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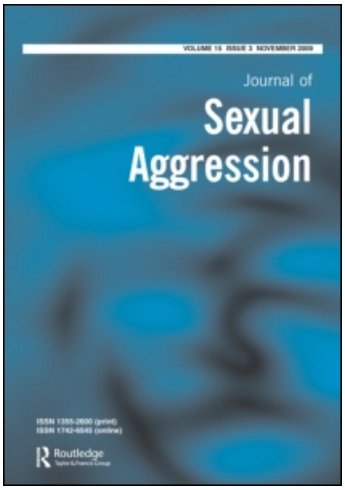

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Recidivism among treated sexual offenders and comparison subjects: Recent outcome data from the Regional Treatment Centre (Ontario) high-intensity Sex Offender Treatment Programme

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Abstract *The present investigation examined a sample of 64 offenders treated at the Regional Treatment Centre (Ontario) Sex Offender Treatment Programme (RTCSOTP) and a sample of 55 untreated sexual offenders from the Ontario region of Correctional Service of Canada. Groups were matched on age at index offence, Hare Psychopathy Checklist–Revised (PCL-R) score and type of sexual offender (i.e. intrafamilial child molester, extrafamilial child molester and rapist). As well, the Rapid Risk Assessment of Sexual Offence Recidivism Scale (RRASOR) was scored on all offenders in the present investigation. Recidivism, based upon officially recorded conviction data, was used as the primary dependent measure. Results indicated that both treated offenders and comparison participants evidenced low sexual recidivism rates (approximately 10% over follow-up periods that extended beyond nine years for both treated and comparison offenders). With reference to high PCL-R treated and comparison offenders, both groups evidenced rates of sexual recidivism approaching zero (one offender in each group recidivated sexually). These data have important implications for those who view treatment with high PCL-R offenders as without hope for success. Both treated and untreated comparison offenders received a wide variety of non-sexual offender programmes directed at criminogenic need areas. Treated offenders who were rated as being higher risk on the RRASOR evidenced substantially lower than predicted rates of sexual offending.*

Keywords *Treatment; sexual offenders; psychopath; recidivism*

Introduction

There have been a number of meta-analyses with reference to the treatment of sex offenders (Hanson, Gordon, Harris, Marques, Murphy et al., 2002; Lösel & Schmucker, 2005) which

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have demonstrated that contemporary approaches to sex offender treatment are effective at reducing recidivism. For example, Hanson et al. (2002) demonstrated that contemporary approaches to sexual offender treatment were associated with reductions in both sexual recidivism (from 17.4 to 9.9%) and general recidivism (from 51 to 32%). None the less, as noted by Hanson, Morton and Harris (2003), there are very few well-controlled studies of sex offender treatment. Some studies have relied on dropouts as comparison groups, which is problematic, because such groups have higher recidivism rates. Further, studies that have focused upon higher-risk groups of offenders are rare.

To complicate matters further, a number of authors have discussed the difficulties associated with finding statistical significance in treatment studies with sexual offenders even if differences exist between treatment and comparison conditions. For example, Barbaree (1997) provides excellent mathematical arguments regarding this matter, discussing such issues as the low base rate at which sex offenders recidivate. Base rate refers simply to the proportion of sexual offenders in a given population who commit an additional offence after release. The most recent evidence regarding sexual offence recidivism indicates that the base rate for sexual recidivism is relatively low, with meta-analyses indicating that approximately 13% of sexual offenders recidivate with a sexual offence over an average follow-up period of four to five years (Hanson & Bussière, 1998). Hanson (2000) has noted that it is very difficult to demonstrate statistical significance unless very large groups are used or there are extremely low recidivism rates in the treated group. For example, Hanson (2000) noted that a treatment programme that reduced recidivism by 40% (15% to 9%) over a five-year follow-up period would require sample sizes of 200 per group to have even a 50% chance of finding a treatment effect. Hanson (2000), however, has argued that research with smaller sample sizes or lacking statistical significance can make an important contribution when pooled with other treatment studies.

There are certain settings which provide an excellent opportunity to conduct outcome studies and which overcome some of the limitations discussed above. The Regional Treatment Centre (Ontario) Sex Offender Treatment Programme (RTCSOTP) is one such exception. This programme has been in existence since 1973, when it was started by Dr W. L. Marshall. From its inception the programme was designed for offenders deemed to be at high risk for sexual recidivism, or who presented with significant treatment needs, or both. One might reasonably predict that such a group of offenders would present with a higher base rate of sexual recidivism when compared with "typical" sex offenders. Although there is probably no one best definition of "typical" when discussing sexual offending, when using this term we are referring to lower-risk groups of sexual offenders not selected on the basis of having significant social skills or psychiatric difficulties.

