the record on appeal. Finally, the petition concluded that respondent "is dangerous to others because his mental disorders create a substantial probability that he will engage in future acts of sexual violence." The State requested that the court enter a finding that respondent is a sexually violent persona and that the court commit respondent to DHS "for control, care[,] and treatment."

¶ 8 B. Probable Cause Hearing

¶ 9 On December 7, 2005, a probable cause hearing was held on the petition. The State presented the testimony of Dr. Fogel, a licensed clinical psychologist who testified that he had been the director of the Illinois Department of Corrections' (DOC's) sex offender evaluation unit for approximately two and one-half years. Dr. Fogel testified regarding the findings and conclusions contained in his report attached to the petition. Specifically, after being qualified as an expert witness, Dr. Fogel explained that, because respondent had committed a sexually violent offense, Fogel conducted a "follow-up screen" to determine whether respondent needed to be interviewed to determine if he had a mental disorder. In his report, Dr. Fogel relied on DOC's

master file, respondent's medical records, police reports, correspondence, and a psychological test and an actuarial measure called "the Static 99." Dr. Fogel interviewed respondent on November 30, 2005. During the interview, respondent spoke about his 1989 offenses. Respondent's versions of events were consistent with the police reports. Dr. Fogel diagnosed respondent with the following disorders, as described by the DSM-IV: "paraphilia not otherwise specified non-consent and antisocial personality disorder." Dr. Fogel explained that to "be diagnosed with paraphilia you have to experience a recurrent intense sexually arousing fantasy, sexual urges or behaviors involving non-human objects, suffering humiliation of one's self or another or children or other non-consenting animals. Also the person has to have acted on these sexual urges or sexual urges or fantasies have to cause the individual distress." Dr. Fogel explained that respondent had rape, control, and domination fantasies since the age of 12 or 13 and that he has acted on those fantasies at least twice. Further, respondent "appears to struggle with the intrusive nature of the fantasies that he has."

¶ 10 Dr. Fogel diagnosed respondent as suffering with antisocial personality disorder because of "a clear history of criminal type behaviors in terms of the problem behavior as well as hands-on offending that he's done, a reckless disregard for the safety of self or others, perpetrating the offenses with a weapon, threatening the victims, [and] his lack of remorse." In addition, respondent continued to fantasize about "his last victim." Dr. Fogel testified, that, "[o]ne particular fantasy [respondent] mentioned was when [his victim] was lying on her back with her legs up, and that was particularly arousing image for him and that the statement that he made was that she was not resisting all that much. That type of statement would be a distortion where he's utilizing that to continue to fantasize about that type of behavior." Dr. Fogel also considered that respondent had never been involved in any type of sex offender treatment.

¶ 11 Dr. Fogel opined that respondent "presents a high risk to sexually re-offend." Respondent is dangerous due to a mental disorder that is congenital or acquired, in that "he suffers from paraphilia, not otherwise specified non-consent." Further, this mental disorder predisposed respondent to commit continued acts of sexual violence. The trial court found that there was probable cause to believe that respondent was a sexually violent person and ordered that respondent be detained at a facility approved by DHS and that he undergo and cooperate with an evaluation by DHS to determine whether he is a sexually violent person as set forth in section 207/5(f) of the Act (725 ILCS 207/5(f) (West 2004)).

¶ 12 For reasons to be discussed latter in this appeal, the case was continued for years without a disposition.

¶ 13 C. Jury Trial

¶ 14 A jury trial began on September 24, 2013, but the trial court ordered a mistrial because of concern for the health of respondent's expert.

¶ 15 A new trial was held on November 13 and 14, 2013. The State presented the expert testimony of Dr. John Arroyo, a clinical and forensic psychologist, employed by DHS as a sexually violent persons' evaluator, who testified as follows. In 2012, Dr. Arroyo conducted an evaluation of respondent on behalf of the DOC to determine whether he was a sexually violent person. Dr. Arroyo reviewed respondent's DOC records, including his disciplinary records, DHS records, including his mental health records, and the facts and circumstances of respondent's criminal history. In January 2012, Dr. Arroyo interviewed respondent for approximately two hours.

¶ 16 Dr. Arroyo testified that the most recent criminal offense on which he relied was a 1990 offense for which respondent, then 29 years old, was convicted of attempted aggravated criminal sexual assault, aggravated criminal sexual abuse, and aggravated unlawful restraint.

Respondent confirmed the following facts and circumstances of the crime in his interview with Dr. Arroyo. Respondent approached a woman from behind in a parking lot, held a knife to her throat, and forced her into some nearby bushes and onto the ground. Respondent then placed duct tape over the victim's mouth and eyes and bound her arms behind her back and unbuttoned her blouse. Respondent ripped off the victim's bra, fondled her breasts, grabbed her crotch, unfastened her pants, and attempted to pull her pants down, at which point respondent heard people approaching. Respondent attempted to carry the victim across the street, but a passing car stopped and respondent dropped the victim in the street.

