“Creating safety and wellness in society

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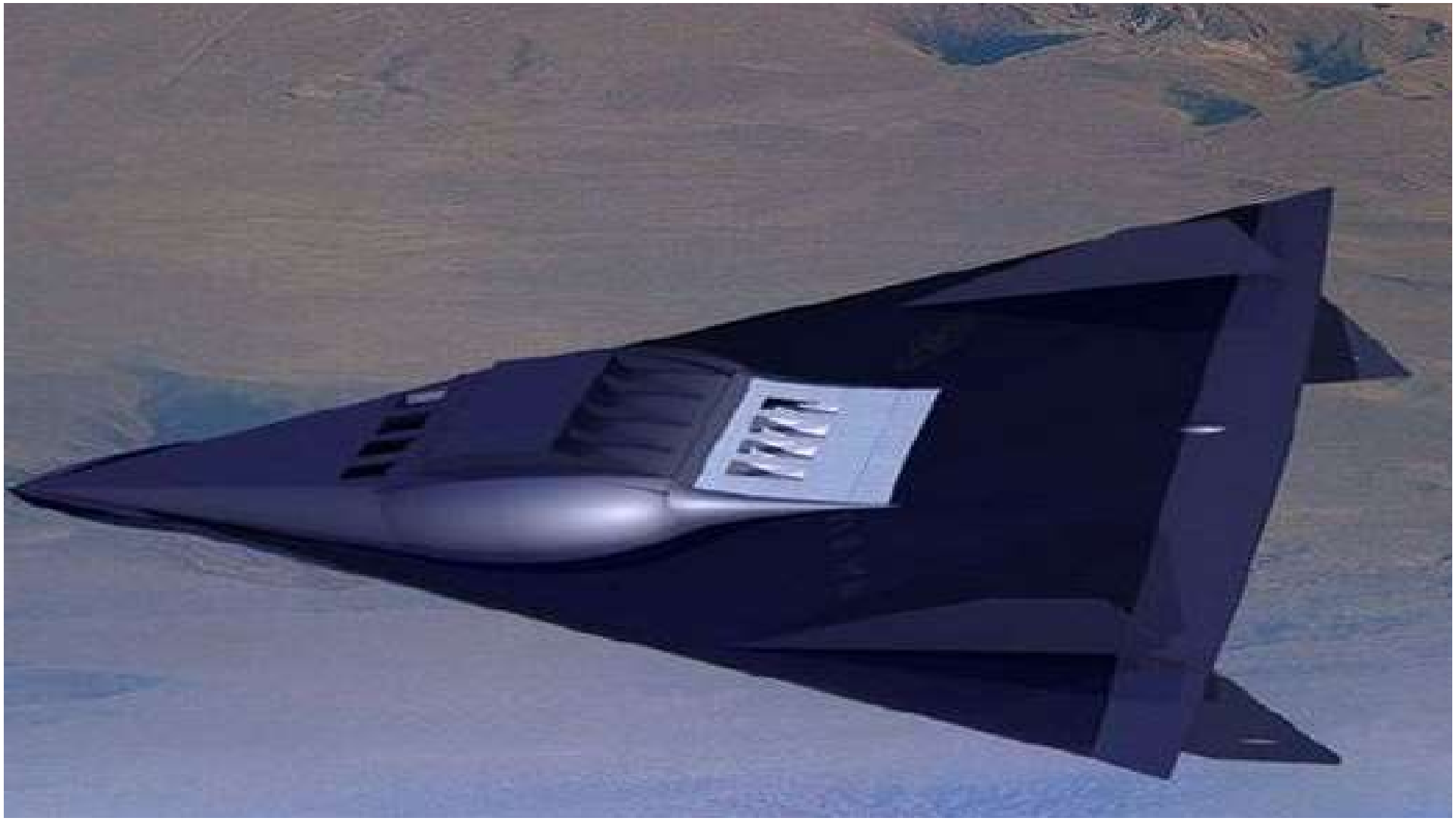


Health and sense of Wellness

Safety and Peace in mind and body

Shalom means completeness, wholeness, health, peace, welfare, safety soundness, tranquility, prosperity, perfectness, fullness, rest, harmony, the absence of agitation or discord. Shalom comes from the root verb shalom meaning to be complete, perfect and full.

One **45-year-old man** had a type of meningitis which limited his activities a great deal. He took **seven weeks** to recover, but didn't suffer any long-term effects after that. This amounted to **0.02 lost years** of healthy life in 2015.

Seven weeks of illness with a high level of impairment.

= 0.02

Years lived with disability

One **60-year-old woman** had severe COPD that limited her a great deal all year round. This amounted to **0.41 lost years** of healthy life in 2015.