The programme has been described elsewhere (see Abracen & Looman, 2004; Abracen, Looman & Langton, 2008; Looman, Abracen & Nicholaichuk, 2000). The RTCSOTP follows a contemporary cognitive-behavioural relapse prevention model of treatment. It is inpatient-based and involves both individual and group-based treatment. As stated above, it is designed to treat high-risk offenders who have multiple treatment needs. Although the programme is described as being relapse prevention-based, many goals associated with new approaches to treatment such as the Good Lives model (see Ward & Maruna, 2007 and Ward & Stewart, 2003 for a description of the Good Lives model) have been incorporated into the programme for many years. Further, in a review of the available treatment programmes on which outcome data have been produced, Hanson (2006) evaluated the literature in terms of their adherence to the risk, needs responsivity principle and noted that, of 118 studies, 27

were rated weak, good or strong (the remaining 91 studies were rejected). The only study rated as "strong" was an earlier evaluation of the RTCSOTP.

There have been several outcome studies published by our team regarding the RTCSOTP (e.g. Abracen & Looman, 2006; Di Fazio, Abracen & Looman 2001; Looman, Abracen, Serin & Marquis, 2005; Looman et al., 2000). Looman et al. (2000) examined an earlier cohort of the programme (those treated prior to 1989). Participants were 89 offenders treated at the RTCSOTP and 89 matched untreated offenders. Participants were matched on the following three variables: age at index offence, date of index offence and criminal history, and followed for an average of approximately 10 years. Proportional analyses indicated that the treated group recidivated sexually at half the rate of matched untreated comparison participants (23.6% versus 51.7%, $p < 0.0001$).

The present investigation represents an attempt to complete a more rigorous evaluation of the RTCSOTP. One limitation of the Looman et al. (2000) study was that little was known about the comparison participants other than information related to the matching variables. As well, the variety of non-sexual offender treatment programmes completed while under the jurisdiction of Correctional Service of Canada (CSC) by both groups were not discussed specifically in the earlier evaluation. Finally, the comparison offenders were released in the Prairie region of CSC (i.e. the provinces of Saskatchewan, Alberta and Manitoba), while the treated group was released in Ontario.

In order to compensate for the above-noted difficulties, the current investigation employed a comparison group regarding whom a comprehensive data set had been created. Data were available on all sex offenders assessed at the Millhaven Assessment Unit (MAU; Ontario, Canada) between 1993 and 1998. The MAU serves as the reception centre for all sex offenders entering the Ontario Region of the Correctional Service of Canada (i.e. serving sentences of two years or more). Initial assessments and recommendations regarding the intensity of sex offender treatment programming needed are made at MAU. As information regarding the MAU has been published elsewhere (see Abracen, Mailloux, Serin, Cousineau, Malcolm & Looman, 2004; Mailloux, Abracen, Serin, Cousineau, Malcolm & Looman, 2003) this information will not be repeated here. From among the offenders attending the MAU a group of sex offenders who did not participate in institutional sex offender treatment were selected. None of these offenders were treatment dropouts. Unfortunately, data regarding the reasons for failure to participate in treatment were unavailable.

Among the available information was the offenders' score on the Hare Psycopathy Checklist–Revised (PCL-R; Hare, 2003). The PCL-R was designed as a measure of personality, but evidence regarding the use of the PCL-R as an actuarial risk scale has demonstrated that it is an excellent predictor of both general and violent recidivism (e.g. Hare, 2003). In the current investigation, subjects were matched on total PCL-R score, among other variables (see below). There are a number of advantages to this methodology. First, offenders would be matched not only on a measure which has been shown clearly to be a state-of-the-art predictor of recidivism but also on a measure of personality. Secondly, given the high-risk nature of offenders attending the RTCSOTP, this methodology would allow theoretically for the comparison of a group of treated offenders meeting the diagnostic criteria for psychopathy and matched untreated offenders.

For the purposes of the current investigation, treatment and comparison offenders were matched on age at index offence (± 6 years), total PCL-R score (± 3) and type of sexual offence (rapist, intra-familial, extra-familial offender).