¶ 17 Dr. Arroyo testified that he also relied on an offense respondent committed when respondent was 28 years old, wherein he was charged with home invasion, residential burglary, and aggravated criminal sexual assault and eventually pleaded guilty to home invasion. Respondent entered a home through a basement door and lunged at a female victim with a screwdriver, knocking her to the floor. Respondent pulled the victim's sweater over her head, pushed up her bra, squeezed her breasts, and pulled her to her knees. Respondent then forced the victim to perform oral sex on him until he ejaculated. Respondent then pushed the victim to the floor and he fled. During respondent's interview with Dr. Arroyo, respondent corroborated the facts of the crime and elaborated on the circumstances of the crime. Respondent told Dr. Arroyo that, prior to the offense, he had been frustrated by recent police investigations and that he had been masturbating in public and stalking women. Respondent also told Dr. Arroyo that he followed the victim home from a gas station. Respondent stated that he was both disgusted with himself and aroused by the violence of the situation.

¶ 18 In addition, Dr. Arroyo testified that he relied on a third sexually violent offense that occurred in 1988, wherein respondent was charged with, not convicted of, aggravated assault. In that case, a woman alleged that respondent approached her on a college campus and asked her

whether anyone had ever told her she was sexy. The woman ignored respondent. Respondent then asked her if she would ever have sex with a stranger and the woman became upset and tried to walk away. According to the woman, respondent followed her and said, "You're dead." The woman yelled for help and bystanders came to her aid. During respondent's interview with Dr. Arroyo, respondent confirmed the facts stated above as reported by the woman, except that respondent denied threatening the woman. Further, respondent told Dr. Arroyo that he had not gone to the college campus with the intent of hurting anyone; however, he became upset when the woman ran off thinking she was better than he.

¶ 19 Dr. Arroyo conducted a risk assessment using actuarial tools to determine respondent's risk of committing future acts of sexual violence. Specifically, Dr. Arroyo employed: (1) the Minnesota Sex Offender Screening Tool Revised (MnSOST–R); (2) the Static–99; and (3) the Hare Psychopathy Checklist Revised (Hare PCL-R). Respondent scored "in the high range of re-offending" under the MnSOST–R, "moderate high" under the Static-99, and a "moderate level of psychopathy" under the Hare PCL-R. Dr. Arroyo identified nine additional risk factors that raised respondent's risk of reoffending, namely: (1) a lack of concern for other people; (2) an inability to follow rules; (3) reoffending while on parole; (4) disciplinary problems during incarceration; (5) deviant sexual interests that were unsatisfied with a consenting partner; (6) disturbing sexual thoughts, such as thoughts about violently and sexually exploiting women; (7) conduct disorder; (8) lack of sex offender treatment; and (9) antisocial personality disorder. Dr. Arroyo found no protective factors (factors that would lower the risk of reoffending) applicable to respondent, such as decreased life expectancy or completion of a sex offender program.

¶ 20 When Dr. Arroyo first evaluated respondent in January 2012, he diagnosed respondent with paraphilia not otherwise specified non-consent and antisocial disorder using the DSM-IV-TR. When the Diagnostic and Statistical Manual of Mental Disorder Fifth Edition

(DSM-5) was released, Dr. Arroyo updated his diagnosis to other specified paraphilic disorder sexually aroused to nonconsenting persons and antisocial personality disorder. Dr. Arroyo explained that paraphilia is an intense and persistent sexual interest other than with "normal physically mature consenting human partners." Paraphilic disorder is "a paraphilia that is currently causing distress or impairment to the individual or paraphilia whose satisfaction entails personal harm or risk of harm to other people." Respondent met the criteria for "other specified paraphilic disorder sexually aroused to nonconsenting persons" because he has a persistent sexual interest in nonconsenting partners, he is aroused by activity and fantasies of deviant sexual behavior, using nonconsenting women that puts them at risk of harm. Dr. Arroyo also explained that he diagnosed respondent with "antisocial personality disorder" because respondent had a pervasive disregard for or a violation of the rights of others, impulsivity, failure to plan ahead, and a reckless disregard for the safety of self or others. Respondent "recognized that what he was doing was wrong, stated that his distortion was that sex was good and that they were enjoying it." Dr. Arroyo testified that these mental disorders are "chronic life-long conditions that do not go away on their own." Dr. Arroyo stated, "It takes treatment [and respondent] hasn't completed any treatment."

