No. 1-09-2162

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SIXTH DIVISION
June 30, 2011

IN THE APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

In re DETENTION of Brad LIEBERMAN, The People of the State of Illinois, Petitioner-Appellee, v. Brad Lieberman, Respondent-Appellant	)	Appeal from the Circuit Court of Cook County 00 CR 80001 Honorable Dennis J. Porter, Judge Presiding.

JUSTICE McBRIDE delivered the judgment of the court.
Presiding Justice Garcia and Justice R. E. Gordon concurred in the judgment.

ORDER

HELD: The judgement of the circuit court of Cook County was affirmed where the evidence did not establish probable cause to believe that respondent was no longer a sexually violent person.

______In these proceedings under the Sexually Violent Persons Commitment Act (Act) (725 ILCS 207/1 *et seq*. (West 2008)), respondent, Brad Lieberman, appeals from an order of the circuit court of Cook County granting the State's motion for a finding that there was not probable cause to believe that respondent is no longer a sexually violent person and ordering that

respondent remain committed to the care and custody of the Illinois Department of Human Services (DHS). On appeal, respondent contends that the trial court erred by granting the State's motion. In our original judgment issued on September 24, 2010, we affirmed the trial court's judgment. On September 29, 2010, the Illinois Supreme Court directed us to vacate that decision and to reconsider in light of *In re Detention of Hardin*, 238 Ill. 2d 33 (2010). After vacating our original order and reviewing *Hardin*, we conclude that a different result is not warranted and we therefore affirm the trial court's judgment.

In 1980, respondent was convicted of multiple counts of rape and sentenced to a number of concurrent terms of imprisonment, the longest of which required him to serve 40 years in prison. Immediately prior to his release from the Illinois Department of Corrections (IDOC) in 2000, the State filed a petition pursuant to the Act seeking to have respondent adjudicated a sexually violent person and committed to the care and custody of the DHS. In 2006, a jury found respondent to be a sexually violent person under the Act based primarily upon the expert testimony of two clinical psychologists who diagnosed respondent with paraphilia not otherwise specified, sexually attracted to nonconsenting persons (paraphilia NOS, nonconsent), a congenital or acquired disorder that affects respondent's emotional or volitional capacity and predisposes him to commit future acts of sexual violence. The expert witnesses also concluded that respondent's mental disorders created a substantial probability that he would engage in future acts of sexual violence if released. Following a dispositional hearing, the trial court ordered respondent committed to the DHS for institutional care in a secure facility until further order of the court. This court affirmed that judgment on direct appeal. See *In re Detention of*

Lieberman, 379 Ill. App. 3d 585 (2007).

On December 10, 2008, the State filed a motion in the in the circuit court of Cook County asking the court to find that there was not probable cause to believe that respondent was no longer a sexually violent person and to order that respondent remain in a secure facility. The State's motion was filed pursuant to section 55 of the Act, which states that after a person has been committed to institutional care, the DHS is required to conduct an examination of that person's mental condition within 6 months of the initial confinement and again thereafter at least every 12 months. The purpose of the reexamination is to determine whether the person has made sufficient progress to be conditionally released or discharged. See 725 ILCS 207/55(a) (West 2008). Here, the State's motion was based upon respondent's second annual statutorily required evaluation. Attached to the State's motion was the October 16, 2008, reexamination report of Dr. David Suire, a licensed clinical psychologist. Dr. Suire identified three purposes for his reexamination of respondent. First, to determine whether respondent suffers from one or more congenital or acquired mental disorders which affect his emotional or volitional capacity and predispose him to commit acts of sexual violence. Second, to determine whether, as a result of his mental disorder(s), respondent is dangerous to the degree that it is substantially probable that he will engage in acts of sexual violence. And third, if the first two questions were answered in the affirmative, to determine whether respondent has made sufficient progress in sexual offense specific treatment to be safely managed in the community under supervised conditional release.

Dr. Suire noted in his report that respondent refused to be interviewed for purposes of his reexamination. According to respondent, he had reached an agreement with his attorney that he

would “never again have to participate in an interview with Dr. Suire, Dr. Buck, or Dr. Wood.” Respondent has refused to participate in any formal sexual offender treatment program while in the IDOC and the DHS treatment and detention facility and he told Dr. Suire that he does not suffer from a mental abnormality.

Dr. Suire’s report explored the following areas in his report: respondent’s personal and developmental history; his educational and employment history; his social and sexual history; his substance abuse history; his mental health history; his medical history; his sex offender treatment history; and his juvenile and adult criminal history. Dr. Suire also considered respondent’s adjustment and treatment in the IDOC and the DHS treatment and detention facility; his history of behavioral issues in the IDOC and DHS, his mental disorders; and risk assessments. In preparing his report, Dr. Suire reviewed, among other things, previous psychological assessments of respondent, records from the DHS treatment and detention facility where respondent was being detained, records from the IDOC, court records, and risk assessment tools.