Method

Participants

The treated group consisted of sexual offenders assessed as presenting with a high risk of recidivism based on actuarial assessment, or presenting with significant treatment needs, or both. All offenders for whom PCL-R data were available were eligible to be included in the study. This included information relating to all offenders treated at the RTCSOTP since approximately 1994. Seventy-one subjects for whom PCL-R data were available and for whom a match could be found in the MAU data set were included in the present study. Although an exact match was found initially for each treated offender using the MAU database, a number of offenders in both the treated and comparison groups were eliminated for a variety of reasons. Seven offenders in the treated group were dropped as no release date was available for the offender or the offender died shortly after release, resulting in a treated group consisting of 64 offenders. With reference to the comparison group, data were available initially on 71 offenders, but the data in relation to 16 offenders were eliminated, resulting in a comparison group consisting of 55 offenders. These offenders were all eliminated as there was some indication on file that they had either started or completed a sex offender-specific treatment programme either in the community or institutionally.

It should be noted that much effort was put into the elimination of all offenders in the comparison group who had attended/completed sex offender-specific treatment programming institutionally or in the community. The initial data in the MAU database did not include information relating to community sex offender treatment, and therefore one of the authors (L. H.) reviewed the files of all offenders included in the "no treatment group" contained in the MAU coding file. All available information was used, including automated databases available to Correctional Service of Canada (CSC) Staff and, where necessary, contacting the staff at various sex offender treatment programmes operating in the Ontario Region of CSC. A third attempt to remove any treated offenders from the comparison group was made by one of the authors (M. F.) given that, in some cases, there was a need to retrieve information that was available only in the CSC archives or where the evidence was unclear as to whether a comparison group offender had attended any sex offender-specific treatment programme. These issues highlight the difficulties of conducting controlled outcome studies in jurisdictions where increasing numbers of sexual offenders are receiving sex offender-specific programming.

For the present investigation, offenders with a score at or above 25 on the PCL-R were defined as high-PCL-R offenders (see Quinsey, Harris, Rice & Cormier, 1998 for a discussion). The Rapid Risk Assessment of Sexual Offence Recidivism Scale (RRASOR; Hanson, 1997) was scored on all offenders included in the present investigation. This measure has been shown to be an excellent predictor of sexual offence recidivism (e.g. Barbaree, Seto, Langton & Peacock, 2001).

Table I includes information regarding the matching variables and criminal history data regarding all offenders included in the present study. As can be seen in Table I, no significant differences were observed between groups on any of the variables included in the table. None the less, as the RTCSOTP offenders were selected for the programme based upon whether they were high risk as assessed by actuarial instruments or presented with significant treatment needs it is likely that the two groups differed on measures not assessed in Table I. It therefore seems reasonable to assume that although matched on various domains, the treated group was of higher need than comparison offenders. As well, among the RTCSOTP group, treatment dropouts were retained in the treated sample and excluded from the comparison group.

Table I. *Background information on Regional Treatment Centre (Ontario) Sex Offender Treatment programme (RTCSOTP) and matched Millhaven Assessment Unit (MAU) comparison offenders.*

	MAU untreated	RTCSOTP
Total PCL-R	$n=55$	$n=64$
	18.75	18.01
Mean number of sexual convictions	$n=55$	$n=63$
	2.47	2.94
Mean number of violent convictions	$n=54$	$n=63$
	1.26	1.29
Mean age at index offence	$n=55$	$n=64$
	30.89	31.23

PCL-R: Psychopathy Checklist–Revised.

Procedure

Treatment and comparison offenders were compared with reference to sexual offence category. Offenders were coded, based on sexual offending histories, as rapists, extrafamilial offenders or intrafamilial offenders. Among the treated offenders, 43.8% were classified as rapists, 28.1% were classified as extrafamilial offenders and 28.1% were classified as intrafamilial offenders. The corresponding rates for the MAU group were 43.6% for rapists and 29.1% and 27.3% for extrafamilial and intrafamilial offenders, respectively. Proportional analyses indicated that there were no significant differences between groups with reference to offence category.