¶ 21 Dr. Arroyo concluded that, in his opinion, within a reasonable degree of psychological certainty, respondent suffers from mental disorders that are congenital or acquired, affect his emotional or volitional capacity, and predispose him to commit future acts of sexual violence. Further, respondent is dangerous because he suffers from mental disorders that are congenital or acquired, namely, paraphilic disorder and antisocial personality disorder. Based upon his clinical evaluation, review of respondent's files, respondent's lack of sex offender treatment, and the actuarial instruments he employed, Dr. Arroyo opined that it is substantially probable that respondent will engage in future acts of sexual violence. Dr. Arroyo defined "substantially

probable" to mean "[m]uch more likely than not." Further, Dr. Arroyo opined that respondent met the criteria for a sexually violent person.

¶ 22 Next, the State presented the expert testimony of Dr. Richard Travis, a clinical and forensic psychologist, employed by DHS as a sexually violent persons' evaluator, who testified as follows. Dr. Travis evaluated respondent on behalf of DHS and considered the same criminal, disciplinary, and treatment history upon which Dr. Arroyo relied. Dr. Travis also relied on his January 6, 2012, interview of respondent. Dr. Travis completed his evaluation on February 14, 2012. Dr. Travis considered respondent's 1981 convictions for burglary and burglary in Iowa. Dr. Travis testified that he considered that respondent actually committed five offenses in one day, and not just the two for which he was convicted. In committing the first two offenses, respondent entered a couple's home, roused them from sleep, threatened them, and demanded drugs; respondent later stated that he might have sexually offended against the woman had he seen her. Dr. Travis then described the next incident that happened the same morning, in which respondent tried to enter a home through a patio door, but fled when the resident called the police. Later, that day, respondent attacked a woman in an alley behind her home. He fled when the woman entered her car and honked the horn. Later the same morning, respondent knocked on a woman's door. When the woman opened the door, respondent was pulling a stocking cap over his face so the woman slammed the door and locked it. Regarding the last incident that day, one for which he was convicted, he saw a woman in her apartment, entered the apartment through the patio door, threatened her with what she thought was a gun, demanded money from her, took $40 from her, made her lie on her bed, made her give him oral sex, made her count to 150, and then left the apartment. Dr. Travis testified that these offenses, which occurred in 1981, were relevant to his opinion regarding respondent because they "show a pattern and longevity of sexual behavior and sexual interest."

¶ 23 Initially, Dr. Travis based his diagnoses of respondent on the DSM-IV-TR, but updated his diagnoses following the release of the updated DSM-5. In a report prepared in 2012, based on the DSM-IV-TR, Dr. Travis diagnosed respondent with "paraphilia not otherwise specified, sexually attracted to nonconsenting females" because, for a period of greater than six months, respondent had sexual urges and interests "that were either troubling to him or created a problem for him and that he had acted out upon and caused harm." Dr. Travis also diagnosed respondent with antisocial personality disorder because of respondent's "criminal history including juvenile antisocial acts that he started acting out in when he was about 11 years old." In addition, Dr. Travis diagnosed respondent with voyeurism, bipolar I disorder, alcohol abuse, and cannabis abuse.

¶ 24 In September 2013, Dr. Travis updated his report to reflect the newly released DSM-5. Based on the DSM-5, Dr. Travis diagnosed respondent with "other specified paraphilic disorder sexually attracted to nonconsenting females in a controlled environment," antisocial disorder, voyeuristic disorder, bipolar I disorder, alcohol abuse, and cannabis abuse.

¶ 25 Dr. Travis diagnosed respondent with "other specified paraphilic disorder sexually attracted to nonconsenting females in a controlled environment" because of the sexual offenses respondent had committed and "others that he has spoken about for [*sic*] which were previously undetected," his "numerous rape fantasies—fantasies that "include kidnapping women, torturing them, causing them pain, sexually assaulting two women at the same time," and his "long history of these sexual attractions to females who tell him no." Respondent "gets sexually aroused and wants to retaliate when feels rebuffed or victimized or in some way rejected, and so that's how that diagnosis fits." Dr. Travis explained that "in a controlled environment" is added to the diagnosis because respondent does not have access to the kind of stimuli he would be exposed to if he were living out in the community or even "if he was in prison" such as "bondage magazines

[which were not] available to him at the treatment and detention facility." Dr. Travis diagnosed respondent with antisocial personality disorder because of respondent's pervasive, long-standing pattern of behaviors that violate the rights of others such as, hostility, deceitfulness, and lack of remorse. These acts began before the age of 13 with acts of shoplifting, theft, vandalism, and, when he was 17, burglary. Later, respondent was convicted of residential burglary and malicious injury to property and continued to engage in antisocial acts "throughout his Department of Corrections incarcerations and also while he's been in treatment and detention facility." Dr. Travis noted that, in 2008, respondent was involved in a fight; in 2010, he refused to "lock up;" in 2011, he banged on the window of a control booth and called a female staff worker a "whore and a bitch;" and, in 2012 he tried to trade in an old radio that had the serial numbers scratched off for a new radio. Respondent has fought with "staff" and "yelled at a treatment provider." Dr. Travis testified that respondent lacked remorse and "seeks excuses for having engaged in his behaviors." Respondent said that the reason he reoffended after he attacked a female student in DuPage County was because "he didn't experience any consequences for that so he thought, 'Oh, I can do more,' and so all these are characteristics of antisocial personality disorder."