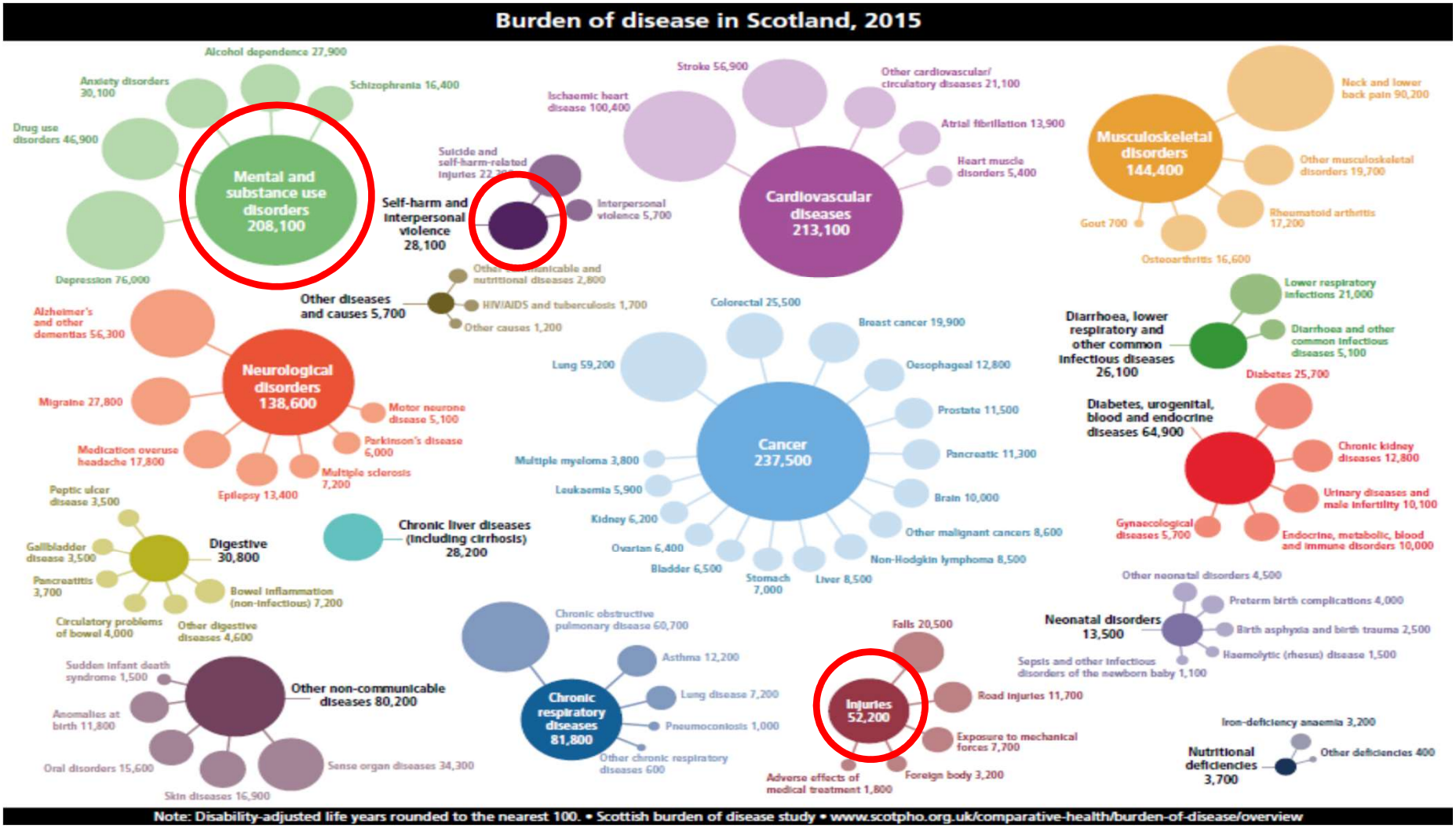
12 months lived with a severe condition and a high level of impairment.