Information regarding recidivism for both the treated and untreated groups was gathered from official police documentation. Royal Canadian Mounted Police (RCMP) Finger Print Service (FPS) records were obtained for all offenders in May 2008. All offences were coded based upon Canadian Criminal Code classifications. The RCMP FPS data are based on any convictions registered within Canada and are not limited to any particular region of the country. This system of reporting offers advantages over jurisdictions where recidivism data are not available easily on a national basis. Only officially registered conviction data were used, as the authors believed this to be the most conservative method of obtaining outcome data. It should be noted that use of charges as well as convictions would necessarily increase the base rate of offending. However, this approach was not adopted in the present study. The rationale for excluding charges was that this approach might allow for the introduction of bias. For example, Davidson (1984) found that treated sexual offenders were more likely to be charged, but no more likely to be convicted for subsequent sexual offences than a matched comparison group of untreated offenders.

Results

Whole sample

Analyses were performed with reference to the proportion of offenders in each group who had recidivated sexually. With reference to sexual recidivism, both groups evidenced low rates of re-offending (11.1% among the RTCSOTP, $n=63$ sample and 9.1% of the MAU comparison group, $n=55$). The mean follow-up period with reference to sexual recidivism was 9.4 years for the treated group and 11.2 years for comparison group, $t_{(1,\ 106.90)}=3.28$, $p=0.001$. Not surprisingly, proportional analyses indicated that there were no significant differences with reference to sexual recidivism. In order to control for length of follow-up, survival analyses

were performed using sexual offence recidivism as a dependent measure. No significant differences were found between groups with the use of the Wilcoxon procedure, Wilcoxon (1) = 0.457, $p = 0.499$.

Programming

Data were collected with reference to the proportion of offenders who completed various types of non-sexual offender-based treatment programmes while under the jurisdiction of CSC. This is considered relevant information, as all core (that is offered on a National basis) Correctional Service of Canada programmes follow a cognitive-behavioural model of treatment and typically address criminogenic targets (e.g. substance abuse). Further, research indicates that participation in CSC core programmes is related to treatment gains/reductions in recidivism (e.g. Millson, Weekes & Lightfoot, 1995). In addition, Abracen, Looman, Di Fazio, Kelly and Stirpe (2006) found that those sex offenders who completed both substance abuse treatment and sexual offender treatment programmes evidenced significantly lower rates of recidivism than those who completed only sexual offender treatment programming. As can be seen from Table II, both treated and untreated groups of offenders received a variety of treatment programmes. No differences were observed between the groups with reference to any programmes for which data could be found on the majority of subjects using t-test analyses. Data with reference to "attitudes programmes" were not available for the majority of treated offenders and therefore these data were not analysed.

High PCL-R subjects

An examination of the data with reference to sexual offence recidivism among high PCL-R subjects revealed that only one high PCL-R offender in the treated group ($n = 14$) and one high PCL-R offender in the untreated group ($n = 17$) recidivated sexually. Proportional analyses revealed that there were no significant differences between groups with reference to this variable.

RRASOR data

Table III includes data on observed and predicted sexual recidivism rates for both treatment and comparison groups as well as the associated confidence intervals around the observed rates. It should be noted that the RRASOR data suggest that, although the groups were matched, the RTCSOTP group were far more likely to fall in the higher-risk ranges with reference to this measure. That is, while 24.1% (13/54) of the comparison sample scored 2 or higher on the RRASOR, 34 of the 62 (54.8%) of the treated group had scores in the same range. For scores of zero and 1 on the RRASOR re-offence rates were somewhat higher than

Table II. *Non-sex offender programmes completed by Millhaven Assessment Unit (MAU) untreated comparison group (percentage who had completed at least one programme) and Regional Treatment Centre (Ontario) Sex Offender Treatment programme (RTCSOTP) clients.*

	Comparison group	RTCSOTP
Family/marital programmes	$n = 55$, 9%	$n = 63$, 8%
Substance abuse	$n = 55$, 22%	$n = 63$, 33%
Personal/emotional	$n = 55$, 51%	$n = 63$, 56%
Community functioning	$n = 55$, 9%	$n = 63$, 21%

Table III. *Re-offence rates for each group by Rapid Risk Assessment of Sexual Offence Recidivism scale (RRASOR) risk bin.*