¶ 26 Dr. Travis testified that respondent's mental disorders are congenital or acquired; the former meaning that they are a part of "your genetic makeup," the latter meaning that they are developed "through your environment, through you living experiences." Further, respondent's mental disorders affected his emotional or volitional capacity, which means that "even when you know something is going to result in consequences or it could result in dangerous consequences, you kind of can't help it." Dr. Travis explained that respondent's sexual urges, sexual interests, antisocial disorder, and substance abuse disorders act as "disinhibitors."

¶ 27 Dr. Travis opined that that respondent's mental disorders predispose him to commit continued acts of sexual violence. When asked how he knew that respondent "currently suffers from these mental disorders," Dr. Travis replied:

> "Regarding the voyeuristic disorder and the other specified paraphilic disorder with the sexual interest in nonconsenting women, sexual interests tend to stay pretty constant. Once you get into you early 20's your sexual interest pattern is pretty well defined. It doesn't change much with time.
>
> ***
>
> The only time that he hasn't been committing sexual assaults is when he's been incarcerated or detained at the treatment and detention facility, and in the treatment and detention facility the fact that he exhibited these things is partly because he doesn't really have a lot of opportunity and he definitely doesn't have the same kind of stimulation that he would have in the community."

¶ 28 Dr. Travis conducted an assessment of respondent's risk of future sexual violence by using two actuarial instruments: the Static 99-R and the Static 2002-R. These instruments look at particular variables and how, as a group, these variables translate to a level of risk associated with recidivism. Regarding both the Static 99-R and the Static 2002-R, respondent scored a six, placing him in the high risk category ("3.77 times more likely to reoffend than the typical sex offender") and the moderate risk category ("2.63 times more likely [to reoffend] than a typical sex offender"), respectively. Dr. Travis explained that he considered the following 11 factors that raised respondent's risk of reoffending that were not considered by the actuarial instruments: (1) Antisocial Personality Disorder, (2) early separation from parents; (3) alcohol abuse, (4) hostility; (5) general self-regulation problems; (6) deviant sexual interests; (7) employment

instability, (8) impulsivity, (9) recklessness, (10) pro-criminal attitudes; and (11) poor problem-solving.

¶ 29 Dr. Travis testified that he considered whether respondent had any protective factors, such as completion of treatment or a severely debilitating medical condition, but that respondent had none.

¶ 30 Dr. Travis opined that, within a reasonable degree of psychological certainty, respondent's risk of sexually reoffending is "in the high-risk category and [that respondent is] substantially probable to commit future acts of sexual violence." Dr. Travis also opined that respondent is dangerous because he suffers from mental disorders that are congenital or acquired, that these mental disorders affect respondent's emotional or volitional capacity and predispose him to commit continued acts of sexual violence, and, that respondent meets the criteria to be found to be a sexually violent person.

¶ 31 During cross examination, Dr. Travis testified that respondent's bipolar disorder was in remission and that his alcohol abuse disorder was in the moderate range. Respondent's last rule violation was in 2012.

¶ 32 Respondent presented the expert testimony on Dr. Phil Reidda, a clinical psychologist, who testified as follows. In the spring of 2011, Dr. Reidda conducted an evaluation of respondent to determine his risk for recidivism. Dr. Reidda reviewed respondent's criminal records and his DOC and DHS records. Dr. Reidda also interviewed respondent twice, for a total of 13 to 15 hours, and performed diagnostic testing. In addition, Dr. Reidda assessed respondent's risk of future sexual violence by employing two actuarial instruments: the Static 99-R and the MnSOST-R. Respondent scored a four on both instruments, placing him in the "moderate-to-high-risk category" under the Static-99.

¶ 33 Dr. Reidda testified that, based on the DSM-IV-TR, he diagnosed respondent with personality disorder not otherwise specified and bipolar disorder. Dr. Reidda explained that personality disorder means that "they don't work and play well with others." The four criteria are: (1) impulsivity, (2) functional level, (3) cognition; and (4) affectivity. Dr. Reidda diagnosed respondent with bipolar disorder based on his shifts in mood and the fact that respondent was previously diagnosed with bipolar disorder. Dr. Reidda opined that respondent did not meet the criteria for civil commitment. Further, it was not substantially probable that respondent would act out sexually in the future.