Dr. Suire performed a risk assessment as part of his evaluation of respondent. In assessing respondent’s risk of reoffending, Dr. Suire relied, in part, on two actuarial instruments to establish a “baseline of risk”: the Static-99 and the Minnesota Sex Offender Screening Tool Revised (MNSOST-R). The results of both of these instruments placed respondent in the “high risk” range. In assessing respondent’s risk of reoffending, Dr. Suire also considered aggravating or “empirical risk factors” that correlate to an increased risk of sexual recidivism as well as “protective factors” that can reduce a sexual offender’s risk of recidivism. Respondent had the following risk factors: deviant sexual interest, a personality disorder, a high “PCL-R score,” self-

regulation problems, impulsiveness and recklessness, hostility, childhood criminality, substance abuse, past violation of conditional release, low remorse and "victim blaming," a "high violence risk assessment guide (VRAG)," sexual entitlement, and seeing himself as posing no risk of reoffending.

Dr. Suire considered respondent's treatment progress, medical condition, and age as potential protective factors but he found that none of these factors reduced respondent's risk of sexually reoffending. Respondent has never participated in sexual offender treatment and therefore this factor did not reduce respondent's likelihood of reoffending. Respondent does not suffer from any medical conditions that might reduce his risk of committing a sexually violent offense. Finally, although age is negatively correlated with the risk of sexual recidivism, current research is unclear as to whether respondent's age at the time of the doctor's report, 48 years old, justified a reduction in respondent's risk of reoffending. Moreover, given respondent's history, high actuarial risk, and other empirical risk factors, it is "unlikely that any reasonable reduction [based upon respondent's age] would reduce his recidivism risk below that of substantially probable."

Based upon his review, Dr. Suire concluded that, to a reasonable degree of psychological certainty, respondent met the diagnostic criteria under the Diagnostic and Statistical Manual of Mental Disorders-Fourth Editions, Text Revision (DSM-IV) for the following diagnoses: (1) paraphilia NOS, nonconsenting females; (2) cannabis abuse; (3) antisocial personality disorder; and (4) narcissistic personality disorder. Respondent's paraphilia met the definition of a "mental disorder" under the Act in that it was a congenital or acquired condition affecting his emotional

or volitional capacity that predisposed him to engage in acts of sexual violence. The other diagnoses, in combination with respondent's paraphilia, increased his risk of sexually violent behavior and thus were also mental disorders under the Act. Dr. Suire concluded that, in his professional opinion and to a reasonable degree of psychological certainty, it was substantially probable that respondent would engage in acts of sexual violence in the future. He therefore recommended that respondent continue to be found a sexually violent person and remain committed to the DHS treatment and detention facility for further secure care and sexual offender treatment until he demonstrates that he has made substantial progress in sexual offense treatment in order to be safely managed in the community on conditional release.

The parties deposed Dr. Suire on April 29, 2009. The doctor gave the following testimony regarding his reexamination report. Dr. Suire acknowledged that some literature suggested that respondent's age would reduce his risk of reoffending. However, he did not believe that such a reduction was appropriate in this case given the "mixed findings and unclear results." Dr. Suire used the original Static-99 actuarial and he acknowledged that a new version of that actuarial has since been released. He also acknowledged that the Static-99 risk estimate does not account for the impact of supervision or the restrictions that would be imposed if respondent was conditionally released. Dr. Suire agreed that, although it would depend on the individual and would be "speculation," a person's aggregate risk estimate would "probably be lower" if that person were under strict supervision. The Static-99 also accounts for a reduction in risk due to age only until the age of 25 years old but not thereafter. Respondent's Static-99 score equated with a 52 percent risk of conviction for a sexual offense within 15 years but Dr. Suire

would not reduce that level of risk if respondent's age was taken into account because "age doesn't have an impact" in respondent's case.

Dr. Suire also acknowledged that the MNSOSTR's estimate of recidivism risk is based on an individual who is under little or no supervision and that the MNSOSTR does not generally account for the level of supervision imposed on a person who is on conditional release. He also agreed that the MNSOSTR is likely a better predictor of risk for people who are under no supervision. However, because Dr. Suire was not convinced that supervision would be effective for respondent, it was inappropriate to discount the MNSOSTR as a risk assessment tool. The MNSOSTR also does not account for age, but Dr. Suire concluded that respondent's MNSOSTR score, which equated to a 57 percent chance of being arrested for a sexual offense within six years of release, would not decrease based upon his age. Dr. Suire noted that actuarial scores are "underestimates" of the likelihood that a person will reoffend even before additional risk factors are considered, and he estimated that, based upon those actuarial scores and risk factors, resondent's likelihood of reoffending if conditionally released was likely to be "substantially" over 60 percent.