RRASOR score	Percentage sex offence recidivism untreated group	95% Confidence interval	Percentage sex offence recidivism treated group	95% Confidence interval	Predicted sex offence recidivism (10-year)
0	11.8% (2/17)	3.9–19.6%	14.3% (1/7)	5.7–22.9%	6.5%
1	4.2% (1/24)	0.0–9.5%	14.3% (3/21)	5.7–22.9%	11.2%
2	18.2% (2/11)	8.0–28.4%	4.8% (1/21)	0–10.1%	21.1%
3	0% (0/1)	–	0% (0/7)	–	36.9%
4	0% (0/1)	–	0% (0/4)	–	48.6%
5	–	–	50% (1/2)	–	73.1%

predicted for treated offenders. None the less, for higher-risk treated offenders the programme appeared to be effective, as evidenced by lower than expected recidivism rates. For example, with reference to treated offenders, for a score of 2 on the RRASOR the confidence interval around the observed recidivism rate did not include the predicted recidivism rate, indicating that the observed recidivism rate was substantially lower than the predicted rate. Confidence intervals could not be calculated for higher scores because none of these offenders recidivated—a significant observation in itself. The exception to this is for a score of 5 for the treated group for which one (of two) offenders committed a new offence. These data suggest that, for the higher-risk subjects, treatment appeared to be associated with significantly reduced rates of sexual recidivism.

Discussion

The purpose of the present study was to investigate the efficacy of the RTCSOTP using the most conservative strategy which could be adopted given the available data. Rather than being concerned about maximizing the probability of finding a statistically significant result, the purpose was to design a study of sex offender treatment outcome which was controlled more tightly than any reported previously in the literature (at least to the authors' knowledge). It might be argued that the studies by Marques and her colleagues with reference to the SOTEP programme (Sex Offender Treatment and Evaluation Project; Marques, Day, Nelson & West, 1994; Marques, Nelson, West & Day, 1994; Marques, Wiederanders, Day, Nelson & van Ommeren, 2005) were controlled more tightly given the use of random assignment in that investigation. None the less, that investigation used selection procedures which resulted in a fairly low-risk sample of offenders being selected (e.g. no more than two prior felony convictions; also see Abracen & Looman, 2004 for a discussion) which would reduce significantly the probability of finding significant results even if the programme was highly effective. As well, offenders were not matched on actuarial assessment instruments related to the prediction of recidivism. Marshall and Marshall (2007), as well as others (e.g. Berk, 2005), have noted the many difficulties associated with random controlled designs, especially when they are used to evaluate applied programmes. Random control designs tend to use very structured approaches that do not correspond necessarily to therapy as it is actually delivered in the field. For example, treatment manuals may not be adapted based on advances in the literature and there is a need for rigid adherence to the information contained within the session materials. As such, the relevance of these designs to applied settings may be more limited than first realized, a point discussed in some detail by Marshall and Marshall (2007),

authors who are very well versed on both conducting outcome research and the delivery of sex offender-specific treatment.

In the current investigation offenders were matched on PCL-R, a measure of psychopathic personality which has been shown repeatedly to be associated with risk for general and violent recidivism (Hare, 2003). As well, offenders were matched on age at index offence and type of sexual offence. As these latter two variables are related clearly to recidivism and not included in the PCL-R, it was felt important to match offenders on these variables. The RRASOR was also scored for all offenders, although groups were not matched on this factor.

Although every effort was made to control for differences between the groups on background variables it is quite possible, in fact likely, that the RTCSOTP sample represented a group with higher treatment needs. As noted above, the RTCSOTP programme is designed specifically for offenders with higher risk and/or needs profiles. For example, Looman (2005) examined 60 consecutive admissions to the RTCSOTP over a two-year period from July 2002 to October 2004. Of these offenders, 57 (95%) suffered from personality disorders (25% borderline personality disorder), 39 (65%) from paraphilias, nine (15%) suffered from a psychotic disorder and 15 (25%) suffered from major depression, while 10 (16.7%) suffered from an anxiety disorder.

As reported recently by Langström, Sjöstedt and Grann (2004), the incidence of psychiatric disorders increases the probability of recidivism in sexual offenders. For example, these authors reported that a diagnosis of personality disorder increased the odds of sexual reconviction by a magnitude of 10 times and a diagnosis of alcohol abuse or dependence more than doubled the odds of a sexual reconviction. Further, we have reported elsewhere that, among those sexual offenders with scores at or above 5 on the Static-99, sexual offenders with diagnoses of both a personality disorder and a paraphilic diagnosis are at somewhat elevated risk of recidivism relative to those without such diagnoses (Abracen & Looman, 2006).