¶ 34 During cross examination, Dr. Reidda testified that he did not consider all of respondent's prior criminal offenses when forming his opinion and diagnoses because he was not provided with the entire "master [DOC] file." Dr. Reidda read the only two police reports that were contained in the file that respondent's counsel gave him. Dr. Reidda did not know about, and therefore did not consider, the other sexual offenses respondent committed, including those in Idaho. Dr. Reidda also testified that respondent "did not know that what he did was wrong. He excuses and justifies his sexual behaviors[,] which is not uncommon to untreated sexual offenders." Dr. Reidda testified that respondent does not believe he needs counseling or treatment to control his sexual impulses.

¶ 35 Respondent testified that he requested sex offender treatment while in DOC but did not receive it. While in prison, he tried to take steps to improve his life; in DOC and DHS, he participated in a variety of non sex-offender treatment courses.

¶ 36 During cross examination, respondent testified that he may have been ineligible for sex-offender treatment while in DOC because of his disciplinary problems, including several instances of "shanks" and alcohol being found in his cell. Respondent had 70 disciplinary tickets

while in DOC. He also was not consistent with participation in core sex-offender therapy while in custody at DHS; he had to take breaks and was suspended from treatment at times.

¶ 37 D. Verdict and Posttrial Motions

¶ 38 On November 14, 2013, the jury found respondent to be a sexually violent person. Respondent moved for a dispositional hearing after a DHS predisposition investigation pursuant to section 40(b)(1) of the Act (725 ILCS 270/40(b)(1) (West 2012)). The State moved for a commitment order under section 40(b)(2) of the Act (725 ILCS 207/40(b)(2) (West 2012)). The trial court found that respondent was in the "third stage of a five-phase [treatment] program" and ordered respondent be committed to a secure facility.

¶ 39 Respondent filed a posttrial motion on December 6, 2013 and an amended posttrial motion on April 17, 2014. Respondent's amended posttrial motion sought a new trial and a dispositional hearing. On July 18, 2014, the trial court denied respondent's request for a new trial, vacated its dispositional order, and granted respondent's request for a dispositional hearing.

¶ 40 E. Dispositional Hearing

¶ 41 A dispositional hearing was held on September 22, 2014. Dr. Travis testified as follows. Dr. Travis based his opinions on his review of respondent's updated records and an additional in person interview. Dr. Travis explained that the DHS sex-offender treatment program was comprised of five phases: (1) evaluation or assessment; (2) accepting responsibility, full disclosure of sexual history and sexual offending pattern; (3) understanding the sex offense cycle; (4) indentifying ways of avoiding reoffense; and (5) creating a relapse prevention and preparation for reintegration into the community. At the time of the dispositional hearing, respondent was in the third phase of the sex-offender program. Dr. Travis testified that the DHS program was specifically designed for high-risk individuals such as

respondent and that there was no comparable sex-offender treatment program in a community setting.

¶ 42 Dr. Travis also testified that, although respondent had made progress, he had not put together a plan for how he will intervene to not reoffend. Further, Dr. Travis was concerned about respondent's history of hypersexuality when he was in the community and exposed to more stimuli than he had experienced in the DHS facility. Respondent needed to develop some "arousal management recondition strategies." Dr. Travis testified that respondent told him that, in May 2014, respondent was out in the community on a writ, and he "talked about visual arousal and physical arousal, and it surprised [respondent] because he hadn't been experiencing that kind of arousal [while in DHS] for a long time." Dr. Travis also opined that respondent had entitlement problems that created a risk for reoffending. Respondent thinks that because he's doing well in treatment, "he deserves to be in the community, he's entitled to be in the community." When Dr. Travis told respondent that he needed some additional skills before he could be released into the community, respondent became angry and argumentative. Dr. Travis opined that respondent's sense of entitlement drove some of respondent's offenses and that respondent needs to develop strategies for managing it before he can safely live in the community. Dr. Travis opined to a reasonable degree of psychological certainty that the appropriate placement for respondent was a secure treatment facility because it provides the level of treatment he needs, "where he can be safely managed," and "there is no place in the community that can provide what he needs right now."

¶ 43 During cross-examination, Dr. Travis testified as follows. While at the treatment detention center, after the probable cause hearing, respondent completed an entry to treatment evaluation," two plethysmograph evaluations, and two psychological veracity examinations, and the following groups: substance abuse and dependency education, social interactions,

self-awareness, introduction for thinking errors, stress management, healthy relationships and sexuality, tactics, autobiography, decision-making model, good lives exploration, anger management and dialectical behavior therapy, and advanced dialectical behavior therapy. Respondent was in the sex offense specific core group for a period of time and was suspended from the group. He rejoined the group, was in it for a year from 2008-2009, "then he withdrew himself;" in 2011 he rejoined the group, and he has attended since then. Dr. Travis testified that "people" with the disorders that respondent have "can be treated outside of the [treatment detention facility] if their risk and needs are low enough."

