Volume 2 | Number 2 | June 2014

# scottish justice matters

# HEALTH AND (IN)JUSTICE

Edited by Andrew Fraser and Maggie Mellon

Featuring: Health Inequalities • Older Prisoners
Mental Health • Drug Misuse • Neuroscience

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ISSN 2052-7950
9 772052 795005

# RECOVERY POSITION

**Nancy Loucks** in conversation with **Dr Oliver Aldridge**.

A renowned expert in the field of addiction medicine, Dr Aldridge is the Medical Lead for Edinburgh, Midlothian and East Lothian Drug Treatment and Testing Order (DTTO) Services.

**OA:** I came to addictions medicine from general practice, and I am seconded as part of a multi-disciplinary team to the Drug Treatment and Testing service covering Edinburgh, Mid- and East Lothian.

My remit is to be responsible for the overall design of the treatment plan … but I do a lot of direct clinical work as well. I feel it's a very fortunate place to work because it is a multi-disciplinary team: everyone who goes to the DTTO has their own social worker, resource worker, and a mental health trained nurse as well.

I'm also on the committee of the Howard League and the board of the Scottish Drugs Forum, and I do some work with Circle as part of their advisory panel.

## NL: How did you become involved in the addictions field?

I became interested in the psychological side within general practice through exposure to people struggling around issues to do with alcohol, smoking and drugs. For the last 10 years I have been working in addictions medicine.

## What got you interested in the justice side of your work?

Initially, I was apprehensive about working in the DTTO: I thought I would be confronted with people who had been forced into treatment. What I discovered was that the DTTO deals with an enormous pool of unmet need: people who are actually very keen to do something different with their lives.

There is sometimes, within health circles, the feeling that drug treatment should be divorced from the criminal justice system. I feel that is impossible and that the two have to work together. That's partly because drug use and involvement in the criminal justice system are often symptoms of deeper underlying issues in the first place, and those issues have become so intertwined, it is artificial to try to separate them.

## You said that there was untapped need: why weren't these people getting help before?

They seem to experience extraordinary difficulties in engaging with services, coming from backgrounds of very significant deprivation and trauma with fractured relationships, often homeless, in and out of custody creating difficulty sustaining engagement with primary care. Sometimes their experiences of life combine to make what can be quite a challenging presentation.

It's also difficult, if you are a service that is not engaged with the criminal justice system, to work with people whose priority needs are determined by it. It's easier to work within it, and there's evidence for that internationally.

## Is there a way of making sure that the justice issue isn't lost or overtaken by the wider health and social care agenda, which seems to focus more on the elderly?

We can't simply do more of the same either in terms of the way we work or in how we deal with drugs, and I very much include within that, alcohol. If we don't change our relationship with alcohol, then all services will be affected: a lot of issues in elderly care, dementia and so on can be traced back to alcohol issues.

## Is there more you think can be done in prevention?

By the time I am seeing people, usually in their late 20s, early 30s, you can trace back a history which, in terms of drug misuse, typically begins with alcohol often aged around 11 or 12, then progresses through a variety of drugs until they start using heroin in the late teens. Mixed in amongst that

is a gradual involvement of the criminal justice system, whether protecting people who are suffering from neglect or getting involved in a more punitive way. Then typically you have failure at school, exclusion and not completing their education.

Then there's also the issue of young men getting drunk and fighting, and that's an enormous risk factor in traumatic brain injury: we know that this is of great importance in terms of violent offending and the risk of further offending, yet it's probably not addressed nearly as much as it ought to be. There isn't enough resource put in either to detecting it or providing facilities for treatment.

If you wind the clock further back before the person started to drink, what you find so often is a background of deprivation and trauma from psychological, physical, sexual abuse

If you wind the clock further back before the person started to drink, what you find so often is a background of deprivation and trauma from psychological, physical, sexual abuse. Often people are in communities with high rates of imprisonment and from backgrounds where they know of people who have been in prison. They may come from families where they have been the child who has witnessed their mother or father being arrested, who has been to visit that parent in prison. So there is a mix of factors, a web of causation, that is difficult to address with a single intervention.

If you look at sociological theories around addiction, then prevention lies in moving back to something that is more culturally cohesive and where people can be helped to be given a sense of meaning and purpose. Jimmy Reid spoke of "alienation": we have to address that.

I think a lot more resource can be put into schools to pick up children who are experiencing trauma generally. So - greater awareness, professionals working more closely together. There's no doubt that the way we treat alcohol could have a significant impact. There's evidence around minimum pricing tending to reduce consumption, particularly amongst very young people.

## But would pricing really have an influence on people who are heavy drinkers?

It's not a panacea. What people often don't realise is the exponential curve of the relationship between alcohol and harm and that there is a cohort of people who are on the tipping point every day of a fatal outcome from drinking. Even if you could reduce their consumption by a very small amount, you can pull them back from the brink, and Scotland unfortunately leads the world with places like Russia in alcohol-related deaths.

## Are there are other things that health can do to have an impact on re-offending?

The WHO definition of health emphasises that health is not just the absence of disease. It is not enough to say that "we're Health, and so social wellbeing is not really down to us", and hopefully that kind of attitude will be eroded by the integration of Health and Social Care. People need support around work, housing, security including financial security, in order for them to feel healthy.

## Anything else?

The people that we see have lives characterised by a lack of resilience, and it takes a long time to build resilience into people; there is no quick fix. Sometimes there is a temptation to very much jump at 'quick fix' solutions and focus on measurable outcomes: the flip side is that you only do what you can measure and sometimes end up with a service which isn't ultimately helpful.

There has to be a willingness to engage with people in the longer term. Ideally I would like to see a move away from a welfare system that seems to be predicated on driving people to a place of fear and insecurity in the hope that this would force them into work - that work often being very inadequate and sometimes harmful - to a system emphasising social security.

## Can you say a bit more about trauma?

One of the things said about people who use drugs is that they are somehow hedonistic pleasure seekers who chose this lifestyle. I think it is an enormous misconception.

When you take a drug on a one-off basis, your body tends to revert back to its baseline in a homeostatic response. But if you take a drug on a regular basis, there is no baseline to return to, and so the body sets a new one. Chronic drug use involves a chronic hyper-activation of the stress response system.

If you take a child whose response system is still developing , and you stress it across multiple different parameters in a toxic way, that also causes a de-regulated stress response system. When they take the drug, it's like introducing a key into a lock: it's the first time they find something that balances out the negative experience they're having, and sometimes it's the only way in which they can feel normal. This concept allows us to link trauma with drug use at a neurological level.

There's an element of course that people with trauma welcome the mind-numbing effect of intoxication, and that can be a driver in itself, but that's a million miles away from someone who's decided to have a good night out. Mostly these are people who have had experience of enormous trauma: drug and alcohol use becomes a dysfunctional way of dealing with it, but it feels at the time to be the most effective thing they've done. So I really don't buy into the idea that the people we are treating are pleasure seekers who couldn't care about society.

The full interview can be heard on www.soundcloud.com/sjmjournal