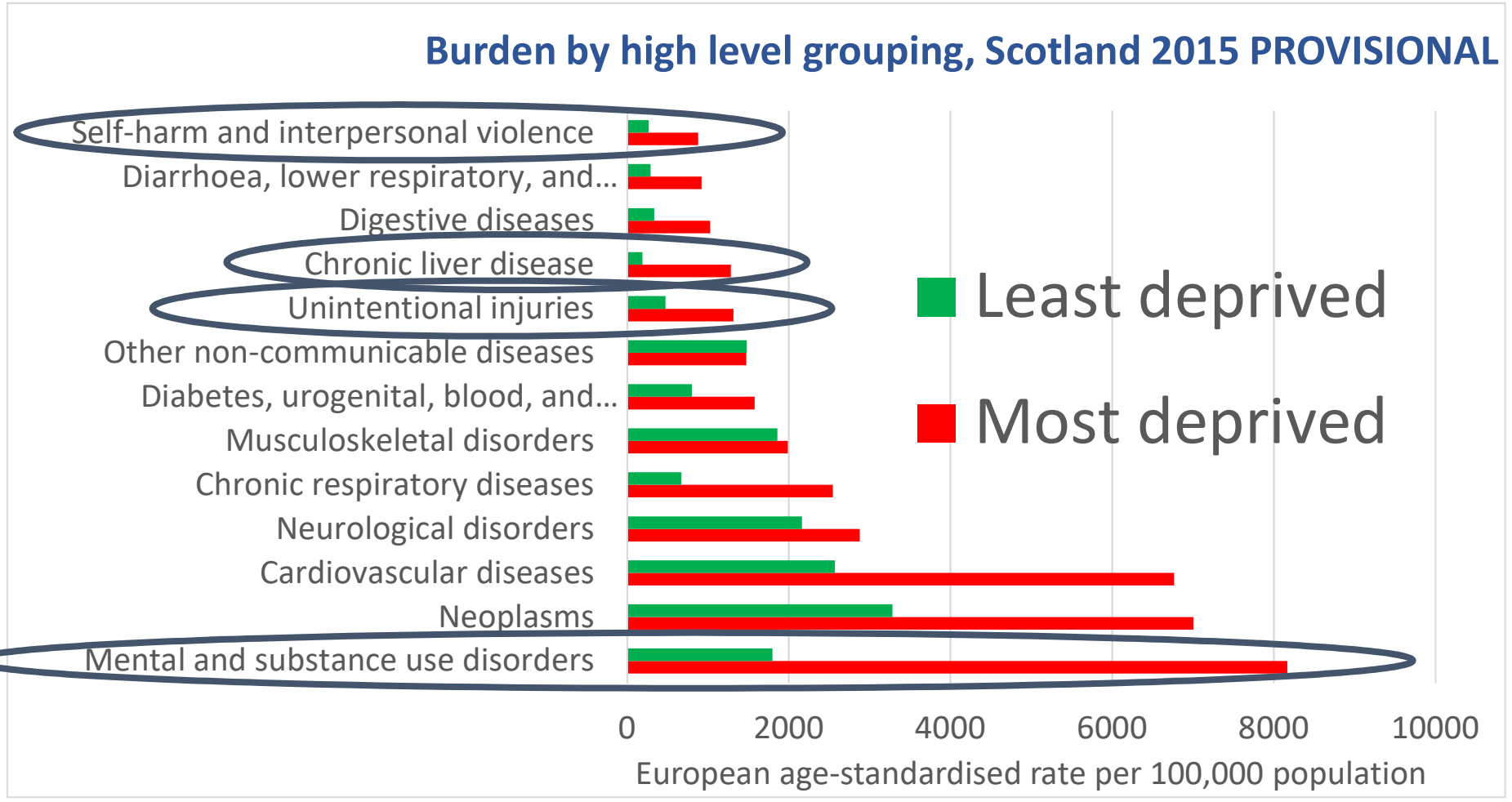
= 0.41

Years lived with disability

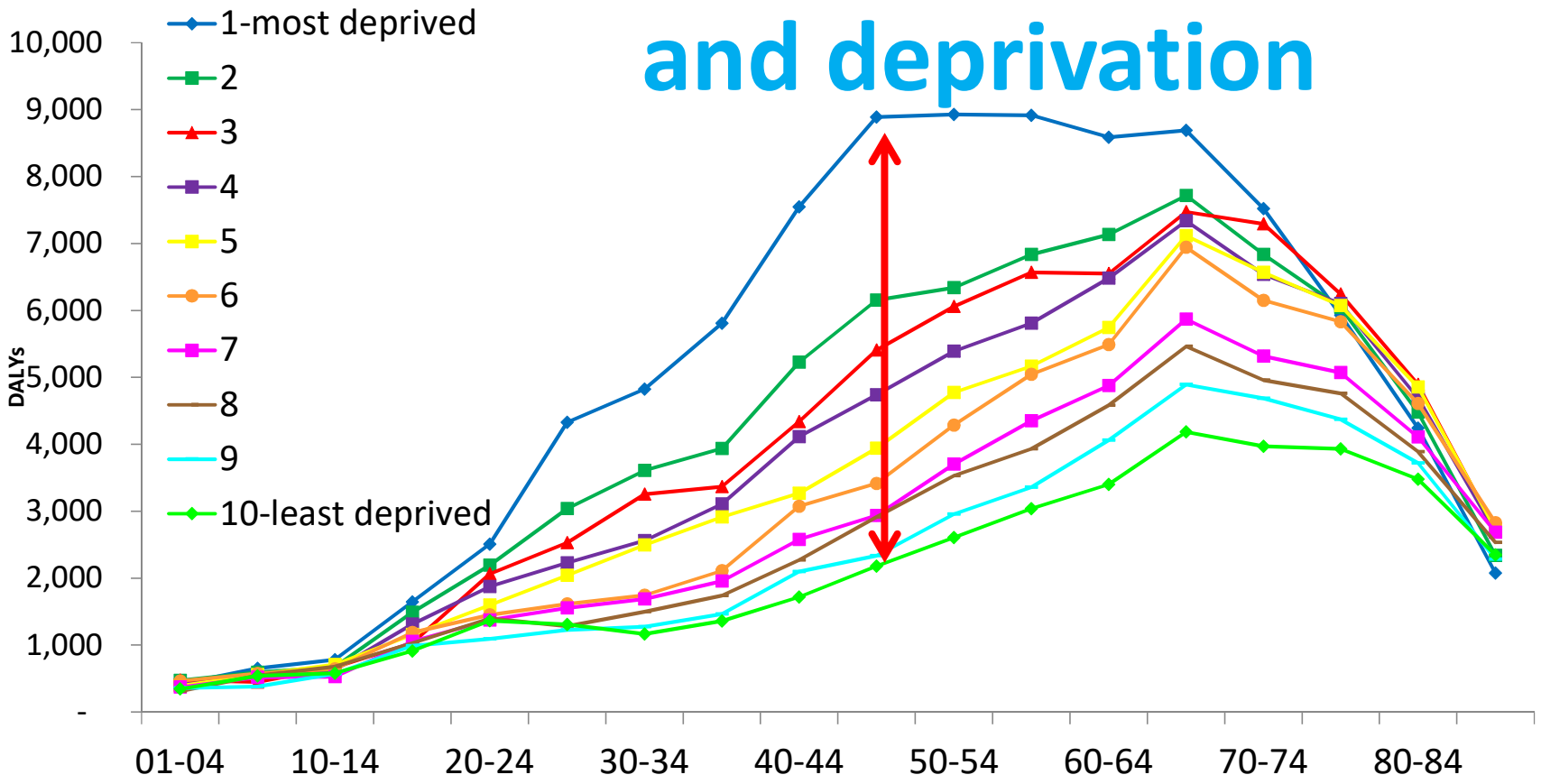
Total DALYs (Years of life lost + years lived with disability) added to the overall disease burden for Scotland by the people in this block of flats in 2015:

57.6 + 9 + 0.02 + 0.41 = 67.03

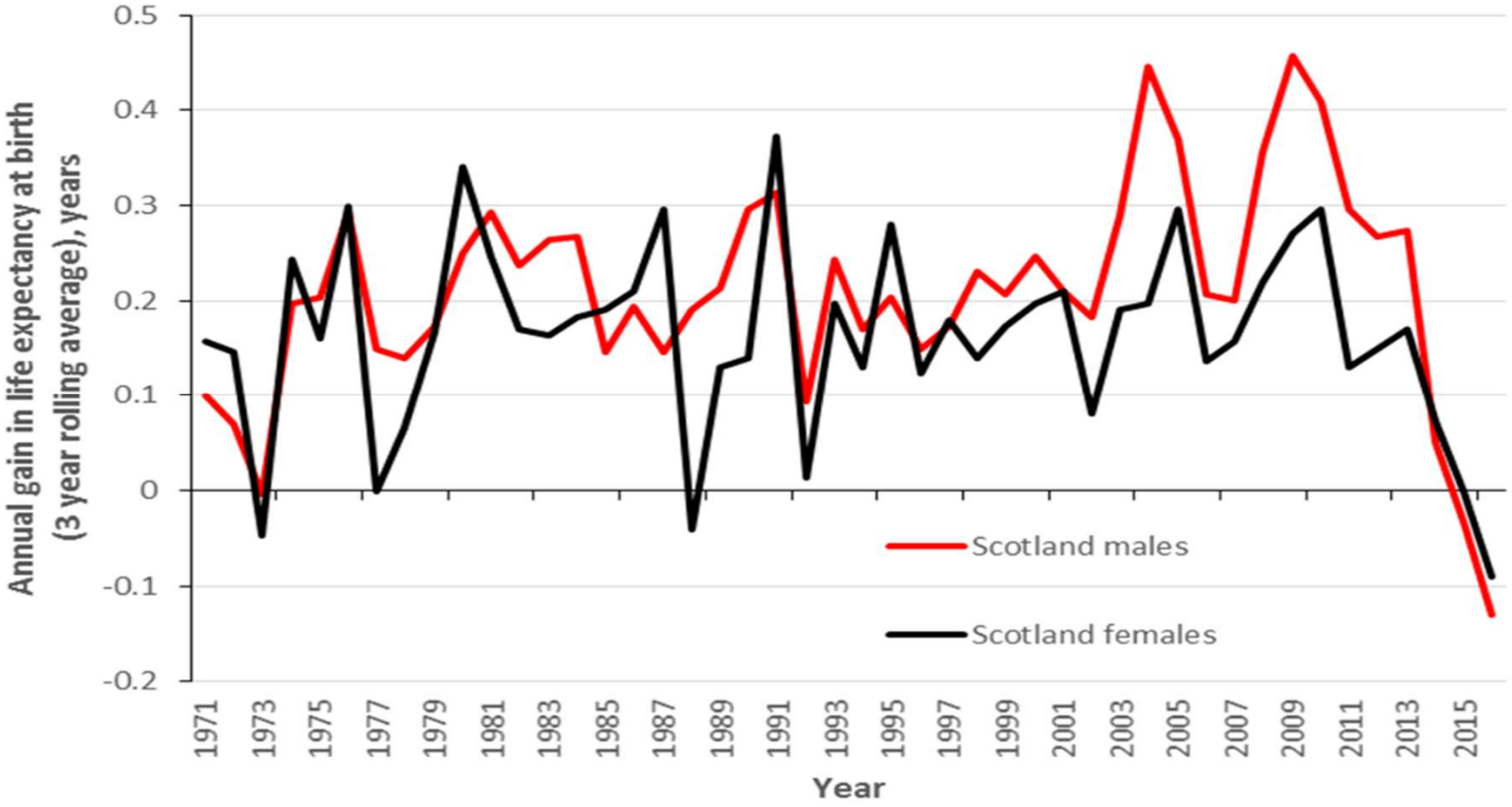

Burden of disease in Scotland, 2015
Alcohol dependence 27,900
Anxiety disorders 30,100
Schizophrenia 16,400
Drug use disorders 46,900
Mental and substance use disorders 208,100
Depression 76,000
Suicide and self-harm-related injuries 22,200
Self-harm and interpersonal violence 28,100
Interpersonal violence 5,700
Other diseases and causes 5,700
Other communicable and nutritional diseases 2,800
HIV/AIDS and tuberculosis 1,700
Other causes 1,200
Stroke 56,900
Other cardiovascular/ circulatory diseases 21,100
Ischaemic heart disease 100,400
Atrial fibrillation 13,900
Heart muscle disorders 5,400
Cardiovascular diseases 213,100
Neck and lower back pain 90,200
Musculoskeletal disorders 144,400
Other musculoskeletal disorders 19,700
Rheumatoid arthritis 17,200
Gout 700
Osteoarthritis 16,600
Alzheimer's and other dementias 56,300
Neurological disorders 138,600
Migraine 27,800
Motor neurone disease 5,100
Parkinson's disease 6,000
Medication overuse headache 17,800
Multiple sclerosis 7,200
Epilepsy 13,400
Colorectal 25,500
Breast cancer 19,900
Lung 59,200
Oesophageal 12,800
Prostate 11,500
Cancer 237,500
Pancreatic 11,300
Multiple myeloma 3,800
Brain 10,000
Leukaemia 5,900
Other malignant cancers 8,600
Kidney 6,200
Ovarian 6,400
Non-Hodgkin lymphoma 8,500
Bladder 6,500
Stomach 7,000
Liver 8,500
Lower respiratory infections 21,000
Diarrhoea, lower respiratory and other common infectious diseases 26,100
Diarrhoea and other common infectious diseases 5,100
Diabetes 25,700
Diabetes, urogenital, blood and endocrine diseases 64,900
Chronic kidney diseases 12,800
Urinary diseases and male infertility 10,100
Gynaecological diseases 5,700
Endocrine, metabolic, blood and immune disorders 10,000
Peptic ulcer disease 3,500
Gallbladder disease 3,500
Digestive 30,800
Pancreatitis 3,700
Bowel inflammation (non-infectious) 7,200
Circulatory problems of bowel 4,000
Other digestive diseases 4,600
Chronic liver diseases (including cirrhosis) 28,200
Other neonatal disorders 4,500
Preterm birth complications 4,000
Neonatal disorders 13,500
Birth asphyxia and birth trauma 2,500
Haemolytic (rhesus) disease 1,500
Sepsis and other infectious disorders of the newborn baby 1,100
Sudden infant death syndrome 1,500
Other non-communicable diseases 80,200
Anomalies at birth 11,800
Oral disorders 15,600
Sense organ diseases 34,300
Skin diseases 16,900
Chronic obstructive pulmonary disease 60,700
Asthma 12,200
Chronic respiratory diseases 81,800
Lung disease 7,200
Pneumoconiosis 1,000
Other chronic respiratory diseases 600
Falls 20,500
Injuries 52,200
Road injuries 11,700
Exposure to mechanical forces 7,700
Adverse effects of medical treatment 1,800
Foreign body 3,200
Iron-deficiency anaemia 3,200
Nutritional deficiencies 3,700
Other deficiencies 400
Note: Disability-adjusted life years rounded to the nearest 100. • Scottish burden of disease study • www.scotpho.org.uk/comparative-health/burden-of-disease/overview