¶ 44 Dr. Reidda testified on respondent's behalf as follow. Dr. Reidda opined that respondent was "an excellent candidate for conditional release." Dr. Reidda based his opinion, in part, on respondent's posttrial activities as reflected in various records that he reviewed. Dr. Reidda testified that "the records were overall quite positive." The records indicated that respondent was "prepared for group," "he was articulate and was capable of making a contribution [and] he was an active participant." Respondent's clinicians "saw him as insightful and rather able to manage." Further, in the recent past, there were no disciplinary tickets; however, there were a couple of behavior incident reports for "very minor" rule violations, such as being out of line "when he was supposed to be in line." Respondent earned a number of certificates by completing the anger management program at DOC and at DHS. Dr. Reidda met with respondent on September 8, 2014, for approximately two hours, and opined that "there was no evidence of a mental disorder [and that respondent's [p]lanning skills were in order." Dr. Reidda opined that respondent "was not a high-risk [to re-offend]," he would "make a good adjustment rather quickly," he "benefitted remarkably from" treatment, he "seems to have insight into his own behavior," he has "a high level of being able to deal with stress" and he adjusted well to DOC and the treatment detention center after the probable cause hearing.

Respondent had been in stage three of the five-phase treatment program for two years. Dr. Reidda opined that, regarding the last two phases, transition and community adjustment, "it would do well for [respondent] to test those skills and to adjust to that [*sic*] in a long-term gradual heavily supervised situation" in conditional release.

¶ 45 Following argument, the trial court addressed and considered each statutory factor enumerated in section 40(b) of the Act (725 ILCS 270/40(b)(2) (West 2014)), stating that it had considered the testimony and reports of Dr. Travis and Dr. Reidda, and that it was adopting the testimony of Dr. Travis. The trial court commended respondent on his "hard work" but found it "disturbing" that respondent lacked a "relapse prevention plan," and concluded that respondent "shall remain in the care of the department being in that he has treatment and for his own benefit as well as the safety of the community and his ability to reach all of the necessities and things that he would have to have to control over to be placed back in society." The trial court ordered respondent committed to a secure treatment facility.

¶ 46 Respondent filed a timely notice of appeal.

¶ 47 II. ANALYSIS

¶ 48 A. Volitional Control

¶ 49 The Act permits the State to extend a criminal defendant's incarceration beyond the time that he would otherwise be subject to release if that defendant is found to be "sexually violent." *In re Detention of Samuelson*, 189 Ill. 2d 548, 552 (2000). At trial, the State must prove beyond a reasonable doubt that the respondent is a "sexually violent person" because (1) the respondent has been convicted of a sexually violent offense; (2) the respondent suffers from a mental disorder; and (3) he is dangerous because his mental disorder makes it substantially probable that he will commit future acts of sexual violence. 725 ILCS 207/5(f), 35(d)(2) (West 2014).

¶ 50 Here, respondent argues that State failed to prove the second and third elements because the State failed to present current evidence that respondent lacked volitional control. The State responds that the lack of volitional control is not a separate element that the State must prove. We agree with the State.

¶ 51 Our supreme court has held that a jury is not required to make an explicit finding that a respondent lacks volitional control. *In re Detention of Varner,* 207 Ill. 2d 425, 432-33 (2003). A lack of volitional control is implicitly required by the Act by its definition of "mental disorder" and by its required burden regarding the likelihood that the respondent will engage in future offenses. *Id*. In addition, the Act requires a finding that it is "substantially probable" that the respondent "will engage in [future] acts of sexual violence." 725 ILCS 207/5(f) (West 2014). In reviewing respondent's argument, we consider whether, after viewing all the evidence in the light most favorable to the State, any rational trier of fact could find that the elements of the offense have been proved beyond a reasonable doubt. *In re Detention of Welsh*, 393 Ill. App. 3d 431, 454 (2009).

¶ 52 The record is clear that the State presented ample evidence to support the jury's finding that respondent suffers from a mental disorder as defined by the Act. "[M]ental disorder" is defined as "a congenital or acquired condition affecting the emotional or volitional capacity that predisposes a person to engage in acts of sexual violence." 725 ILCS 207/5(b) (West 2014). At trial, Dr. Arroyo and Dr. Travis testified that, in 2012, using the DSM-IV-TR, they diagnosed respondent with paraphilia not otherwise specified, with a preference for nonconsenting females and antisocial disorder. Then, in 2013, using the updated DSM-5, they diagnosed respondent with other specified paraphilic disorder nonconsenting and antisocial disorder. In addition, both Dr. Arroyo and Dr. Travis testified that respondent suffers from mental disorders that are congenital or acquired, affect his emotional or volitional capacity, and predispose him to commit

future acts of sexual violence. Accordingly, the State established, beyond a reasonable doubt, that respondent suffered from a mental disorder.