Dr. Suire did not believe that attaching a Global Positioning System (GPS) tracking devise to respondent if he were on conditional release would reduce his risk of sexually reoffending. He also did not believe that imposing a strict curfew on respondent would significantly reduce his risk of recidivism. Supervision works best on a person who has a long "build up" phase to sexually offending and, in respondent's case, he committed his sexual offenses on people he had just met and did so without a lengthy "grooming process." Ultimately,

Dr. Suire did not believe that any combination of restrictions imposed upon respondent if he were conditionally released would lower his risk of reoffending to a level below substantially probable.

Dr. Suire found respondent's refusal to participate in formal sexual offender treatment a "significant issue" because participation in treatment is a "major protective factor" that can reduce a sexual offender's risk of reoffending. Dr. Suire was aware that respondent may have had legal reasons for refusing to consent to treatment, such as having to admit he lacked volitional control, but this did not alter the doctor's conclusion that respondent cannot derive any benefits from treatment until he participates in it. Moreover, because respondent has refused to participate in treatment, Dr. Suire could not say that respondent would effectively participate in treatment if he were conditionally released. The doctor was unsure that therapy within the community would be a reliable risk-reducer for respondent because he has never participated in treatment and because he is "very manipulative," lacks "self-insight," and might not be forthcoming with a therapist.

Dr. Suire did not know whether respondent's paraphilia was specifically a congenital or acquired mental disorder but he believed it to be a combination of both. The doctor explained that a congenial condition is one that is inherited and an acquired condition is one that is learned. Dr. Suire and others in his field were unsure as to whether paraphilia was specifically a congenital or acquired condition but all conditions fall into one of these two categories. Finally, Dr. Suire explained that a person's "mental condition" or general functioning is a broader issue than that person's mental disorders. An examination of a person's mental condition includes a

review of, among other things, that person's social and vocational functioning, education, intelligence, and ability to follow rules. According to Dr. Suire, every evaluation includes a review of a person's mental condition and mental disorder.

On June 12, 2009, respondent filed a response to the State's motion in which he claimed that there was probable cause to justify his discharge or conditional release. Respondent's motion attacked Dr. Suire's report on the grounds that it (1) improperly focused on respondent's "mental disorders" rather than his overall "mental condition," (2) placed undue influence on respondent's failure to participate in treatment, (3) failed to determine whether respondent's mental disorders is congenital or acquired, (4) based its ultimate conclusions solely on respondent's past criminal behavior, and (5) improperly relied on actuarial instruments to predict respondent's likelihood to reoffend.

On July 14, 2009, the trial court held a hearing during which the parties argued their respective motions and no witnesses testified. Following that hearing, the trial court granted the State's motion and found that there had not been "any significant change" to warrant a full evidentiary hearing on whether respondent had made sufficient progress to be conditionally released or discharged. This appeal followed.

At the time of each reexamination under the Act, the detained person receives notice of the right to petition the court for discharge. 725 ILCS 207/65(b)(1) (West 2008). If the committed person does not affirmatively waive that right, like respondent in the present case, the court must set a probable cause hearing to determine whether facts exist to warrant a hearing on whether the respondent remains a sexually violent person. 725 ILCS 207/65(b)(1) (West 2008).

If the court finds that there is probable cause to believe that the respondent is no longer a sexually violent person, it must set a hearing on the issue. 725 ILCS 207/65(b)(2) (West 2008).

The Act also allows a person who has been committed to institutional care to petition the court for conditional release once certain time requirements have been met. See 725 ILCS 207/60(a) (West 2008). If the person files such a petition, the court must appoint one or more examiners to examine the committed person and make a written report. 725 ILCS 207/60(c) (West 2008). The State has the right to have the person evaluated by experts of its choice. 725 ILCS 207/60(c) (West 2008). The court must thereafter hold a probable cause hearing to determine whether cause exists to believe that it is not substantially probable that the person will engage in acts of sexual violence if released or conditionally discharged. 725 ILCS 207/60(c) (West 2008). If the court so determines, it must hold a hearing on the issue. 725 ILCS 207/60(d) (West 2008). We review the trial court's finding of no probable cause *de novo*. See *In re Stambridge*, No. 4-10-0206 (Ill. App. March 30, 2011) (reviewing the trial court's probable cause determination *de novo* where the court considered only the written reports of the parties' expert witnesses).