Burden by high level grouping, Scotland 2015 PROVISIONAL
Self-harm and interpersonal violence
Diarrhoea, lower respiratory, and…
Digestive diseases
Chronic liver disease
Unintentional injuries
Other non-communicable diseases
Diabetes, urogenital, blood, and…
Musculoskeletal disorders
Chronic respiratory diseases
Neurological disorders
Cardiovascular diseases
Neoplasms
Mental and substance use disorders
Least deprived
Most deprived
0
2000
4000
6000
8000
10000
European age-standardised rate per 100,000 population

SBOD 2016: Male burden by age and deprivation



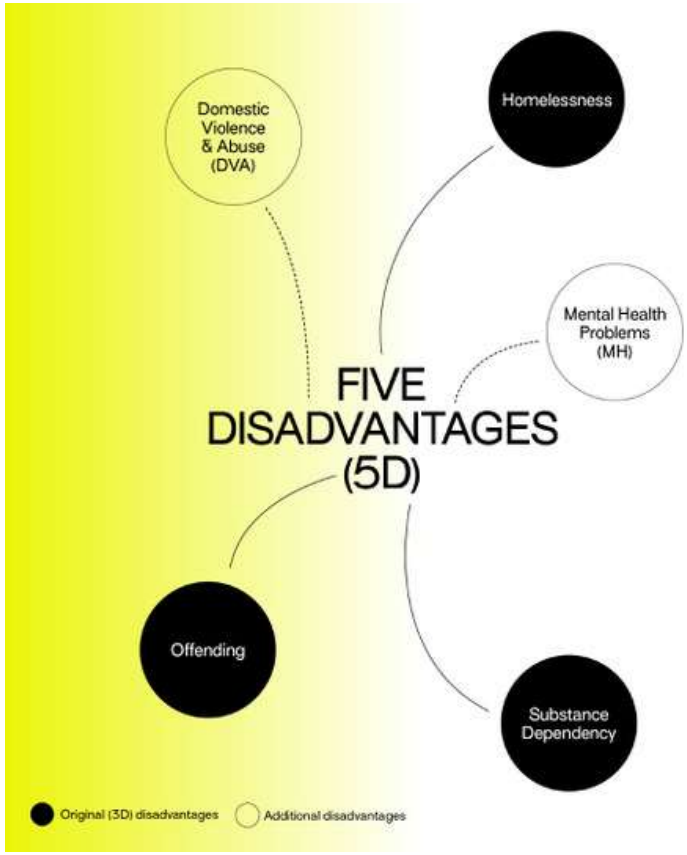
Annual gain in life expectancy at birth (in years): Scotland (1970-2017, 3 year rolling averages)



www.lankellychase.org/connected

https://www.scotphn.net/wp-content/uploads/2018/09/Violence-Prevention-Framework.pdf


Homelessness
Substance Dependency
THREE DISADVANTAGES
Offending
28,800
experience two out of these three
156,700
experience one of these disadvantages only
5,700
people in Scotland experience all three
191,000
in total have a relevant experience across these three disadvantages in a typical recent year
Number of people who experience severe and multiple disadvantage (3D) over a year in Scotland


Domestic Violence & Abuse (DVA)
Homelessness
Mental Health Problems (MH)
FIVE DISADVANTAGES (5D)
Offending
Substance Dependency
Original (3D) disadvantages
Additional disadvantages

Routes in – poverty, violence & trauma

- **A background of poverty** – most prominent in the most extreme forms of Severe and Multiple Deprivation (SMD)
- **Adverse childhood experiences** - physical and/or sexual abuse, disrupted schooling and, in some cases, local authority care
- **Troubled young adulthood** - poor mental health, substance misuse, and difficulties in both the labour market and interpersonal relationships
- **Violence** – a pervasive role that violence continues to play throughout the life course, in childhood home, at school, in the local community, city centre streets, in hostels, in intimate relationships, or other settings in adulthood