The rationale for the conservative methodology employed in the current investigation was that it is very difficult to interpret the results of the individual studies available in the literature based on the significant limitations inherent in their designs. Excellent work, such as the meta-analysis reported by the collaborative research project (see Hanson et al., 2002), represents one method of overcoming such limitations. However, such research does not represent a substitute for improved methodology. The design of the current study represents an improvement over many published studies which have not employed comparison samples or which have not evaluated the use of a contemporary cognitive-behaviourally based treatment programme.

The fact that the comparison group also recidivated at a relatively low rate suggests that the non-sex offender-specific programming which many had completed may have been effective at reducing the risk of this relatively lower-risk, lower-need sample and would be in keeping with the known efficacy associated with a number of these programmes. This result is also consistent with recent research results by Hanson and Thornton (2008), who attributed a general decrease in the recidivism rates of sexual offenders to the "programme-rich environment" available within CSC institutions during the 1990s.

It is, of course, possible that the results of the present study indicate that the RTCSOTP is not a particularly effective programme. However, given the difficulties associated with finding significance when relatively small samples are used and/or with very low base rates (e.g. approximately 10% with reference to sexual recidivism for both groups included in the current investigation), the authors do not believe that this is the most parsimonious explanation. The present data need to be evaluated in light of the previous research by our team (e.g. Looman et al., 2000), in which a much larger pool of comparison offenders were

available and which therefore allowed for the comparison of a much higher-risk group of offenders treated at the RTCSOTP.

Further, the RRASOR data appear to reinforce this perspective. As noted earlier, a larger proportion of the treated group than the comparison group fell into the higher-risk range on the RRASOR. In spite of this fact the two groups evidenced similar rates of sexual offence recidivism. The likelihood that the RTCSOTP sample represented a higher-need group also suggests that the RTCSOTP programme reduced the risk level of treated offenders to those of the non-treated comparison group.

It should also be emphasized that the offenders in the RTCSOTP group who scored in the higher-risk bins on the RRASOR evidenced significantly lower rates of sexual recidivism than predicted by the RRASOR. These results are in keeping with the perspective of Andrews and Bonta (2003); Bonta & Andrews, 2007) that treatment is most effective with higher risk offenders. Further, Looman (2006) observed a similar pattern of results with a much larger sample of treated offenders who attended the RTCSOTP. It should be noted that, given the relatively limited number of comparison group offenders in the moderate and higher-risk bins of the RRASOR, it is hard to know how to interpret these data.

There are very few controlled studies on the treatment of psychopathy. Further, according to the criteria established by Wong (2000), there have been no studies which have investigated the efficacy of a comprehensive inpatient-based treatment programme with reference to psychopathy (as defined by the PCL-R) using a matched untreated comparison group. In the current study, for men scoring higher than 25 on the PCL-R both the treated and the untreated group had very low recidivism rates. Unfortunately, these results do not speak to the efficacy of sexual offender treatment in the reduction of recidivism among sex offenders who score high on the PCL-R; however, they do suggest that the popular notion that psychopaths invariably re-offend is mistaken. It may be that the completion of other correctional programming had an impact on the recidivism rates of the untreated group.

As noted by Wong and Hare (2005), "even modest reductions in the use of aggression and violence by psychopaths would be of enormous benefit to society" (p. 9). As some have argued that psychopaths are untreatable (see Hare, 1998 for a review), any indication of treatment efficacy with reference to this condition is of critical relevance. Although far from resolving the ongoing debate regarding whether treatment is effective with psychopaths, studies such as that reported here add to the accumulating evidence that even the highest-risk groups of offenders may be responsive to treatment, or at least may be manageable when released into the community. It should also be emphasized that offenders in both groups received treatment geared towards criminogenic need areas. In any case, the fact that only one high PCL-R subject in both groups recidivated sexually flies in the face of arguments to the effect that psychopaths are untreatable.

It is our perspective that the available evidence suggests that when cognitive-behavioural treatment is used, designed specifically for high-risk groups of offenders and delivered by qualified professionals, there should be every expectation that reductions in recidivism will be observed (see Abracen et al., 2008 for an extended discussion of this topic). Regardless of how the reader interprets the results of the present investigation, the fact that virtually no high PCL-R offenders recidivated sexually counters the prevailing notion that sex offenders, and especially psychopathic sex offenders, would evidence significant rates of sexual offence recidivism. The implications for jurisdictions that might commit an offender based upon a history of sexual offending and a diagnosis of psychopathy are clear, especially where the assessor is asked to make the pronouncement that the offender is more likely than not to commit a sexual offence in the future.

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