In *Hardin*, 238 Ill. 2d at 36, our supreme court considered the quantum of evidence necessary to support a sexually violent person commitment petition at a probable cause hearing. The respondent in *Hardin* had been convicted of various sexually violent offenses and, immediately prior to his scheduled mandatory supervised release period, the State filed a petition seeking to commit the respondent under the Act. The petition was supported by a written report by a licensed clinical psychologist who determined that the respondent met the criteria for civil

commitment as a sexually violent person. That psychologist was the only witness called at the subsequent probable cause hearing. He testified that his opinions were based on materials customarily relied on by evaluators of sexually violent persons. The doctor testified that the respondent suffered from the mental disorders of paraphila, not otherwise specified, nonconsenting persons, and personality disorder. Left untreated, these diseases made respondent likely to re-offend, a conclusion supported by the respondent's test results and "repeated rejection of offers for sex offender treatment while in prison." *Hardin*, 238 Ill. 2d at 37.

The trial court found no probable cause to believe that the respondent was a sexually violent person who was likely to reoffend and therefore ordered that he be released and placed on MSR. The trial court agreed with the respondent that his current convictions alone could not be used to meet the statutory criteria and found that no testimony had been presented as to any behavior by the respondent that would give probable cause to believe that he suffered from a mental disorder. *Hardin*, 238 Ill. 2d at 37-38. The court also found that there was no basis for the State's petition other than respondent's past convictions because the State had presented no evidence that respondent continued to have "an unusual interest in teenage girls." *Hardin*, 238 Ill. 2d at 38. The State appealed the trial court's finding of no probable cause and the appellate court reversed that finding and remanded for further proceedings. *Hardin*, 238 Ill. 2d at 38.

On appeal, our supreme court considered "whether the appellate court gave sufficient deference to the trial court's credibility and probable cause determinations in reversing the finding of no probable cause to believe respondent is a SVP." *Hardin*, 238 Ill. 2d at 43. The court began by noting that to support a finding of probable cause in a SVP proceeding, the

evidence must establish that the subject of the petition "has been found guilty, delinquent, or not guilty by reason of insanity, mental disorder, or mental defect of a sexually violent offense," "has a mental disorder," and "is a danger to others because the mental disorder causes a substantial probability that the subject will commit acts of sexual violence. *Hardin*, 238 Ill. 2d at 43, citing 725 ILCS 207/5(f), 15(b) (West 2006).

The court resolved the question of the proper quantum of evidence in a probable cause hearing by adopting the evidentiary standard established by the Wisconsin Supreme Court in *Watson*. It observed that in *Watson*, the court addressed the quantum of evidence needed to support a finding that a respondent is a sexually violent person under the Wisconsin sexually violent person statute. *Hardin*, 238 Ill. 2d at 46 (noting that the Wisconsin SVP statute is substantially similar to the Illinios SVP statute). The court in *Watson* explained that "the purpose of a probable cause hearing in a SVP proceeding is 'to show that there is a substantial basis for going forward with the commitment, when it is virtually certain that if probable cause is found, the person will remain in custody until' the end of the proceeding, thus providing 'a barrier to improvident or insubstantial commitment petitions which are not likely to succeed on the merits.'" *Hardin*, 238 Ill. 2d at 46-47, quoting *Watson*, 227 Wis. 2d at 201. Further, the *Watson* court noted that "a probable cause hearing is merely a 'summary proceeding to determine essential or basic facts as to probability' and 'is concerned with the practical and nontechnical probabilities of everyday life in determining whether there is a substantial basis for bringing the prosecution and further denying the accused his right to liberty.' " (Internal quotations omitted). *Hardin*, 238 Ill. 2d at 47, quoting *Watson*, 227 Wis. 2d at 204.

Our supreme court concluded its review of *Watson* by observing:

> "In a SVP probable cause hearing, the Watson court merely required the State to 'establish a plausible account on each of the required elements to assure the court that there is a substantial basis for the petition.' *Watson*, 227 Wis. 2d at 205. In making that determination, the trial judge must consider 'all reasonable inferences that can be drawn from the facts in evidence.' *Watson*, 227 Wis. 2d at 205. The requirement that the evidence supporting each element be 'plausible' indicates that trial judges need not ignore blatant credibility problems, but the *Watson* court stressed that this type of hearing was 'not a proper forum to choose between conflicting facts or inferences.' *Watson*, 227 Wis. 2d at 205. Consequently if after hearing the evidence, the trial judge decides the probable cause determination is supported by a reasonable inference, the cause should be held over for a full trial." *Hardin*, 238 Ill. 2d at 48.

