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“I felt like a robot”: A Retrospective study differentiating Life Course Persistent Offenders within a Substance Misuse cohort.

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Abstract

Prison populations in the U.K have continued to rise each year, and whilst certain crime figures often remain steady over time, the continued increase has coincided with a surge in drug related deaths and convictions for drug related offences. Historically, substance misuse has been treated as a "later life" problem resulting in psychological research failing to adequately identify clear, concise, and successful treatment pathways. The current study aims to begin filling this void. Thematic analysis was undertaken to understand existing treatment pathways, identify any gaps in existing services, highlight any successful interventions and identify any commonalities across the offender sample. Semi-structured interviews were conducted with 12 graduates from a residential rehabilitation programme, who had been free from criminal justice involvement for at least 12 months post-treatment.

Findings identified numerous failings across community substance misuse services such as ineffective treatment pathways and a lack of collaborative working. Strikingly, the study identified a potential pre-disposition for addiction, with some evidence to support a link between deficits in childhood such as emotional recognition, understanding and processing, that may contribute to the development of addiction and criminality. Such findings were further reinforced from a quantitative perspective using a multi-dimensional Smallest Space Analysis. Results indicated the possibility of three narratives, which were combined with the qualitative data to support recommendations for the possible improvement in treatment pathways.

Summary of Acronyms

ADHD…… Attention Deficit Hyperactivity Disorder

ASD …….. Autistic Spectrum Disorder

LCPO……. Life Course Persistent Offending

ACE…… Adverse Childhood Experiences

T&S…… Therapy and Services

C&S…… Consequences and Symptoms

Contents

Introduction

Prison populations in the U.K have continued to rise each year with data suggesting in 2017 alone, between the months of May and August, there was an increase of 1,200 prisoners (Trevelyan, 2018). It is suggested that whilst certain crime figures will often remain steady over time, the continued increase has coincided with a surge in convictions for drug related offences (Trevelyan, 2018). Given that addiction is often a life-long condition, it is not surprising that drug related offences play a significant role within life course persistent offending (LCPO) (Hser et al., 2015). Consequently, substantial research has attempted to explore precursors to addiction and criminality with findings identifying that childhood displays of anti-social behaviour increases the likelihood of LCPO (Whitmore et al. 1997; Phil & Peterson 1991; Davis & Florian 2004; Andersson & Magnusson, 1987; Satterfield et al., 1982). Furthermore, despite the increased knowledge, research has continued to highlight that children displaying such tendencies remain vulnerable to a multitude of poor outcomes in later life such as substance abuse, suicide and criminal behaviour (Davis and Florian, 2004; Hodgins et al., 2008; Murray et al., 2010). This may be due to a significant emphasis being placed on the "causes" of anti-social behaviour, which has consequently attributed the blame to a complex mixture of genetical, biological and environmental factors, thus causing much conflict amongst existing literature (Ellis,2005; Bohman, 1996; Gabrielli & Mednick, 1984; Latvala et al., 2020).

Concerningly, early interventions derived from such research have been less effective in reducing the development of offending behaviour (Hayes, 2020; Weisburd, 2003). Examples of this include parenting programmes which were introduced worldwide to target

poor parenting methods within families deemed to be “high risk” of criminality (Wilson, 2014). Such programmes have attracted substantial criticism for many reasons including low attendance rates, family disengagement and inappropriate referral processes (Wilson, 2014). It is evident that parenting programmes rely upon parents accepting an element of blame for their child’s anti-social behaviour, and whilst this may well be true, it would be naïve to assume that parents would not be resistant to this type of intervention. Furthermore, inadequacies within the referral processes have identified that past research may have inadvertently contributed towards inequalities in existing child mental health services (Wilson, 2014). Examples of this include parents being delayed in obtaining neurodevelopmental assessments for their children, often being referred to parenting classes to rule out poor parenting before any healthcare provider has even seen the child in question (Wilson, 2014). Such processes immediately defer blame to the parents and indirectly stereotypes them as a direct result of their child’s behaviour (Wilson, 2014). To assist in reducing some of the inequalities currently faced by those presenting with anti-social behaviours, insight into the complexities associated with LCPO needs to be considered constructively, with less emphasis placed on deferring blame and more on supporting the person at risk, regardless of the original cause.

There is a catalogue of existing literature that aims to explore the trajectory of criminal behaviour, with perhaps the most novel early work being conducted by Moffitt (1993) surrounding the differentiation of offenders based on causal life factors. He suggests that offenders fall into one of two categories, adolescent limited or LCPO (Moffitt, 1993). The research posits that a significant causal factor for lifelong offending appears to be neuropsychological problems such as Attention Deficit Hyperactivity Disorder (ADHD) or neuropsychological dysfunction brought on by early childhood trauma, pre-term exposure to

illicit substance, stress or maternal malnutrition. Interestingly, it suggests the cause of the neuropsychological dysfunction is irrelevant in terms of outcomes, believing that the reinforcement of a child's particular narrative, through continued social encounters, more likely facilitates the life course persistency of the anti-social behaviour (Moffit, 1993). Moffitt (1993) argues that even the most loving of parents or nurturing teachers will find problematic behaviour difficult to contend with and will feel frustrated trying to manage the anti-social behaviours displayed by a child with neurological dysfunction. He suggests this will naturally impact upon the way the child is spoken to or managed and this differentiated attitude, whether conscious or unconscious, reinforces the child's narrative. This reinforcement, coupled with the symptoms of neuropsychological dysfunction such as increased impulsivity, difficulties in receptive language and cognitive processing, fuels the ongoing development of criminality.

Despite this pioneering notion, it seems when evaluating adolescent limited offending there is minimal elaboration on why some teenagers, despite having seemingly good childhoods with good early pro-social behaviour, begin to deteriorate in adolescence. Offending beginning in later childhood appears a social phenomenon as developmental psychology suggests that social constructs are already in existence by the time the child hits late adolescence (Wiecko, 2014). Some have even argued that late onset offending does not exist suggesting the data used to determine its existence is unreliable (Wiecko, 2014). One explanation proposed for adolescent limited offending is, adolescent admiration of "delinquent peers", arguing that during the transition phase from childhood to adulthood, children will seek independence from their care givers and this independence is often epitomised by those who do not follow pro-social rules (Friedlander, 2013). For example, early starters of LCPO will often display a certain level of independence before they reach

their teens, seemingly following their own rules as opposed to the rules imposed by authoritative figures. This may be perceived by teenagers as a means of gaining independence (Hirschi, 1995) with some adolescents becoming more inclined to mimic the anti-social behaviour to achieve more autonomy over their lives. As time progresses the adolescent limited offender begins to recognise there are more rewards for pro-social behaviour as opposed to anti-social behaviour meaning this offending period can end quite abruptly (Hirschi, 1995).

This explanation certainly appears plausible for adolescent limited offenders, yet many substance misuse studies have identified that those who suffer difficulties with addiction often start taking substances in their teens and continue to abuse substances and offend right through to late adulthood (Oesterle et al., 2011). Arguably, this ignites several debates surrounding why many teenagers can experiment with substances during this time frame, but do not continue into active addiction, through to notions of a possible pre-disposition or addictive personality. Regardless, it is evident that addiction does not discriminate affecting individuals from various backgrounds, upbringing and cognitive ability (Hodgins et al., 2009). Some have even argued that offenders who commit crime to fund their addiction should not be considered LCPO as their criminal activity would not exist without the need to fund their addiction (Sampson & Laub, 2017). Nevertheless, it is evident that prisoners with drug related offences such as shoplifting, possession and possession with intent to supply, make up a substantial amount of the prison population, and such crimes continue to have a high rate of recidivism. Consequently, if substance misuse is not considered as a cohort within the realms of LCPO, it mitigates the emphasis on early intervention for drug related offences suggesting that substance misuse is a “later life problem” and overlooks the possibility of a pre-disposition to addiction. It is this conflict in

the literature surrounding substance misuse and criminality which requires further examination. To facilitate effective treatment pathways, consideration must be given to offender trajectories in relation to substance misuse, particularly when drug related offences and drug related deaths are continuing to increase year upon year (Alenezi et al., 2021).