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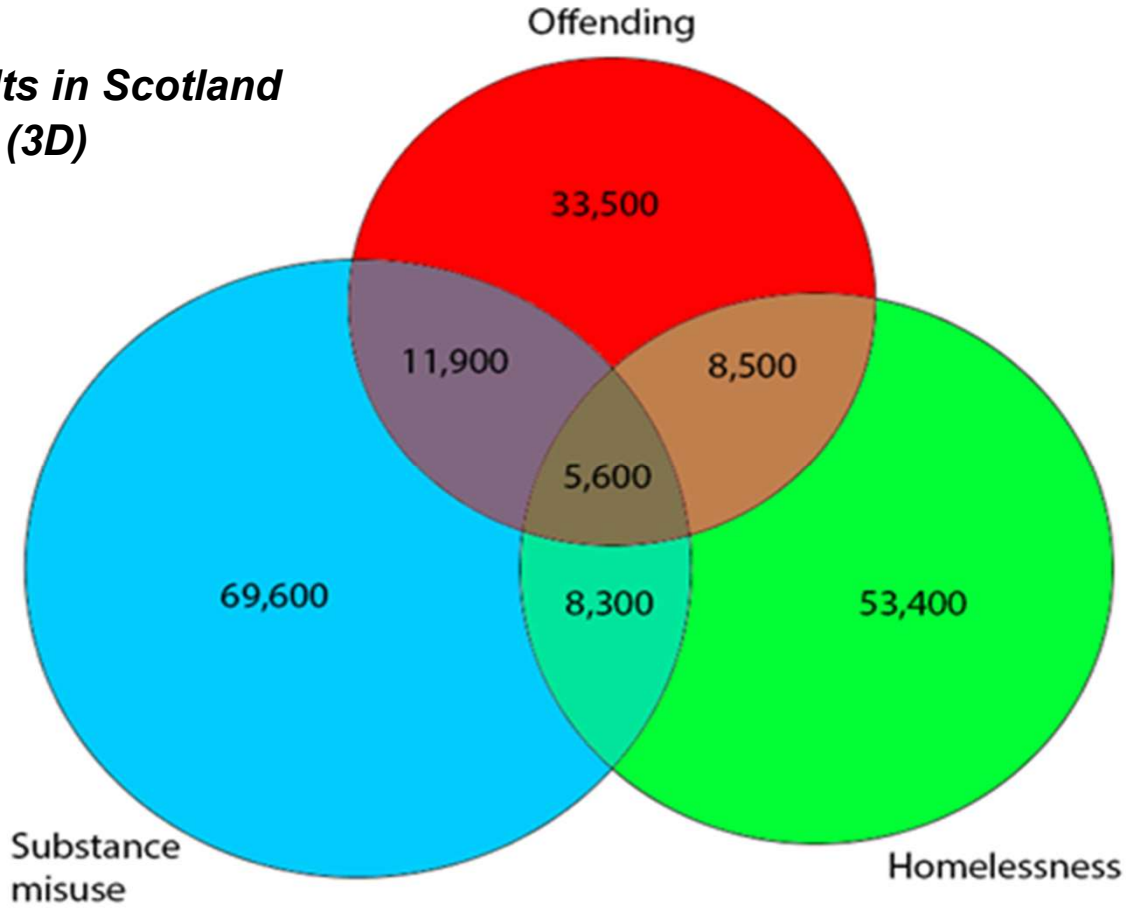
Ecological Framework of violence & trauma

At individual level: • being a victim of child abuse • having a psychological or personality disorder • exhibiting delinquent behaviour • using and depending on alcohol and drugs	At relationship level: • exposure to poor parenting practices • violent parental conflict • martial discord • low socio-economic status •Delinquent peers and gangs
At community level: • exposure to poverty • high unemployment • high crime levels • local illicit drug trade • inadequate services for victims	At societal level: • exposure to economic inequality • gender inequality • cultural norms that support violence • weak economic safety nets

www.who.int/violenceprevention/approach/ecology/en

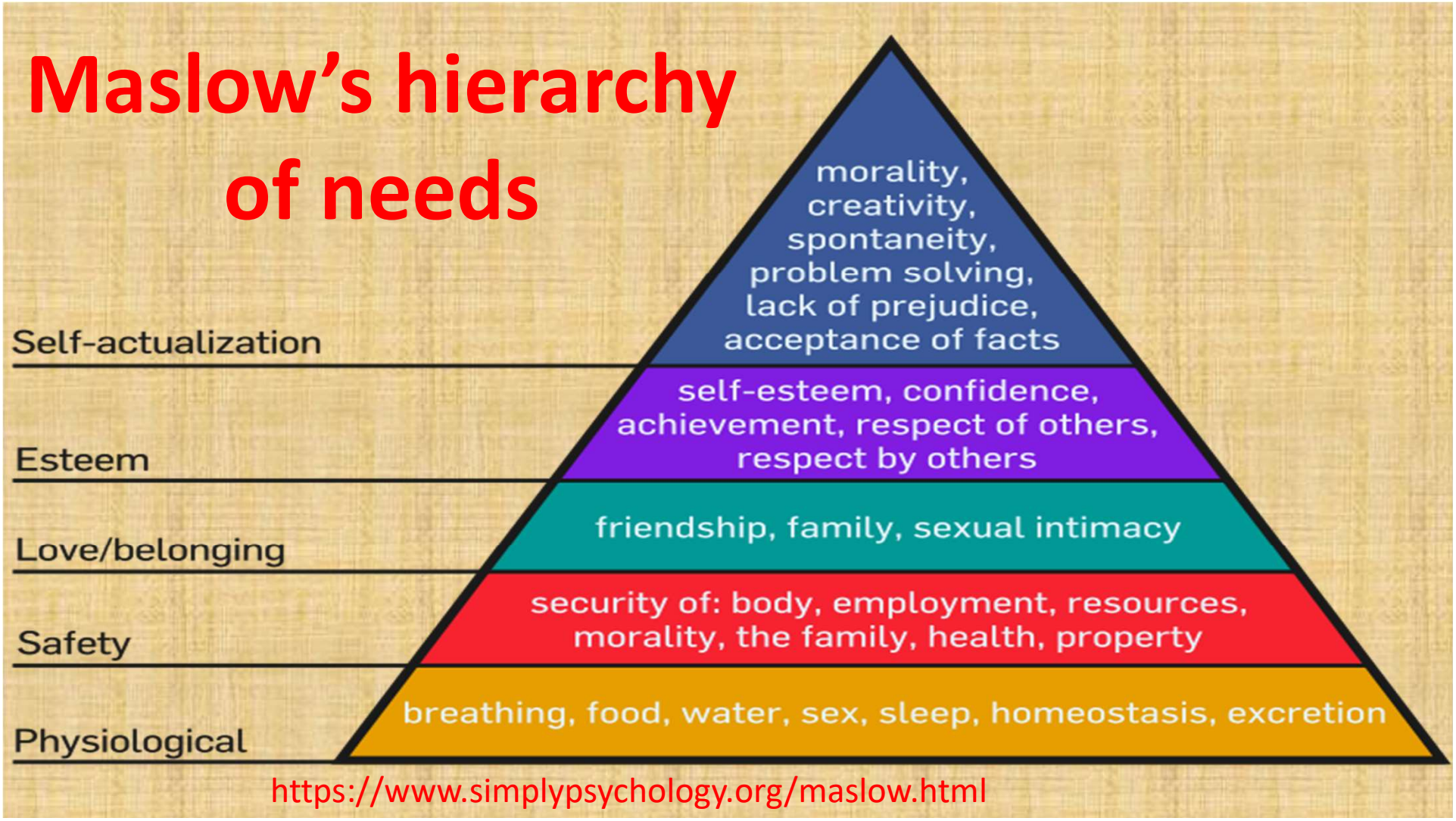
Scale & Overlap of Severe Deprivation

Numbers of Adults in Scotland by <u>Current</u> SMD (3D)