Applying these principles, our supreme court found that the trial court did not apply the correct evidentiary standards in finding that the State had failed to establish probable cause. *Hardin*, 238 Ill. 2d at 48. Specifically, the trial court "relied on a full and independent evaluation of [the State's expert's] credibility and methodology" and "weighed the conflicting evidence presented during both the direct and cross-examination of the State's sole witness, *** as well as

delving extensively into the credibility of his expert testimony." *Hardin*, 238 Ill. 2d at 49. The court stated that these factors "are well beyond the scope of the limited inquiry in a probable cause hearing" and that "[a]s long as the State presented enough evidence at the hearing to 'establish a plausible account on each of the required elements,' providing 'a substantial basis for the petition' when all reasonable factual inferences are considered, probable cause is established." *Hardin*, 238 Ill. 2d at 49, quoting *Watson*, 227 Wis. 2d at 205.

Our supreme court also found that the State presented testimony on each of the three required elements from its expert witness, who "unquestionably had extensive experience as a clinician, a SVP evaluator, and an expert witness in SVP cases." *Hardin*, 238 Ill. 2d at 49. The State's expert diagnosed respondent with two mental disorders based upon his interview with respondent, his review of the respondent's criminal records and master file, and the diagnostic criteria of the DSM-IV. The court noted that the State was not required to show more than a "plausible account" on this element and that, at a probable cause hearing, "the court should not attempt to determine definitively whether each element of the State's claim can withstand close scrutiny as long as some 'plausible' evidence, or reasonable inference based on that evidence, supports it." *Hardin*, 238 Ill. 2d at 51-52. The court found that the testimony of the State's expert on the DSM-IV criteria and the evidentiary bases for his diagnosis were "adequate to survive that relatively low threshold standard." *Hardin*, 238 Ill. 2d at 52. Regarding the requirement that the respondent be substantially likely to reoffend, the court addressed the respondent's concern that the State could use his past convictions in every case to claim that he had a mental disorder and that it was substantially probable that he would engage in future acts of

sexual violence. It observed:

> "Although probable cause deals with practical probabilities rather than absolute certainties, more is required of the State than mere argument. The State must provide actual evidence, even if based at least in part on behaviors and traits reflected in prior convictions, to support a finding that the respondent meets each of the three probable cause elements. That evidentiary burden includes a showing that the respondent is substantially likely to re-offend based on the presence of a mental disorder." *Hardin*, 238 Ill. 2d at 52-53.

The court found that this element was satisfied by the testimony of the State's expert as to the respondent's scores on psychological tests and his unique type of victims as support for his opinion that the respondent presented a substantial risk of reoffending. *Hardin*, 238 Ill. 2d at 53. Thus, the court found that the State had met its burden and it therefore upheld the appellate court's reversal of the trial court's finding of no probable cause. *Hardin*, 238 Ill. 2d at 54.

In this case, respondent contends that the trial court's finding of no probable cause must be reversed because Dr. Suire's report focused on improper statutory criteria, because respondent's actuarial scores and risk factors demonstrate a sufficiently low risk of recidivism, and because Dr. Suire failed to determine whether respondent's paraphilia non-consent is a congenital or acquired mental disorder.

Respondent did not present any evidence to the trial court on his own behalf. The only

evidence before the trial court was the written report and deposition of Dr. Suire. Therefore, under *Hardin*, the question before us is whether that evidence established a "plausible account" or probable cause to believe that respondent was no longer a sexually violent person. The Act defines a sexually violent person as an individual who "has been convicted of a sexually violent offense *** and who is dangerous because he or she suffers from a mental disorder that makes it substantially probable that the person will engage in acts of sexual violence." 725 ILCS 207/5(f) (West 2008).

In his written report, Dr. Suire opined that, do a reasonable degree of medical certainty, respondent suffered from paraphilia NOS, nonconsent, which met the definition of a "mental disorder" under the Act because it was a congenital or acquired condition affecting his emotional or volitional capacity that predisposed him to engage in acts of sexual violence. The other diagnoses, in combination with respondent's paraphilia, increased his risk of sexually violent behavior and thus were also mental disorders under the Act. Dr. Suire concluded that, in his professional opinion and to a reasonable degree of psychological certainty, it was substantially probable that respondent would engage in acts of sexual violence in the future. He therefore recommended that respondent continue to be found a sexually violent person and remain committed to the DHS treatment and detention facility for further secure care and sexual offender treatment until he demonstrates that he has made substantial progress in sexual offense treatment in order to be safely managed in the community on conditional release.

We find that the evidence before the trial court did not establish probable cause to believe that respondent was no longer a sexually violent person. Instead, the evidence established that

respondent continues to suffer from a mental disorder that makes it substantially probable that he will commit acts of sexual violence if released into the community. The evidence also established that respondent had not made sufficient progress to be discharged or conditionally released.