Given the strong connections between criminality and neuropsychological conditions it makes sense to consider substance misuse in relation to mental health. The prevalence of co-morbid ADHD and substance misuse is significantly high across a plethora of studies, with figures suggesting that children with ADHD are nearly 3 times more likely to struggle with addiction into adulthood (MacDonald, 2021; Jadidian et al, 2015; Klein et al, 2012; Molina et al, 2018). Frustratingly, the figures surrounding children or adults getting a diagnosis for ADHD, when they are actively admitting to taking substances, is extremely low, verging on non-existent (Foulds & Newton-Howes, 2021). It appears this is a consequence of practitioner concerns surrounding the abuse of stimulant therapies often used to treat ADHD symptoms, in conjunction with complex and confusing diagnostic overlaps.

Current data suggests that adults in active addiction are more likely to be diagnosed with a personality, mood or anxiety disorder as opposed to ADHD, and whilst in some cases these diagnostic labels may well be accurate, there remains the possibility that the symptoms of ADHD were present in early childhood, but missed (Foulds & Newton-Howes, 2021). Nevertheless, it is evident that when ADHD and substance misuse coincide, the substance misuse is often more prolific and cognitive impairment appears more severe, making treatment outcomes less successful (MacDonald, 2021; Jadidian et al, 2015; Klein et al, 2012; Molina et al, 2018). Furthermore, it is no coincidence that despite low diagnostic rates, there is a disproportionately high number offenders across the criminal justice system who do have

a diagnosis of ADHD. Given that those who abuse substances are less likely to get a formal diagnosis, it is plausible to assume that despite figures being extremely high they are also likely to be underestimated (Young & Cocallis, 2021).

Unfortunately, when considering mental health in more general terms across offending populations the disparity amongst offenders with mental health conditions and those without is significant. Recently, Skinner and Farrington (2021) published a longitudinal study on the medical data and self-reported symptoms of 394 men who had been monitored since aged 8. The results indicated that LCPO and Late Onset offenders were over twice as likely to have disabling mental health conditions, hospital intakes and physical illness. Given the evident complexities with diagnostic overlaps, multiple co-morbidities and inequalities in diagnostic assessments for those who admit to abusing substances, it appears optimistic to assume that continued publication of such complexities will in turn reduce the systemic inequality already in existence. This is reinforced by evidence that suggests despite years of increased awareness, children who display anti-social behaviour are still facing difficulties in accessing treatment and diagnostic assessments (Davis, 2013). Therefore, it is worth considering placing more emphasis on treating symptoms as opposed to identifying the "cause".

For several years it has been highlighted that one of the difficulties in early diagnosis is the overlapping symptoms across a plethora of different diagnostic labels (Davis and Florian, 2004; Hodgins et al., 2008; Murray et al., 2010). Furthermore, it is no secret that some diagnostic labels appear to be more favourable than others given the "blame" or "stereotype" attached to them (Broomhead, 2013). Examples of this include Attachment Disorder, which is heavily associated with neglect and abuse in early childhood leading to

unstable and dysfunctional relationships with care givers. The difficulty with such labels is that the symptoms coincide with other diagnostic criteria, most notably ADHD and Autistic Spectrum Disorders (ASD) (Sadiq et al., 2012). Therefore, it is no surprise that misdiagnosis occurs with some parents being reluctant to accept a diagnosis for their child if it falls under Attachment Disorder as opposed to ADHD or ASD (Sadiq et al., 2012). Furthermore, many parents have suggested that parental separation is often used as a justification for not considering a child for an ADHD or ASD assessment, with professionals suggesting that any form of "childhood trauma", including a relationship breakdown can lead to Attachment Disorder (Brennan & Shaver, 1998).

Concerningly, living through a pandemic has now been categorised as an Adverse Childhood Experience (ACE) (Calvano et al., 2021), suggesting that the current generation of children requiring assessment for ADHD or ASD may now face an increased inequality of service, refusal to assess, or misdiagnosis because of the recent COVID-19 pandemic. To reduce or mitigate such inequalities it may be more beneficial to direct treatment pathways to treat the symptoms as opposed to battling through often complex, underfunded, and confusing diagnostic pathways. Identifying similarities in symptom presentation and treating such symptoms may facilitate treatment pathways which are not constrained by obtaining a particular diagnostic label. In considering this approach for a cohort of offenders who have been susceptible to addiction, it could pave the way for more effective early identification and intervention. One such symptom, which is very much under researched and appears considerably overlooked is, Alexithymia.

Alexithymia is defined as a significant difficulty in recognising one's own emotional states. Despite the limited research available to date (Sifneos, 1996), Alexithymia has been

reported as a common symptom existing from childhood through to adulthood. It has been linked to a substantial number of mental health conditions including ADHD, Autistic Spectrum Disorders (ASD), Anxiety, Depression, Schizophrenia, PTSD, Attachment Disorder, eating disorders and addiction (McCaslin et al, 2006; Donfrancesco et al, 2013; Edwards et al, 2006). Most notably, the evidence available highlights that Alexithymia has a significant negative impact on treatment engagement, positive outcomes and retention rates (Kooshki et al, 2021).

Concerningly, there has been minimal development in terms of effective treatment options for those who present with higher levels of Alexithymia. Possibly the most interesting research in this area to date stems from physiological and neuroscientific studies that have identified that Oxytocin, which naturally occurs in the body, may play a significant role in increasing people's ability to recognise and verbalise emotions. The potential problem is that their study consisted of externally administering Oxytocin through the nose to allow participants an immediate increased dose of Oxytocin (Samur, 2021). Whilst the benefits were evident, it is likely that this option for substance misuse patients would be highly controversial, and the administration technique alone could be considered "triggering" for someone in addiction. Nevertheless, the findings still are in their infancy, and it is difficult to determine over how long a patient would need to inhale the Oxytocin to establish long term outcomes without repeated use of the externally inhaled substance. Such findings should not be ignored however, as there is an ever-increasing body of evidence to support that group therapy can naturally increase the levels of Oxytocin within the body, which may explain the reduction in reported symptoms of Alexithymia following group therapy interventions (Mohebi et al, 2021). Identification of symptoms such as Alexithymia alongside an exploration of the most effective treatment options, may assist in enabling more targeted

interventions for those individuals who do not fit neatly into diagnostic criteria. Optimistically, this could place the person back into the centre of the intervention, regardless of any complex profile.