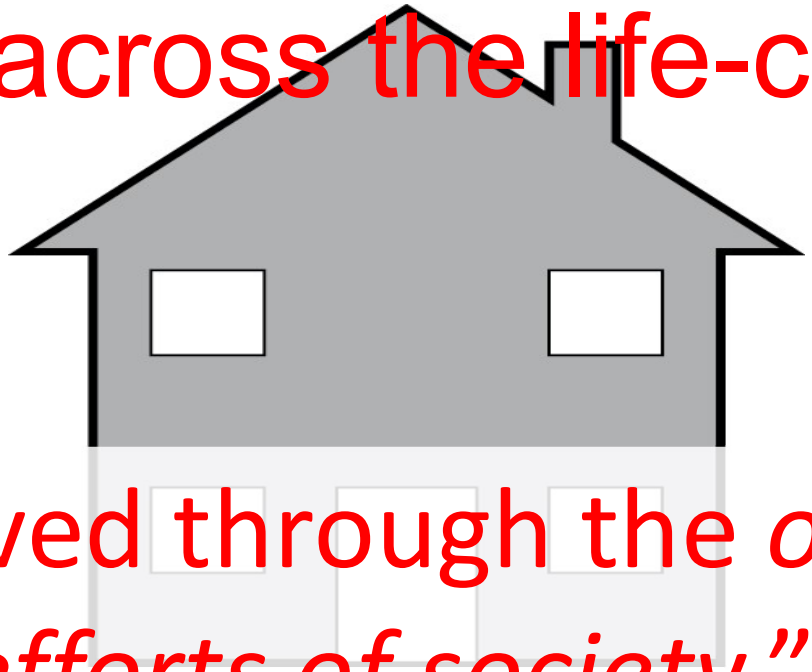
Sources: Weighted combination of SCJS, GUS, HL1, HHiS, SDMD, DESTIT, SPS-PS, CJS

Maslow's hierarchy of needs



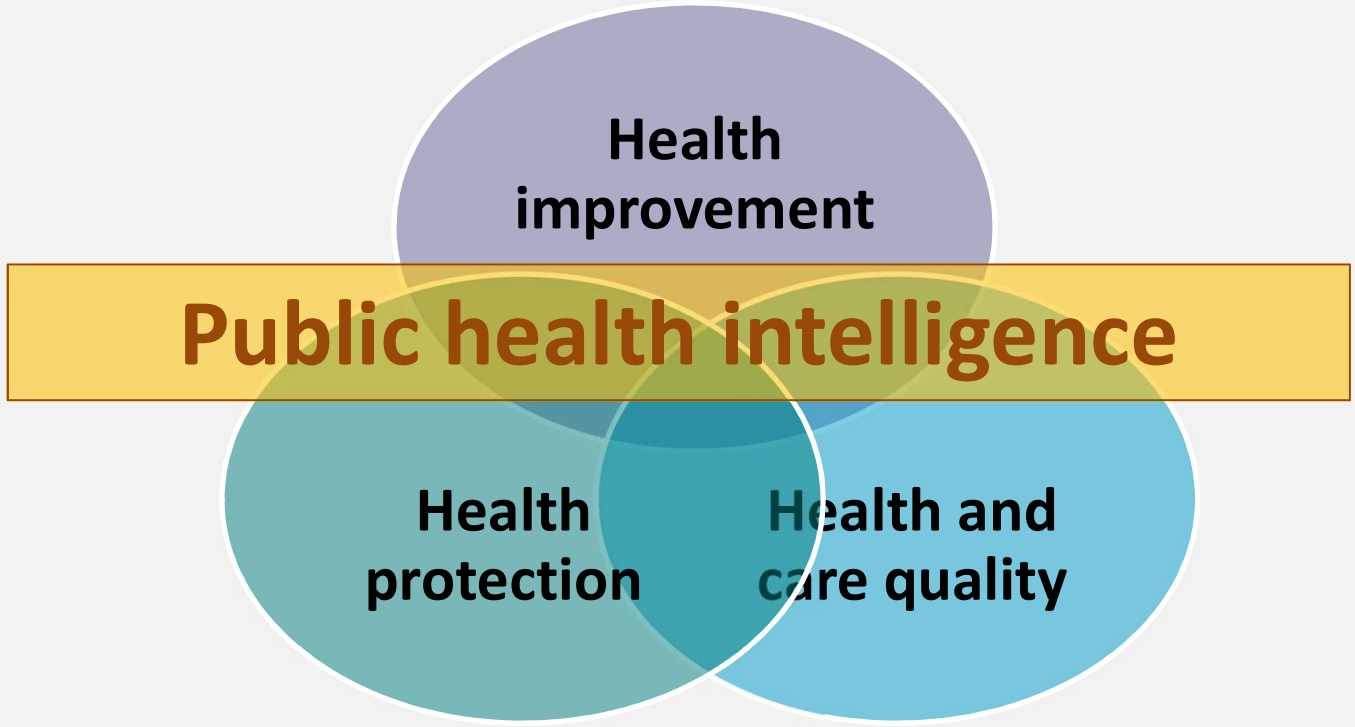
https://www.simplypsychology.org/maslow.html

“A good (safe) house is the underpinning foundation of wellbeing across the life-course.....”