Respondent nevertheless claims that Dr. Suire's report improperly focused on respondent's "mental disorders" rather than his overall "mental condition." Respondent asserts that the phrase "mental disorder" does not appear in section 55 of the Act and that, instead, the Act requires the court to consider respondent's overall "mental condition," which includes, among other things, his social and vocational functioning, intelligence, and ability to abide by the rules. Similarly, respondent claims that Dr. Suire's consideration of whether it was "substantially probable that respondent will engage in acts of sexual violence" was improper because this phrase is not used by the Act as a standard for conditional release or discharge. We disagree.

When a committed person such as respondent is reexamined under section 55 of the Act and does not waive his right to petition for discharge, the court is required to conduct a probable cause hearing to determine "whether facts exist that warrant a hearing on whether the respondent remains a sexually violent person." 725 ILCS 207/65(b)(1) (West 2008). A sexually violent person is one who "is dangerous because he or she suffers from a *mental disorder* that makes it *substantially probable that the person will engage in acts of sexual violence*." (Emphasis added.) 725 ILCS 207/5(f) (West 2008). In light of this language, we find nothing improper in Dr. Suire's consideration of respondent's mental disorders and whether it was substantially

probable that respondent would engage in future acts of sexual violence. As the trial court noted, respondent's continued commitment depends on an examination of these issues and his status as a sexually violent person.

Further, Dr. Suire considered other aspects of respondent's mental condition and did not focus solely on respondent's mental disorder. In his deposition, Dr. Suire explained that a person's mental condition, which is broader than his mental disorder, is "considered as part of any evaluation" and that there is "no evaluation that you ever do without considering mental condition and mental disorder." An examination of someone's mental condition, the doctor testified, includes consideration of, among other things, social and vocational functioning, intelligence, ability to abide by the rules, and the ability to be assertive and express needs. Dr. Suire's report reflects that he considered respondent's mental condition, including respondent's developmental history, educational and employment history, social and sexual history, substance abuse history, mental health and medical history, sex offender treatment history, and his criminal history. Dr. Suire also considered respondent's adjustment and treatment in the IDOC and DHS, history of behavioral issues in the IDOC and DHS, and actuarial instruments that provide estimates of respondent's likelihood of recidivism. When discussing respondent's adjustment and treatment while committed to the DHS, Dr. Suire's report makes note of, among other things, respondent's intellect, verbal abilities, participation in recreational activities, compliance with facility rules, ability to express his concerns, and lack of conflict with his peers. The same section of Dr. Suire's report also identifies DHS progress notes, which discuss respondent's participation in a newspaper, regular meetings with his therapist, and some of the topics

discussed in those meetings. The doctor's report also states that while respondent's behavior and compliance "have improved somewhat over this review period," respondent has continued to demonstrate a "willingness to violate rules," and "an unwillingness to accept responsibility for his own actions."

Our review establishes that Dr. Suire considered respondent's overall "mental condition" in preparing his report and arriving at his conclusion that respondent should remain committed to the care and custody of the DHS. Moreover, Dr. Suire properly considered whether respondent suffers from a "mental disorder" and whether it is "substantially probable that respondent will engage in acts of sexual violence."

Respondent next claims that Dr. Suire's consideration of respondent's refusal to participate in sexual offender treatment was improper because such treatment is not a prerequisite to discharge or conditional release. Respondent asserts that under section 55 of the Act, the proper consideration is whether respondent has made "sufficient progress" to be discharged or conditionally released. See 725 ILCS 207/55(a) (West 2008).

We find nothing improper in Dr. Suire's consideration of respondent's refusal to participate in formal sexual offender treatment. Dr. Suire explained that participation in treatment is a "major protective factor" that can reduce a sexual offender's risk of reoffending. Respondent's refusal to consent to treatment also went to the issue of whether he would participate in treatment if he were released into the community. Dr. Suire explained that he could not say that respondent would be able to effectively participate in sexual offender treatment if he were released into the community because respondent does not have a history of such

participation. Thus, Dr. Suire found respondent's refusal to participate in treatment to be a "a significant issue" and a "major reason" why the doctor did not believe respondent should be eligible for conditional release. Moreover, participation in formal sexual offender treatment has been considered in numerous cases as a relevant factor in determining whether a committed person has made sufficient progress to be discharged or conditionally released. See, *e.g.*, *In re Detention of Cain*, 341 Ill. App. 3d 480, 483 (2003); *In re Commitment of Blakey*, 382 Ill. App. 3d 547, 552 (2008); *Ottinger*, 333 Ill. App. 3d at 121-22. Finally, although Dr. Suire agreed that one of the "main reasons" he did not believe respondent should be released was his refusal to participate in treatment, the doctor's report and deposition make clear that this was not the only factor relevant to his ultimate conclusions.