The evidence appears clear that trauma, genetics and brain development may all play a role in contributing towards the development of criminality (Whitmore et al. 1997; Phil & Peterson 1991; Davis & Florian 2004; Andersson & Magnusson, 1987; Satterfield et al., 1982; Brower & Price, 2001). This makes taking a "casual" approach to criminality extremely complex with multiple facets that could be assumed as unpreventable in terms of early intervention (Hayes, 2020; Weisburd, 2003). Consequently, it appears appropriate to accept that the causes of a child's anti-social behaviour may well be irrelevant, particularly when the child's behaviours demonstrates that damage has already been incurred. For example, if the "cause" of the anti-social behaviour is poor parenting, the effects of such parenting are already visible, suggesting an existing impact on the child. This implies that whilst parental education may be required, such education may prove futile unless complemented by interventions targeted to support the child for the effects of the poor parental choices already incurred (Wilson, 2014). The same can be said for genetics and brain development, particularly in hidden disabilities, as such causes may only be identified after the child begins to display anti-social behaviour. In this instance, the evidence indicates, that the "cause" may not even be identified or pursued given the stereotypes held against parents of children who display challenging behaviours (Davis and Florian, 2004; Hodgins et al., 2008; Murray et al., 2010). Notably, it does not appear to be a coincidence that such stereotypes coincide with delays in early diagnosis for conditions such as ADHD and ASD where the symptoms of such conditions can mimic those associated with trauma informed behaviours (Kenny, 2016; Benstead, 2019; Sandler, 2016; Graham, 2017). Moreover, it

appears that the implications of such complexities may well be reflected in the ever-increasing number of prison populations presenting with mental health conditions, which some suggest is as high as 90% (The House of Commons, 2017).

Given the apparent lack of effective intervention for substance misuse cohorts despite the increased knowledge and awareness, it appears appropriate to address some of the inherent systemic failings from a differing perspective. Despite its limitations, Moffit (1993) established the foundations needed to begin predicting offender trajectory. Typologies and narrative based models have continued to develop significantly since, improving insight into offender profiles, behaviours, and motivations. Ioannou et al (2016) made significant headway in criminal psychological studies by drawing together the relevance of emotions in crime commissioning, which reinforces the assumption that emotion is relevant to offender's motives and behaviours. Emotion has since been successfully explored across a multitude of different criminal cohorts such as contract killers, rioters, psychopathic and personality disordered offenders and young offenders (Willmott & Ioannou, 2017; Goodlad et al, 2019; Ioannou et al, 2018; Yaneva et al, 2018). Therefore, by taking a narrative approach to addiction it may provide similar insight into this offender population. Utilising this approach, allows the offender to be considered as the expert, enabling a deep and meaningful interpretation which goes beyond the realms of purely statistical data. There appears from the existing literature to be a gap in research for LCPO, because the answers to effective crime reduction strategies for drug related offences may not lie within identifying the "cause", but from the deficits that can result from such causes. Recognising that drug related offences stand out as "unique" amongst current theories of LCPO, it is logical to try to understand what makes this cohort different to other offender populations.

Utilising a symptom driven perspective as opposed to a "causal" perspective could determine whether consistent deficits are identifiable amongst such offenders. If consistencies are found it may enable more effective treatment pathways in both adult and child support services; more targeted use of public resources; and, reduce current inequalities amongst service provision for children identified as high risk for LCPO. The current study aims to fulfil this void, and given the complexities outlined, it seems appropriate to approach such research initially from a qualitative perspective to enable a deep and varied understanding of the interwoven issues associated with a substance misuse cohort of offenders (Goodley & Tregaskis, 2006). However, it may also be beneficial to complement such findings by exploring any differing narratives to determine the possible impact, on treatment outcomes. Ex-Offenders who have undergone therapy and have remained out of the criminal justice system, are best placed to reflect upon their experiences throughout their lifespan. Furthermore, they may be able to provide insight into which elements of their therapy were most effective during their treatment process, enabling a deeper understanding into effective treatment pathways.

Method

1a) Data Analysis

Thematic analysis was utilised to identify, understand, and report any consistent patterns or themes within the obtained data. Braun and Clark's (2006) six step guide provided the foundations for the process. The researcher familiarised herself with the data through transcription, and subsequent repeated reading. During the familiarisation phase the researcher took notes to generate initial coding ideas. Codes were generated electronically throughout the transcripts and perceived evocative lines were highlighted (Appendix 1). Thematic Maps were used to enable a visual representation of patterns and themes emerging.

Overarching themes were identified, enabling sub-themes to be considered for similarities and differences. The Thematic Maps were then re-ordered, establishing which themes may be discarded, encompassed into one theme, or rephrased allowing for an articulate analysis of the research question (Appendix 2). A thematic table was generated, which assisted in organising and summarising the quotes alongside the themes and sub-themes generated, ensuring each theme remained concise and clear (Braun & Clark, 2006). Following a review of the thematic table it became apparent, when evaluating the consequences and symptoms associated with addiction, that the cohort of offenders interviewed displayed differentiated themes. This suggested a possible identification of more than one narrative or criminal trajectory within the offenders interviewed. Therefore, the thematic table was split into two separate tables, one for the purpose of evaluating consequences and symptoms (C&S) and one for evaluating Therapy and Services (T&S) (Appendix 3). The C&S thematic table was then utilised to generate 30 variables derived from the interviews which was subsequently turned into Quantifiable data. The data was then analysed using a Smallest Space Analysis (SSA) through Multi-Dimensional Scaling to generate objective results from the data obtained. The T&S thematic table revealed strong themes throughout the data set regardless of any narrative emerging, and as such, continued to be analysed thematically.

1 b) <u>Participants</u>

Twelve Participant were recruited based on their participation in a highly successful U.K based residential rehabilitation programme and no inducements were given for their participation. The study contained eight males and four females, who were recruited after permission was sought from the founder of the residential programme. Consequently, the study was promoted via word of mouth and during Aftercare sessions amongst graduates of the programme, with participants being afforded the opportunity to show an expression of

interest. All participants had been free from criminal justice involvement for 12 months or more at the time of the interview, with their last offence documented being before they entered the residential programme. Interviews were held virtually due to the Covid-19 pandemic. However, risk assessments were implemented and reviewed by Huddersfield University's ethics panel to ensure the mental wellbeing and physical safety of the participants and researcher. Participants were able to choose a time to suit them which allowed them to be free from commitments and distractions during the interview process.

1 c) <u>Materials</u>

An interview schedule was derived which included personal questions initially to generate a rapport with the participants (King & Horrocks, 2010). Open ended questions were then utilised throughout to allow for a flexible and natural discussion. An information sheet (Appendix 4) and debrief form (Appendix 5), was shared electronically to inform participants of the research topic in further detail, along with consent form (Appendix 6) for them to give verbal consent. Microsoft Teams was initially suggested to conduct and record the interviews, however, many of the participants frequently used Zoom to facilitate aftercare sessions through the pandemic. Therefore, following a discussion with the participants it was jointly decided that Zoom would be a more user-friendly platform for participants to access. The Interviews were audio recorded through Zoom but not saved to the Zoom platform to avoid any risk of data breach. Instead, the audio recordings were downloaded onto a password protected computer and stored within a password protected file until they were transcribed and subsequently deleted. Microsoft Office was used to highlight extracts within the data set and Microsoft review comments facilitated the generation of codes to be incorporated alongside the extracts to summarise them. The thematic maps were generated using Mind view software and then copied into Word for final submission of the research.

Microsoft Word was also used to generate the thematic tables and SPSS software was utilised to allow an exploration of the variables drawn out from the data set. Subsequently, SPSS was utilised to run the Smallest Space multi-dimensional analysis.