¶ 53 In addition, the State presented ample evidence to establish that respondent is dangerous because his mental disorder makes it substantially probable that he will commit future acts of sexual violence. Dr. Arroyo testified that respondent is dangerous because he suffers from mental disorders and that these mental disorders make it is substantially probable that respondent will engage in future acts of sexual violence. Dr. Travis testified that respondent's risk of sexually reoffending is "in the high-risk category and [that respondent is] substantially probable to commit future acts of sexual violence." Dr. Travis also opined that respondent is dangerous because he suffers from mental disorders. Therefore, the State established beyond a reasonable doubt that respondent is dangerous because his mental disorder makes it substantially probable that he will commit future acts of sexual violence.

¶ 54 Respondent notes that the State's witnesses relied on acts that respondent committed in the past and that he had not committed an act of sexual violence since being incarcerated despite being in contact with female staff. The jury heard this evidence as well as the testimony of Dr. Arroyo and Dr. Travis, who testified that respondent had life-long mental disorders and that he had not been treated for them. Dr. Arroyo testified that respondent's mental disorders are "chronic life-long conditions that do not go away on their own," stating that "It takes treatment [and respondent] hasn't completed any treatment." When Dr. Travis was asked how he knew that respondent "currently suffers from these mental disorders," he replied that, "Regarding the voyeuristic disorder and the other specified paraphilic disorder with the sexual interest in nonconsenting women, sexual interests tend to stay pretty constant. *** It doesn't change much with time." Therefore, after viewing all the evidence in the light most favorable to the State, a rational trier of fact could find beyond a reasonable doubt the elements required to prove that

respondent is a sexually violent person. See *In re Detention of Welsh*, 393 Ill. App. 3d 431, 454 (2009).

¶ 55 B. Expert Evaluators

¶ 56 Next, respondent argues that the trial court abused its discretion by admitting the testimony and evaluations of Dr. Arroyo and Dr. Travis, because their evaluations exceeded the number of authorized evaluations under the Act. 725 ILCS 207/30(c), 35(b) (West 2014). Respondent contends that sections 30(c) and 35(b) of the Act clearly limit the State to two evaluations; one from DOC and one from DHS.

¶ 57 "The decision of whether to allow expert testimony is committed to the sound discretion of the trial court, and the court's decision will not be reversed absent an abuse of that discretion." *Lieberman*, 201 Ill. 2d at 606. Section 30(c) of the Act provides that, after the trial court determines that probable cause exists, it must order the individual to be taken into custody and transferred to an appropriate facility for "an evaluation as to whether the person is a sexually violent person." 725 ILCS 207/30(c) (West 2012). Section 35(b) of the Act provides in part that the State may present expert testimony from both the DOC evaluator and the DHS psychologist. 725 ILCS 207/35(b) (West 2012).

¶ 58 In this case, Dr. Fogel, a DOC psychologist, performed the evaluation of respondent in December 2005 that supported the State's original petition, and Dr. Bruckner, a DHS psychologist, evaluated respondent in January 2006, after the court found probable cause. The case remained pending for a long period of time. The record shows that respondent's case remained pending for eight years after the probable cause hearing because respondent sought repeated continuances and repeatedly requested appointment of experts. In addition, in 2009, the case was set for trial but respondent's attorneys failed to appear and new counsel was appointed. Then, in 2010, at respondent's requests, the trial court appointed four different evaluators on four different

occasions. By the time respondent was ready for trial in 2013, nearly eight years had passed since Dr. Fogel and Dr. Bruckner had evaluated respondent, and their contracts with the State had expired.

¶ 59 Respondent contends that, because he was evaluated by Dr. Fogel in 2005 and Dr. Bruckner in 2006, the State was limited to these two evaluations at trial because section 35(b) permits the State only one evaluation each from DOC and the DHS.

¶ 60 The primary objective in construing a statute is to ascertain and give effect to the intent of the legislature. *Lieberman*, 201 Ill. 2d at 307. The most reliable indicator of legislative intent is the language of the statute. *Id*. at 308. Statutory language is to be given its plain and ordinary meaning. *Id*. Statutory construction presents a legal question subject to *de novo* review. *Evanston Insurance Co. v. Riseborough*, 2014 IL 114271, ¶13.

¶ 61 Section 35(b) provides as follows:

> "At the trial on the petition it shall be competent to introduce evidence of the commission by the respondent of any number of crimes together with whatever punishments, if any, were imposed. *The petitioner may present expert testimony from both the Illinois Department of Corrections evaluator and the Department of Human Services psychologist.*" (Emphasis added.) 725 ILCS 207/35(b) (West 2012)

¶ 62 In *In re Commitment of Brown*, 2012 IL App (2d) 110116, this court answered the question respondent raises here, namely whether section 35(b) of the Act restricts the State to two evaluations. We held that "[t]he plain language of section 35(b) speaks to the testimony the State may present at trial, not the number of evaluations it may obtain, by providing that the petitioner may present expert testimony from both the DOC evaluator and the Department of Human Services psychologist. Nothing in the language of this section *or any other section of the statute*

prohibits the State from obtaining more than two evaluations." (Emphasis added.) *Brown*, 2012 IL App (2d) ¶16.