Respondent also claims that the trial court's judgment should be reversed because his actuarial scores and risk factors demonstrate a sufficiently low risk of recidivism. Respondent disputes Dr. Suire's risk assessment findings on the grounds that he did not utilize the revised Static-99, which would place respondent's risk estimate at "between 30.8 and 48.5 percent," and that the risk factors upon which the doctor relied demonstrate that respondent should be discharged or conditionally released. We disagree.

Initially, there is nothing in the record to establish that the revised Static-99 was available at the time Dr. Suire conducted respondent's second annual reevaluation. Moreover, Dr. Suire explained that actuarial tools provide "underestimates" of the likelihood that a person will sexually reoffend and that he does not use actuarial tools in isolation. Rather, he uses them to obtain a "baseline" estimate of risk and then considers other "aggravating or "protective" factors

that are not accounted for by the actuarial tools and that can raise or lower the risk of reoffending. The doctor explained that none of the protective factors applied to respondent and that respondent had a number of aggravating factors that elevated his risk of reoffending. Respondent also does not appear to contest the results of the MNSOSTR actuarial, which also placed respondent at a high risk of reoffending.

Respondent also takes issue with the risk factors Dr. Suire considered for respondent's second annual evaluation, which are the same as those he considered for respondent's first annual reevaluation. Respondent claims that some of the risk factors Dr. Suire considered in his current report are not mentioned in one of the authorities from which the doctor derived them and that other risk factors the doctor considered have a low correlation to risk of recidivism. As evidence of this claim, respondent references portions of Dr. Suire's testimony from the proceedings in respondent's first annual reexamination that he attached to his response to the State's motion for a finding of no probable cause.

Respondent's argument is without merit. In the prior proceedings that respondent references, Dr. Suire acknowledged that some of the risk factors he used were not mentioned in one of the articles he relied upon but he also clarified that he derived risk factors from two articles. He also acknowledged that some of the risk factors he mentioned had a small correlation to risk of sexual recidivism but he cautioned that using terms such as "moderate" or "small" risked "misrepresenting the meaning of a correlation." Even after acknowledging these issues, Dr. Suire was nevertheless of the expert opinion that respondent continues to suffer from mental disorders that create a substantial probability that he will engage in acts of sexual violence

if released into the community.

Respondent next claims that the trial court's judgment must be reversed because Dr. Suire failed to determine whether respondent's paraphilia is congenital or acquired. Respondent asserts that his civil commitment is constitutionally appropriate only if he suffers from a mental disorder that creates a substantial probability that he will engage in acts of sexual violence if he is released. See *Kansas v. Crane*, 534 U.S. 407, 151 L. Ed. 2d 856, 122 S. Ct. 867 (2002). Respondent then points out that the Act defines a mental disorder as "a *congenital or acquired* condition affecting the emotional or volitional capacity that predisposes him to engage in acts of sexual violence." (Emphasis added.) 725 ILCS 207/5(b) (West 2008). Respondent relies upon a portion of Dr. Suire's deposition testimony as evidence that the doctor's recommendation against respondent's discharge violates the Act because he failed to specify whether respondent's paraphilia is congenital or acquired.

During his deposition, Dr. Suire gave the following testimony under questioning by defense counsel on the issue of whether respondent's paraphilia is congenital or acquired:

> "Q. The statute says that the mental disorder has to be either acquired or - - what's the phrase they use? Is it in your report, congenital or acquired?
>
> A. Yes.
>
> Q. Did you do any kind of examination of Mr. Lieberman or assessment to determine whether his alleged paraphilia non-consent disorder is congenital?

A. All conditions would be either congenital or acquired.

Q. One or the other?

A. It's congenital or acquired, either.

Q. Okay. Is Mr. Lieberman's paraphilia non-consent disorder congenital?

A. It depends on who you talk to. Some people - -

Q. I am asking you.

A. In my opinion it's a combination of a congenital and acquired condition, but the literature is not clear under which it is. Congenital, acquired would be everything. If you are asking which it is, no, I didn't analyze whether it was congenital or acquired.

Q. That's what I'm asking. So you don't know if Mr. Lieberman's paraphilia non-consent is congenital?

A. No one knows whether it's congenital or acquired. That's not known. It's one or the other.

Q. But you don't know which?

A. We don't know which.

***

Q. How would you know - - be able to tell if Mr. Lieberman's paraphilia non-consent is congenital? Is there a specific test you could run?