1 d) <u>Procedure</u>

Each participant was sent a Zoom link entitled "Research" via an agreed email address outlining an agreed date and time for their interview. Upon logging into the interview participants were shown an information sheet via screen share and a consent form, they were asked to read along with the researcher whilst this was being verbally read out to them. Participants were then asked if they still wished to continue with the research after receiving the full information surrounding the study topic, their rights to withdraw, and, how their data will be used and stored. Once participants gave verbal consent, they were asked to pick their own pseudonym, some found this difficult and requested one be chosen for them. Participants were then advised to remember the agreed pseudonym and to quote it to the researcher should they have any requests to remove elements, or all their data, up to five days after their interview had terminated. The interviews lasted between 30 – 70 minutes and were dependent upon the information each participant wished to divulge in response to the open-ended questions. Once a rapport had been established, questions were asked to facilitate responses in line with the aims of the research. Once the interviews had concluded, participants were thanked for their participation, debriefed verbally and a debrief form was shared via screen share on Zoom containing relevant support numbers along with the researchers and supervisor's details.

2) **Reflexivity**

The researcher has a family member who has experienced addiction and therefore has personal experience of some of the issues discussed within the current study. The researcher has also worked previously with a cohort of substance misuse offenders both in a community setting and within a prison environment. However, whilst the researcher was aware of the rehabilitation centre through their previous role they have never worked there. The previous professional experience with a substance misuse cohort of offenders did contribute towards the researcher's motivations in trying to resolve some of the negative aspects associated with addiction and to provide insight into the value of services already in existence. Such experiences may have led to a bias within the identification of themes contained within the data. However, the use of the SSA enabled a quantitative perspective to substantiate the findings and to mitigate any potential bias.

3) Results

The thematic analysis of the T&S revealed two core themes across the entire data set. The themes and sub-themes identified are reported in table 1.

Table 1: Themes that emerged across the entire data set

Themes		Sub themes
Ineffective Community Services	The complexities associated with the ethos and treatment options available within community-based	1. Need for early intervention 2. Inefficient collaborative working &

	substance misuse services.	Treatment outcomes
Effective Residential Therapy	The key components that facilitate recovery success and reduce recidivism in offenders who have accessed residential rehabilitation.	1. Safe and Structured environment 2. Group Therapy Outcomes

The data pertaining to the C&S was re-analysed using factor analysis to generate variables that may assist in establishing any differentiation within the offender population. The variables were then placed into thematic maps which appeared to display the possibility of three narratives appearing from the data set (Appendix 2). Table 2 shows the variables generated from the thematic maps which were believed to be associated with each over-arching narrative.

Table 2: The variables found within the data set to inform the Multi-Dimensional Analysis

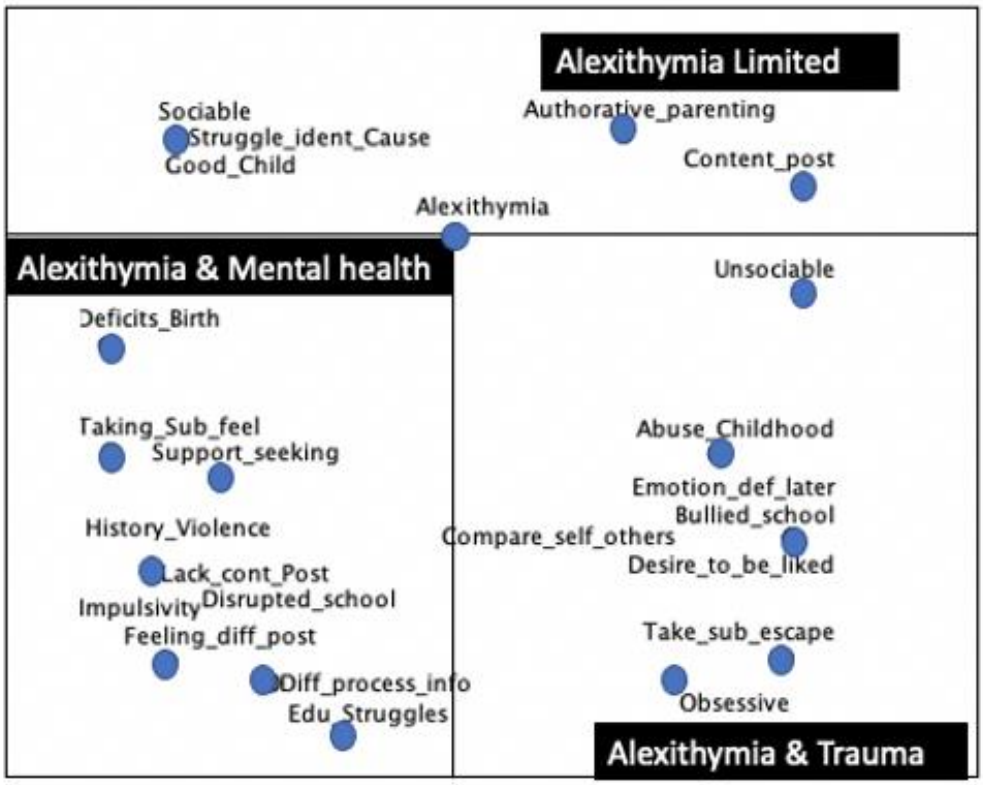
Narrative		Variables strongly associated
Mental Health and Alexithymia	A total of 17 variables were thought to be associated with a mental	Lack of Contentment post treatment, Good Childhood, Difficulties

	health and Alexithymia narrative.	processing information, Educational Struggles, Disrupted Schooling, History of Violence, Impulsivity, Support Seeking, Feeling Different Post-Treatment, Sociable, Struggle to Identify a cause, Taking Substances to Feel, Lack of Empathy, Deficits from Birth, ADHD traits, Alexithymia
Trauma and Alexithymia	A total of 13 variables were thought to be associated within a Trauma and Alexithymia narrative.	Abuse in Childhood, Unsociable, Taking Substances to Escape, Suicidal Tendencies, Lack of Confidence, Delayed Emotional Deficits, Obsessive, Bullied, Desire to be liked, can identify a cause to substance abuse, Compares self to others,

		Contentment post-treatment, Alexithymia
Alexithymia	A total of 5 variables were thought to be associated with an Alexithymia only narrative.	Content post treatment, good childhood, Struggle to identify cause of substance misuse, sociable, Alexithymia

The Multi-Dimensional Analysis was performed in the form of a Smallest Space Analysis (SSA) via SPSS. The stress test revealed a Tuckers co-efficient of 0.882 which Dugard et al. (2010) suggests is a good fit. Nevertheless, whilst the goodness of fit measures was considered, Borg and Lingoes (1987) argue that there is no simplified way of understanding how good or bad the fit is within multi-dimensional scaling as it is reliant upon a combination of the number of variables present, and the logical strength of interpretation. Therefore, for the purpose of the current study, the goodness of fit was reinforced by the thematic underpinnings, as the SSA, in this instance, was to provide a quantitative understanding of the data set, to substantiate existing findings, and provide an object overview of the data. A total of 20 variables were identified as enabling a differentiation of the offender sample across three narratives. Figure 1 provides a visual representation of the findings from the SSA.

Figure 1: Smallest Space Analysis of the distribution of variables identified in the Thematic Analysis



When analysing the data from the SSA, Alexithymia was evident within all three narratives, therefore, it was included in all three descriptors. However, whilst the finding of Alexithymia throughout the data is a novel and highly significant finding, it did not assist in differentiating offenders. Therefore, table 3 summarises the key findings associated with the narratives identified.