¶ 63 Respondent argues that the State failed to prove that Dr. Fogel and Dr. Bruckner were unavailable for trial. However, this argument is not material because the statute did not limit the State to using Dr. Fogel and Dr. Bruckner's evaluations. See *id*. The State was not obligated to calling Dr. Fogel and Dr. Bruckner as witnesses even if they were available. See *id*. In addition, the State presented only two evaluators at trial. Accordingly, the trial court did not abuse its discretion by admitting the testimony and evaluations of Dr. Arroyo and Dr. Travis.

¶ 64 We note that, although respondent cites section 30(c) of the Act to support his argument, he does not develop this argument in any manner. Further, respondent fails to explain how section 30(c) applies here to limit the State's ability to call witnesses to testify regarding updated evaluations made necessary by respondent's repeated lengthy delays in bringing his case to trial. Accordingly, respondent's contention that section 30(c) supports his argument is waived or forfeited. See Ill. S. Ct. R. 341(h)(7) (eff. Feb. 6, 2013) (requiring that an appellate brief contain an "Argument, which shall contain the contentions of the appellant and the reasons therefor [and, further,] Points not argued are waived").

¶ 65 C. Secure Treatment Facility

¶ 66 Respondent also argues that the trial court erred by ordering him confined for institutional care in a secure treatment facility. Respondent asserts that, according to both Dr. Travis and Dr. Reidda, respondent "availed himself of treatment ***and had progressed considerably well." Specifically, respondent notes that Dr. Travis testified that respondent had completed phase three of a five-phase treatment module, had completed numerous evaluations, and participated in groups, including the sex-offense specific core group. In addition, respondent notes that Dr. Reidda testified that respondent showed no current evidence of a mental disorder, had good

planning skills relating to conditional release, had earned a certificate for completing an anger management program, and had "benefited remarkably" from treatment.

¶ 67 After a judgment that the respondent is a sexually violent person, the trial court shall enter an initial commitment order pursuant to a hearing. 725 ILCS 207/40(b)(1) (West 2014); see also *In re Commitment of Fields*, 2014 IL 115542, ¶ 49 Section 40(b)(2) of the Act provides that a person adjudicated as a sexually violent person may be confined to receive institutional care in a secure facility or released from confinement subject to conditions. 725 ILCS 207/40(b)(2) (West 2014). In making this determination, the trial court must consider: (1) the nature and circumstances of the behavior that was the basis of the allegation in the petition for adjudication as a sexually violent person; (2) the person's mental history and present mental condition; and (3) 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 2014). The Act does not mandate that the trial court choose the "least restrictive" alternative. *In re Commitment of Brown*, 2012 IL App (2d) 110116, ¶19. A trial court's decision to commit a sexually violent person to institutional care in a secure facility will not be reversed absent an abuse of discretion. *Id*. An abuse of discretion occurs only where the trial court's decision is arbitrary, fanciful, or unreasonable, or where no reasonable person would take the view adopted by the trial court. *People v. Hall*, 195 Ill. 2d 1, 20 (2000).

¶ 68 In this case, at the dispositional hearing, the State presented the detailed testimony of Dr. Travis, who testified that respondent was at high risk to reoffend and had not completed the treatment stage that involves preparing a plan to avoid reoffending in the community. In addition, Dr. Travis testified that respondent did not have arousal management strategies or strategies to cope with his sense of entitlement and anger issues. Dr. Travis did not recommend conditional

release because he opined that respondent could not safely live in the community until he developed more productive arousal management strategies and a firm relapse prevention plan.

¶ 69 The record shows that the trial court heard and considered evidence pertaining to all of the relevant factors prior to ordering respondent committed to a secure facility. We cannot say the trial court's decision to commit respondent to a secure facility is unreasonable or arbitrary. Respondent's expert witness, Dr. Reidda, disagreed with Dr. Travis's opinion that treatment in a secure treatment facility was needed for respondent. However, it is not the function of this court to reweigh the evidence, make credibility determinations, or resolve conflicting evidence. See *In re Ehrlich*, 2012 IL App (1st) 102300, ¶76. Accordingly, we determine that the trial court did not abuse its discretion when it committed respondent to a secure facility for treatment as opposed to conditional release.

¶ 70 III. CONCLUSION

¶ 71 For these reasons, the judgment of the circuit court of De Kalb County is affirmed.

¶ 72 Affirmed.