> A. No, not at all.
>
> Q. There's no way to tell?
>
> A. *** My understanding is we are not required to identify between the two, but it has to be one or the other, but we don't have to conclude which it is, and I don't think we could. I don't think I can say one way or another whether it's congenital or acquired. It's probably both, but I don't know for sure.
>
> Q. If you can't tell if it is congenital and you can't tell if it is acquired, how can you tell if it's one or the other?
>
> A. Because everything that anybody does is either congenital or acquired. Either you inherited it or you learned it. Those are the only two possibilities."

The trial court disagreed with respondent's argument, noting the use of the word "or" in the Act's definition of a mental disorder and Dr. Suire's testimony that respondent's paraphilia was either congenital or acquired.

The Act requires a mental disorder to be a "congenital or acquired condition." 725 ILCS 207/5(b) (West 2008). In this case, Dr. Suire explained that respondent's paraphilia is either congenital or acquired and that, although the mental health field was unsure of whether paraphilia non-consent is congenital or acquired, in his opinion it was "probably both." We find that this testimony fully satisfied the requirements of the Act. Contrary to respondent's argument, the Act does not require a greater finding as to whether the mental disorder is

specifically congenital or acquired, and respondent does not provide any authority in which a court has interpreted the Act to impose such a requirement. To adopt respondent's interpretation of the statute and to require such a finding would impose the type of precise and bright line rules that the United States Supreme Court cautioned against when it observed:

> "[T]he Constitution's safeguards of human liberty in the area of mental illness and the law are not always best enforced through precise bright-line rules. For one thing, the States retain considerable leeway in defining the mental abnormalities and personality disorders that make an individual eligible for commitment. [Citation]. For another, the science of psychiatry, which informs but does not control ultimate legal determinations, is an ever-advancing science, whose distinctions do not seek precisely to mirror those of the law. [Citation]." *Crane*, 534 U.S. at 413, 122 S. Ct. at 871.

Respondent's final contention is that the trial court's judgment should be reversed because the alleged disorder upon which respondent's commitment rests is unconstitutionally based solely upon his past criminal behavior.

______Respondent raised this argument in his prior appeal and we found it to be without merit. We noted that in *In re Detention of Samuelson*, 189 Ill. 2d 548 (2000), our supreme court found that the Act is not subject to challenge on either double jeopardy or *ex post facto* grounds. See *In re Detention of Lieberman*, slip op. at 45. In *Samuelson*, the court held that proceedings under

the Act are civil rather than criminal in nature and that confinement pursuant to the Act is not punitive. Therefore, the initiation of commitment proceedings under the Act does not constitute a second prosecution for double jeopardy purposes. *Samuelson*, 189 Ill. 2d at 559. The court also held that the Act does not implicate *ex post facto* concerns because it does not have retroactive effect. The court explained that a defendant "cannot be involuntarily committed based on past conduct" but, rather, "[i]nvoluntary confinement is permissible only where the defendant presently suffers from a mental disorder and the disorder creates a substantial probability that he will engage in acts of sexual violence [if released]." *Samuelson*, 189 Ill. 2d at 559. In reaching these conclusions, the court relied upon the United State's Supreme Court's decision in *Kansas v. Hendricks*, 521 U. S. 346, 138 L. Ed. 2d 501, 117 S. Ct. 2072 (1997), in which the United States Supreme Court considered the constitutional validity of a Kansas statute similar to the Act and held that it did not raise *ex post facto* concerns or violate the prohibition against double jeopardy.

We continue to adhere to our prior holding and again find respondent's contention to be without merit. Dr. Suire reviewed a number of factors in addition to respondent's past criminal actions in arriving at his conclusions that respondent was substantially probable to commit future acts of sexual violence and that he should not be released into the community. Moreover, as explained in *Samuelson*, a diagnosis of paraphilia based upon past criminal behavior does not mean that respondent is being punished or detained for that behavior. Rather, respondent is being detained because he presently suffers from a mental disorder that creates a substantial probability that he will engage in acts of sexual violence if released. We therefore find no

constitutional violations arising out of respondent's continued commitment under the Act.

Finally, our conclusions in this case are consistent with *Hardin*. In finding no probable cause, the trial court did not weigh the credibility of the witnesses or choose between competing expert testimony. Instead, the only evidence before the trial court was the written report of one expert witness who was of the opinion that respondent continued to suffer from mental disorders that made it substantially probable that he would commit acts of sexual violence if released into the community and who therefore recommended that respondent continue to be found a sexually violent person and remain in the care of the DHS. In relying upon this expert testimony and finding no probable cause, the trial court did not exceed the standards set forth in *Hardin*.

For the foregoing reasons, the judgment of the circuit court of Cook County is affirmed.

Affirmed.