Table 3: Summary of narratives identified

Mental Health and Alexithymia	The term "mental health" may be seen as a broad and unspecific generalisation,

	however, the variables associated with this subsection of offenders appeared to be commonly associated with multiple diagnostic possibilities. Difficulties in Processing information, Educational Struggles, Feeling Different Post-Treatment, Disrupted Schooling, Impulsivity, History of Violence and Lack of contentment post-treatment were found in a hundred percent of the participants believed to fall within this narrative. Given the concerns outlined previously surrounding overlapping symptoms and mis diagnosis, it would not be appropriate to attach a diagnostic label to this sub-group. Despite this, it appears that the variables associated with this narrative are likely connected with neuropsychological dysfunction.
Trauma and Alexithymia	The variables that appeared to differentiate this subsection of offenders were heavily weighted towards trauma. Variables such as abuse in childhood, being bullied at school, desire to be liked and taking substances to escape were reported in a hundred percent of the participants who appeared to fall

	within this overarching narrative. Interestingly, a hundred percent of the participants also reported a delayed onset of Alexithymia.
Alexithymia	This narrative appears to have emerged because of a lack of "explanatory" variables. This participant sample did report similar variables to the mental health and trauma cohort such as a hundred percent reporting contentment post-treatment, being sociable, having a good childhood and struggling to identify a cause to their substance misuse and criminality. However, within this narrative there were no reports of trauma or symptoms that would be indicative of a neuropsychological disorder. There was some evidence within the SSA that authoritative parenting may be contributing factor, however, the participant sample is not big enough to make any generalisations of this at this stage. Consequently, it was the lack of symptoms that warranted a differentiation of a possible less occurring, but in need of acknowledging narrative.

Analysis and Discussion

To effectively identify solutions and recommendations the data must first be analysed and understood holistically. Two prominent themes emerged across the entire cohort of participants regardless of their overarching narrative. The themes were therefore thematically analysed first to enable holistic oversight of the core issues associated with the offender population. Those core issues were then considered in conjunction with the results from the SSA to inform and support possible solutions for any differentiated treatment pathways needing to be considered.

Therapy and Services

Theme 1: Ineffective Community Services

Sub-theme 1: Need for Early Intervention

It is not surprising given the literature surrounding the development of criminality (Hser et al., 2015; Whitmore et al., 1997; Phil & Peterson, 1991; Davis & Florian, 2004) that a need for early intervention would be highlighted within the data set. Many of the participants expressed an early recognition of difficulties which were not effectively identified or managed by professionals.

Jamie line 17

"I didn't know how to talk, teachers were just teachers, they were there to help you learn, but we didn't learn, school was about education and talking wasn't really an option."

Jamie describes his frustration with school, indicating that verbalising his emotions was extremely difficult from a young age. He was not alone in his opinion, and when

participants were asked to reflect upon the age they may have benefitted from support, many argued a need for early interventions to be delivered within school.

Bill line 62

"I think end of primary school age, getting them to be emotionally honest, not just with themselves, but with their peers and the adults around them."

Similarly, Bill expresses a difficulty in verbalising feelings as a child and he indicates that primary school age would be the most effective opportunity for early intervention. He goes on to explain why he thinks this.

Bill line 56

"I think it is far more difficult to get a teenager to turn things around than it is a child"

Arguably, Bill raises a valid point, particularly considering the extensive research surrounding the risks in teenage years associated with "admiration for delinquent peers" and a "need to seek independence from care givers" (Friedlander, 2013; Hirschi, 1995). Marty reinforces the importance of early support for recognising and processing feelings.

Marty line 18

"I didn't do that throughout my life and had I been given the support to do that, I think the outcome would have been drastically different. It's massive and that could have changed everything."

He later goes on to explain that emotional wellbeing should be given more attention than academia, arguing that addiction is a symptom of an existing early childhood problem. This disputes the current literature surrounding substance misuse cohorts not being considered within the context of LCPO (Sampson & Laub, 2017). Instead, it reinforces the notion that substance misuse is not a "later life problem".

Marty line 58

"It isn't actually about the addiction, it's about how to deal with life and that's what we all need to know and all needed to know when we were kids not maths and English."

However, given that Alexithymia is heavily present throughout the data set, it appears that the difficulties in verbalising emotions stems from an inability to recognise and process them. Therefore, it would be naïve to assume that simply giving children the opportunity to talk within school would facilitate better outcomes. If a child cannot recognise or process how they are feeling then verbalising such feelings would be near on impossible. Jess touches on the need for intervention to go beyond facilitating a safe space to talk.

Jess Line 61

"Children would definitely benefit from half the stuff we did in there, the drama, the painting and things are all very childlike activities."

Jess is referring to the different aspects of therapy she received during her residential programme and the benefits it would have in supporting children. Nathan reinforces her views.

Nathan line 92

"Why treat us now, we could have been getting support years and years ago and look at all the damage we have caused between then and now, and how much money the government have wasted."

Indeed, systemic failings were consistently reported throughout the data, with failed opportunities for intervention being reported from early childhood through to adulthood.

Stix line 48

"There are a number of systemic failings from childhood right up to adult services."

Unfortunately, the systemic failings Stix describes is also reflected in community-based adult interventions for substance misuse cohorts leading to inefficient collaborative working throughout community substance misuse teams and mental health services.

Sub-theme 2 : Inefficient Collaborative working and Treatment outcomes

The data set revealed repeated failings whereby community substance misuse services failed to work in conjunction with therapeutic services to provide effective intervention. Jane describes how community services enabled her to continue using substances.

Jane line 73

"They would just see me every so often and give me a few needles, give me a prescription and off I went. They just enabled me to get free drugs basically."

This supports the findings within the current literature that mental health appears to be treated separately to addiction, despite substantial evidence implicating a need for collaborative working (Skinner & Farrington, 2021). Marty reinforces the need for services to work together to facilitate more effective treatment outcomes.

Marty Line 54

"I have done detox with loads of people, and I don't know any that got well from detox. The funding doesn't even need to be reduced it needs to just be given to the right services that actually work…. Oh, and mental health really needs to be joined up with drug services."

Jayne Reinforces this assumption

Jane Line 89

"I don't understand why mental health is treated separately to addiction neither…. we clearly need help, and we clearly need therapy, and if we need therapy to resolve the issues going on in our heads then that is clearly a mental health problem."

Many participants commented on feeling "lucky" to be offered residential rehabilitation.

Cameron Line 42

"I was going to get my script …. and it just happened that the guy I was seeing, my support worker, had gone through the rehab and now this is luck really, this is absolutely luck, and I'd go in weekly, and week after week just to collect my script and the only reason I did that

was because it was my back up plan if I am honest. I was getting that so if I couldn't get drugs I had got something to take."

Cameron describes similar experiences of enablement that allowed him to continue using illicit substances. Concerningly, like many participants he also places his success in recovery down to "luck", implying that community-based services do not actively promote residential rehab as a treatment option. Jamie shares a similar story.

Jamie line 47

"I have got people who know I am in the follow-on house now and they know that I have done the programme and they say they want to do it and I want to get help now. I tell them go to their drugs worker, but the drugs workers don't push rehab they just keep us going round and round in circles. Like I was shocked me, when I found out that this place existed because all they wanna do is shove you in prison, and the amount of money its costing the government to keep us in prison and keep giving us scripts. They could of done this years ago and they wouldn't have to deal with us anymore."

Despite the negative reports of community-based services some participants did acknowledge the need for them, but in line with existing literature argued a requirement for services to be more streamlined with clearer treatment pathways (Hayes, 2020; Weisburd, 2003, MacDonald, 202, Klein et al., 2012).

Jess Line 61

"I definitely think there needs to be more structure in community services, like what they do should complement the rehab so it's like a stepping-stone to rehab if that makes sense. There is a place for community services but not the way they work right now."

It appears the lack of joined up working is also impacted upon by the veracity of the offending. Worryingly, existing literature highlights that the offending is likely to be more prolific, and substance misuse more excessive, when it is accompanied by neurological dysfunction such as that associated with ADHD or early childhood trauma (Molina et al., 2018; Klein et al., 2012, Jadidian et al., 2015). Stix goes on to describe how individuals who appear to fall into this category, face inequalities within community-based services.

Stix Line 48

"I think in my adult years, what I have found with community drug services is that the more chaotic you are the less help you get, they kind of put you down as a lost cause, but the more chaotic you are the more help and support you should be getting, instead they do brief intervention which is harm reduction, giving out needles and HIV tests, are you eating, here's a food voucher off you go, because in their heads your soon to be someone else's problem, next week you're going to be in prison and someone else's problem and then the prisons put you in a hostel and then that's the hostels problem and then you get kicked out of the hostel and it becomes the drug agencies problem again, so it's just a vicious cycle."

Stix clearly outlines a need to differentiate substance misuse offenders to enable identifiable treatment pathways which are more likely to generate success for that offender based on the characteristic's observable by practitioners. As highlighted in previous research,

Criminal Narrative's enable a solution focused approach (Ioannou et al, 2016; Willmott & Ioannou, 2017; Goodlad et al., 2019; Ioannou et al, 2018; Yaneva et al, 2018). Without this approach it appears that poor outcomes still occur, community treatment remains trial and error and drug related deaths and offences continue to increase (Alenezi et al., 2021). The data corroborates the literature that ineffective collaborative working leads to poor and inefficient treatment outcomes (Hayes, 2020; Weisburd, 2003, MacDonald, 202, Klein et al., 2012). Jayne describes her dismay at community services not informing her of all the treatment options available to her.

Jayne Line 73

"Yea they just don't actually help you, like the drugs counsellor never even told me rehab was an option, I thought that was just for famous people not me."

Jess appears equally frustrated with the poor outcomes that existed for eight years because of ineffective community services.

Jess Line 19

"I mean my god it doesn't take a rocket scientist to figure out that those services don't work, and aren't working, but the government actually think it is saving them money, when really one stint in rehab has given them now 8 years of not paying for methadone, needles, hospital intakes and that's not to mention all the cost's associated with the crime I was committing."

Many of the participants referred to underlying mental health issues not being addressed by services. Which supports the findings discussed by Foulds and Newton-Howes

(2021) that figures surrounding sourcing a formal diagnosis, when actively admitting to taking substances, is extremely low. DJ highlights his frustrations on this matter.

DJ Line 92

"From what I know now, substance misuse and criminality is the symptom of poor mental health. To be honest the mental health service is absolutely shocking to substance misuse, they don't class it as mental health they see it as completely separate and I know my mental health deteriorated and I needed support long before the addiction or criminal behaviour came along."

Some of the participants even went as far as to suggest that rehabilitation programmes should not necessarily be associated with addiction. Nathan suggests that residential rehabilitation should be considered for generalised mental health conditions.

Nathan Line 90

"For me personally as I have said, the services before rehab were a waste of time, I think everybody and to be honest even people that aren't addicts but people with mental health issues in general should go to rehab. Rehab isn't actually really about addiction it's about mental health, and they are missing a trick here really cuz all these mental health services are not fit for purpose."

Upon further exploration it is easy to see why poor outcomes exist, as existing community-based service appear to approach addiction from a purely physiological perspective as opposed to a psychological perspective. Jake highlights this perfectly when he discusses his experiences.

Jake Line 44

"Well when I first started accessing services you could do a detox at home through your doctor……ya know someone would come out and check ya heart rate every now and then, but support wise there wasn't a lot, you know there was no understanding of what it was, it was just the health issues really, no understanding of why you were the way you were, you know so to start with it wasn't very helpful. I can't remember how many times I have done detoxes but it was quite a few and I used to just finish them, feel better physically, and think oh I am alright again now and then off I went again. I have lost track of the different services I went to……..basically all the ones the doctor refers you to and a lot of them you would go…and they would be like right you have got to be sober for six months before we will help ya, and it's like, well ya know, you're missing the point I need your help because I can't be sober for six months, I can't be left alone with my head for six months sober it will drive me insane, so you're in a catch 22. So I paid for 3 private detox's but again they were nothing like the rehab, you're in for a few weeks, you learnt a bit about what alcohol does to your body, a little bit about guilt and shame and then they send you on your way again."

This medical approach to addiction was reinforced by Marty who describes his experience with a Community Psychiatric Nurse.

Marty Line 32

"I told this one CPN once that I have been taking a pack of codeine in one go and he was like weeeellll you just have to be careful of stomach ulcers, I was like oh ok. He was like I will try get you some stuff for your stomach to prevent you getting an ulcer. Like it was such a medical thing to say and I was like oh ok."

The lack of early intervention, ineffective collaborative working, and ineffective treatment outcomes appeared to leave many participants questioning how they would be able to come off substances.

Cameron Line 52

"The addiction was that strong that I just couldn't find a way out, I just could not find a way out."

All the participants expressed some form of disappointment with community-based services, many commented on methadone maintenance programmes being outdated, a lack of person-centred care and most significantly a lack of therapeutic intervention. It appears that over the years many forensic services have become more specialised, such as the expansion of specialist support for personality disordered offenders, or those with learning disabilities (Jheeta et al., 2021; Hudson et al.,2011). However, it seems that substance misuse teams are still lacking in specialised knowledge within the community. Jamie describes the realities of community-based understanding, as opposed to that of the understanding he observed in rehab.

Jamie Line 41

"I have never seen ought like this rehab, my drug workers were just reading out of a book there was no therapy or support, like I used to say, for instance I couldn't get heroin, and then I went and took amphetamine, and the drugs workers were shocked like why would you take an upper to replace a downer. But they don't get it a drug is a drug it's not about the drug."

Given the emphasis throughout the data highlighting that rehab has provided significantly positive outcomes in comparison to prison, detox units and community-based services. It makes sense to attempt to understand what makes rehab so successful. The answers to this have been explored in detail within theme 2.

Theme 2: Effective Residential Therapy

Sub-theme 1: Safe and Structured Environment

One of the key findings pertaining to the previous literature was the association between substance misuse and early childhood experiences (Davis & Florian, 2004; Hodgins et al., 2008; Murray et al., 2010). The data reinforced this when participants expressed a need to feel accepted, and this was significantly evident amongst those who reported Adverse Childhood Experiences.

Stix Line 42

"When I first went into rehab I was blown away by one statement from my therapist and he said to me I am going to love you until you love yourself and that was what was missing when I was a kid was nurture, when I went into rehab I was treated like a human being, even the institutions from my past were prison environments and to some extent the children's homes were prison like environments, the staff are there to contain you, there is no nurture and there was a lot of brutality in prison. There was never anything, so when I went into rehab the kindness and acceptance of me was the most significant thing."

This statement epitomises that regardless of the "cause" the damage to the child has already been incurred. It is evident, due to the nature of his disclosures, that Stix was subject

to Social Services intervention, which would have likely included parental education. Despite this he still expresses a lack of resolve in this area right up until accessing rehab. This reinforces assumptions that parental education may well be failing to address the symptoms left behind from poor parental choices (Wilson, 2014). Nevertheless, it is evident that regardless of trauma or upbringing many participants required a safe and structured environment to fully engage in their therapy.

DJ Line 68

"Yea it was a calming environment, a nurturing environment….yea it was just generally like a safe environment."

When participants were asked to comment on the types of therapy, they had experienced in rehab it became clear why a safe and structured environment would need to be in place. Many participants reported feeling uncomfortable with the types of things they were asked to do throughout their treatment.

Jake Line 56

"Yea definitely, some of the things that I thought could be a bit childish in rehab, like at the end of the week you had to design a poster or do a role play or a painting, which I really struggled with. I hate all the attention being on me so having to stand up and pretend to be a meerkat or crawl round the floor and be a mouse, it was the most difficult thing I have ever had to do in my life, first week there they asked me to do a dance routine and I said look I don't even dance when I have had fifteen pints, but bringing the fun aspect into it and making it a group thing ya know you feel daft because I am 34 sat on the floor designing a poster with felt tip pens but you know it was all beneficial."

A commonality amongst many of the participants interviewed was their insistence that they needed to "put on an act", and whilst their reasons for "faking" who they were differed depending on their narrative, they all expressed difficulties in allowing themselves to participate and speak honestly in front of a group of people. It became evident through the data analysis that most of the participants needed a very regimented structure and support network to guide them through the therapeutic stages required to enable them to succeed.

Cameron Line 92

"Because I don't know it's the process, the detox, then the house and then being around other addicts and then working through the topics, I had to be treated regimental in ways and just talking, talking is the thing you know, it sounds mental but talking in a safe place and with others who understand, you see relationships change and people change, it is a very well set up programme here ya know."

It appears the therapists are more emotionally aware and receptive to the needs of those accessing the treatment than the residents themselves. However, they use this as an opportunity to guide the residents into recognising their emotions for themself.

Jamie Line 31

"A lightbulb has clicked and the way I got put there was like it wasn't my choice, so I was looking for excuses to leave and I never got it. They see so many come through that they know if you're searching for reasons to leave and see straight through ya. So, yea I can't fault them for that cuz fair play I never thought I would have had all the support I have had."

The result of working through those emotions in a Safe and Structured environment is that every single participant agreed they have been given firm foundations to build upon when their treatment had concluded.

Bill Line 44

"The rehab gives you the tools and the foundations to build your life back up in a safe and secure environment."

Given the severity of the Alexithymia found throughout the data set, it is difficult to comprehend how individuals have been able to feel reconnected to their emotions, particularly considering the ineffective treatments found to date for Alexithymia throughout the literature (Kooshki et al., 2021). It appears that the group therapy may provide some answers to this.

Sub-theme 2: Group Therapy

As mentioned previously Samur et al. (2021) identified that Oxytocin, which occurs naturally in the body, may play a role in increasing people's ability to recognise and verbalise emotions. However, the technique for administering Oxytocin to a substance misuse cohort could have proven to be highly controversial. Despite this, there was some evidence emerging that group therapy naturally increases the levels of Oxytocin in the body and preliminary findings had proved to be promising for reducing the symptoms of Alexithymia (Mohebi et al., 2021). The current study has reinforced such findings. All the participants spoke highly of the benefits surrounding group therapy regardless as to whether they felt uncomfortable in group settings.

Stix Line 62

"Yes it was learning empathy, I have never had empathy before or if I did I didn't know how to recognise it, and to feel the joy it taught me to evaluate my behaviours in life and visually see the impact of those behaviours from other people in a safe and secure environment, and actually learning to communicate with other people, I mean I had to confront my abuser in front of 30 other people and they showed me empathy, and I learnt how to show empathy to others, I learnt how I should behave and that the thoughts I have are normal, they aren't unique to me, when I said I don't feel anything I wasn't alone in that, but together we learnt how to behave and how to process those thoughts more effectively."

What Stix describes appears to be a reconnection to feelings and emotions that he has never felt before. However, upon closer inspection it appears that the residents learn how to cognitively recognise their emotions as opposed to feeling them. This concept is difficult to grasp, but the data repeatedly revealed that residents almost had to learn how to recognise physiological symptoms and behaviours by process of elimination to determine exactly what it is that they are feeling.

Jess Line 55

"It sounds so simple doesn't it talking, but gods honest truth if I thrash that out with someone they will say to me, oh I got that before I went to an interview it's just nerves isn't it, and then I'm like oh ok, so that makes sense now, this must be what nervous feels like then, cuz I'm going to an interview, and then over time it becomes easier to recognise. So I now know if I have something big coming up like an interview or an event and I get the runs and my stomach feel funny that it's not a bug, it's nerves, so that process of recognising that becomes quicker and easier to understand over time the more I am exposed to it."

Jess's statement really highlights how difficult it is for emotions to be recognised, understood, and then processed. Reports such as this were significantly high across the whole cohort of those interviewed. It appears that the group therapy pushes people out of their comfort zone which sometimes manifests anger, once the anger is released, it enables the group, with the guidance of the therapist to work through and verbalise the emotion that may be fuelling the anger.

Marty Line 48

"There was a patch when I was getting really frustrated, not with them but with myself, I felt like I just couldn't speak and couldn't verbalise what I wanted to say, it made me really low at one point because I got really angry and frustrated with myself that I couldn't verbalise what was going on for me. But then I had a really tough group, and everyone basically laid into me and challenged me about everything and it's just what I needed because I got really angry and everything that I needed to say just came out in anger which enabled everyone to work through the real emotion with me and explain it."

Marty also goes on to evidence why community services may not be able to effectively support those who access their service.

Marty Line 32

"It's like even with CPN's, and every service I came across they ask the same things why do you use? How are you feeling? I don't know if I knew that I wouldn't be here, so you just tell them what they want to hear because if you say, I don't know, then they think you're not engaging or you don't care, which isn't fair really because the fact that I am there shows I want help but If I don't know how I feel or why I use how can I tell you."

It appears that over the years the "putting on an act" the residents report, may be fuelled by having to continually lie to those they meet, giving socially acceptable answers as opposed to speaking openly and honestly. There is no doubt that this would have contributed towards negative treatment outcomes within the community. Moreover, it may have assisted in fuelling "causal" attitudes amongst existing literature as many recommendations have arisen from trying to tease out the "why" or the "cause" of someone's behaviour (Whitmore et al., 1997; Phil & Peterson, 1991; Davis and Florian 2004; Andersson & Magnusson, 1987). Alexithymia has been identified as being linked to many mental health conditions, therefore if group therapy is as effective as it appears from the current study, many people may benefit its findings.

It appears plausible to suggest that given the current literature surrounding Alexithymia (Sifneos, 1996; Kooshki et al., 2021; Samur, 2021), and the findings in the current study, that group therapy does effectively target Alexithymia associated with a substance misuse offender population. Given that Alexithymia was found across the entire cohort of participants these findings are significant and it is evident from the data that the narratives may enable more effective and concise treatment pathways to emerge across the community and residential services currently available. Consequently, each overarching narrative was explored.

Combining the results of the SSA with Thematic findings

SSA is a non-metric multidimensional scaling procedure that assumes behaviours and characteristics may be viewed categorically when relationships between variables can be examined objectively. Therefore, the SSA represents the co-occurrence of variables, such as the consequences and symptoms identified in the present study. Such variables can be viewed as distances in a geometrical space, allowing for a visual representation of the association to

become observable. The closer any two points are to each other symbolises a higher association, whereas the points located closer to the centre, such as Alexithymia in the present study, are less likely to show a differentiation. To understand the overarching narratives, it is important to note that some offenders did report variables that would appear to be associated with multiple narratives. However, when the data from the SSA was combined with the thematic findings (Appendix 2), it became clear that each participant did report enough variables associated with one of the overarching narratives to be confidently differentiated. Approximately 37 percent of participants fell within the Alexithymia and Mental health Category, another 37 percent fell within the Alexithymia and Trauma category with 26 percent falling within the Alexithymia Limited category.

Alexithymia Limited

As outlined in the results summary, this narrative was unique in that there was a lack of explanatory variables to enable an understanding of this offender sub-section. Nevertheless, the therapeutic outcomes for this subsection appeared to be highly successful. All participants within this overarching narrative felt contentment post-treatment despite not being able to identify a cause for their criminality or substance misuse.

Jayne Line 8

"I can't say that there is anything that really sticks out to be honest"

Jess is referring to past incidents which may have contributed to her life path. Such views were shared by all the participants within this cohort. However, they also reported an awareness of their emotional difficulties from a young age.

Marty Line 20

"I felt like a robot, I couldn't feel normal, I didn't feel joy, I didn't feel sadness."

Interestingly, some of the participants in this cohort also reported taking substances for the feeling it gave them. It is possible that the Alexithymia itself fuels a pre-disposition to become addicted to substances if exposed to them making it plausible to assume that the Alexithymia limited category seek the feelings they struggle to experience. The participants within this narrative did repeatedly appear to show more self-awareness of Alexithymia, and it seems that despite explanatory variables, such as those associated with trauma or neuropsychological disorder, treatment outcomes were seemingly consistently successful.

Marty Line 20

"Since I have been in rehab...I can...recognise the symptoms of sadness and that's enabled me to think about why I feel sad, like oh I feel sad because of this. But to be able to recognise that now is like a whole new experience."

This suggests that whilst their residential treatment was successful, this cohort may have been adequately treated in a community setting had they been identified correctly and afforded the opportunity to engage in group therapy similar to that provided in the residential setting. Unfortunately, not all narratives displayed the same feelings of contentment posttreatment, and this was particularly evident within the Mental health and Alexithymia narrative.

Mental Health and Alexithymia

Lack of contentment was consistently reported across this cohort, however, this did not appear to be because of failings within the residential treatment programme. Many of the participants showed symptoms of an underlying, and in some cases undiagnosed, neuro-psychological condition, which appeared to impact on their ability to absorb the learning from their therapy as effectively as others. This led to participants expressing a need for more understanding surrounding their neuropsychological conditions to effectively move forward.

Jamie Line 28

"I was on about it this morning that I want to speak to a therapist because I am in a good place, but I don't know something just feels like I still don't understand why my head is the way it is…. I am not comfy"

The previous literature highlights the significance of ADHD and its association with substance misuse (MacDonald, 2021; Jadidian et al, 2015; Klein et al, 2012). The participants who fitted within this narrative displayed evidence of impulsivity, difficulties in processing information and educational struggles which can all be indicative of ADHD. Regardless of the cause, it was evident that participants felt confused, different, and frustrated with themselves for struggling to retain the therapy they had experinced. Furthermore, some participants evidenced feeling conflicted and worried about possible switch addictions.

Cameron Line 80

"I actually know now my caffeine intake is pfftt, I still drink cans of coke but coffee"

Cameron was not alone in this, many of the participants within this narrative reported taking substances to "induce" a feeling, which seems controversial as this does not conform with long standing theories of addiction surrounding "escapism" (Adams, 2008). It was apparent this participant sample actively sought substances for the feeling they gave. In Cameron's example, it is possible that the caffeine may be an attempt to slow down the mind. ADHD medication is often stimulant based but has the opposite effect of a stimulant on a person with ADHD, in essence, it slows their thought processes down (Walker, 2010). It is possible therefore, that because therapy works to strip away negative behaviours and coping strategies during treatment, it may leave those with underlying neuropsychological difficulties with conflicting and confusing thought processes. On the one hand coffee may act as a form of self-medication which allows them to function better, yet on the other hand the therapy has increased their awareness to not rely on substances. Furthermore, given that the common treatment for ADHD is stimulant medication, they may feel reluctant to seek medical advice surrounding their concerns. It is possible therefore, that this narrative is at a higher risk of relapse following treatment without complimentary psychological or psychiatric intervention running alongside. Interestingly, the same concerns were not found in the Alexithymia and Trauma narrative.

Alexithymia and Trauma

The main concern associated with this narrative was the desire to be liked or accepted post-treatment and their need to compare themselves to others.

Stix Line 30

"I sometimes find myself in situations where…. if I am around professionals, I still feel like an 8-year-old child."

"I still feel people will look at me differently."

Stix and Jillian both expressed a lack of confidence and feeling inferior to others post-treatment. This narrative appears best explained by theories surrounding Escapism (Adams, 2010), Adverse Childhood Experiences (Forster et al., 2018) and Early attachment difficulties (Davidson & Ireland, 2009). All the participants reported taking substances to escape and could identify a starting point to their Alexithymia. The awareness and resilience they gained through residential treatment was evidently a protective factor and was displayed throughout all the interviews that fell within this narrative. The therapy they had received appeared to effectively treat both their previous trauma and associated Alexithymia, leaving them expressing contentment post-treatment from which we can conclude that such stand-alone Residential rehabilitation appears to be the most effective treatment for this narrative.

Conclusions and Recommendations

Analysis of the themes supported existing literature revealing ineffective treatment pathways, poor outcomes and a lack of collaborative working amongst many substance misuse services. Poor outcomes were reported across prison settings, detox units and community-based services. These findings reinforced the importance of early intervention from childhood through to adult services and highlighted the significance of residential treatment programmes for substance misuse and mental health conditions.

The SSA provided a unique opportunity to explore potential treatment pathways, identifying a need for the differentiation of offenders to enable support services to identify the type and level of support necessary to increase successful outcomes. For example, the

Alexithymia Limited category appears to be a cohort which could be effectively managed and treated within community services. This cohort would first need to be identified and then engaged in group work to help with recognising, verbalising, and processing emotions. For this to be successful the group work should be similar to that provided in the residential setting.

The Mental Health and Alexithymia category would benefit from additional support and identification of underlying neuropsychological dysfunction during and after their residential treatment. This will help ensure the therapy they receive remains accessible to them and afford them opportunities to explore any difficulties they have in retaining the therapy undertaken. Therapists may be able to identify those requiring more support using the variables identified in the SSA alongside subtle cues, such as seeking stimulants like caffeine to improve focus. However, without specialist psychological or psychiatric knowledge, this cohort appears to be most at risk of relapse following residential treatment without clear psychological guidance and understanding.

The Alexithymia and Trauma narrative were highlighted as the group who benefited the most from residential rehabilitation. The therapy on offer appears to target any past trauma with any associated Alexithymia. The main risk factors highlighted for this cohort appeared to be lack of confidence, desire to be liked and comparing themselves to others. However, their awareness of these issues through therapy appears to have afforded them the protective factors necessary to support them in their recovery.

Despite the useful findings identified within the current study there are limitations due to the lengthy timescales associated with thematic analysis and the number of people

interviewed within the study limits. However, it provides a foundation to support further quantitative research in this area. Also, the therapies discussed are unique to the participating residential rehab therefore, it is highly likely that treatment outcomes may differ across other residential programmes. Future research may wish to explore the intricacies of group therapy in more detail to ensure that such success can be mimicked across other residential programmes and community settings. Nevertheless, the variables and associated narratives found may assist in facilitating a screening tool which could be used by substance misuse services to develop more streamlined treatment. Hopefully, this could assist in increasing collaborative working between community services and residential rehabilitation services; improve outcomes across both settings; and, help to reduce some of the inequalities faced by substance misuse offender populations.

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