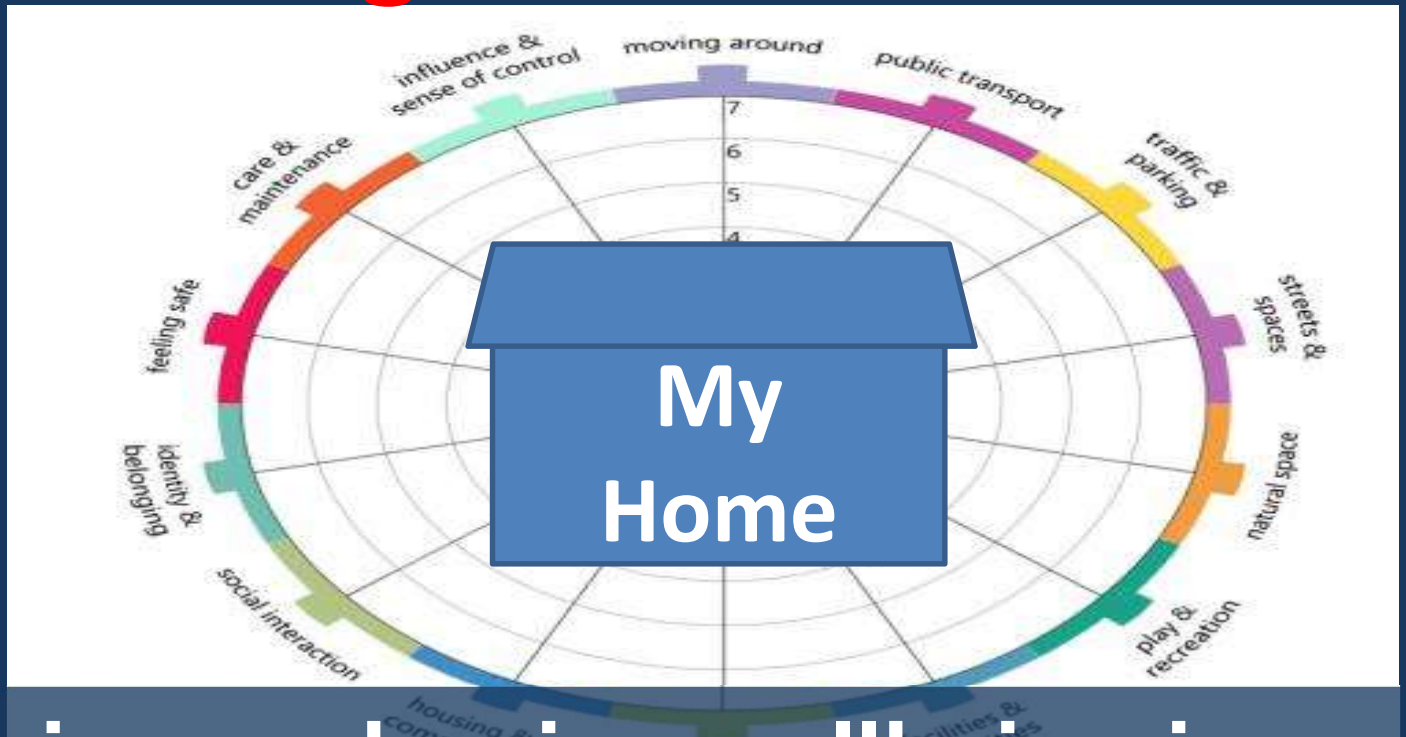


“.....achieved through the *organised efforts of society*.”

Applying the Public Health Lens



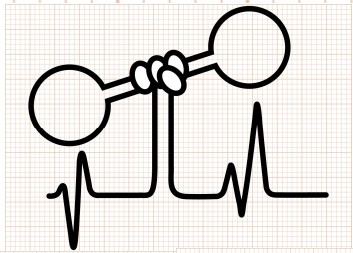
The ‘Home’ is the bedrock salutogenic environment



Housing underpins wellbeing in society

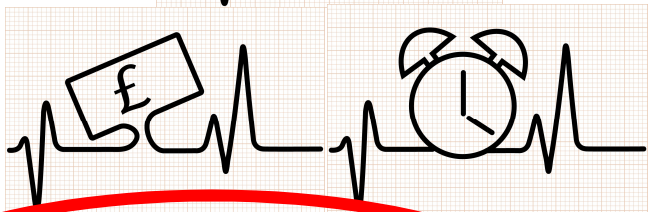
The ECG of Wellbeing

The critical building blocks
of wellness across the lifecourse:

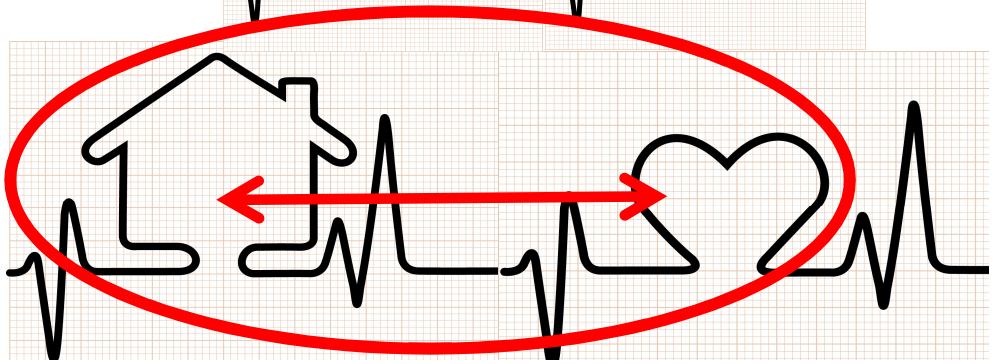


1. Rafters
2. Relationships

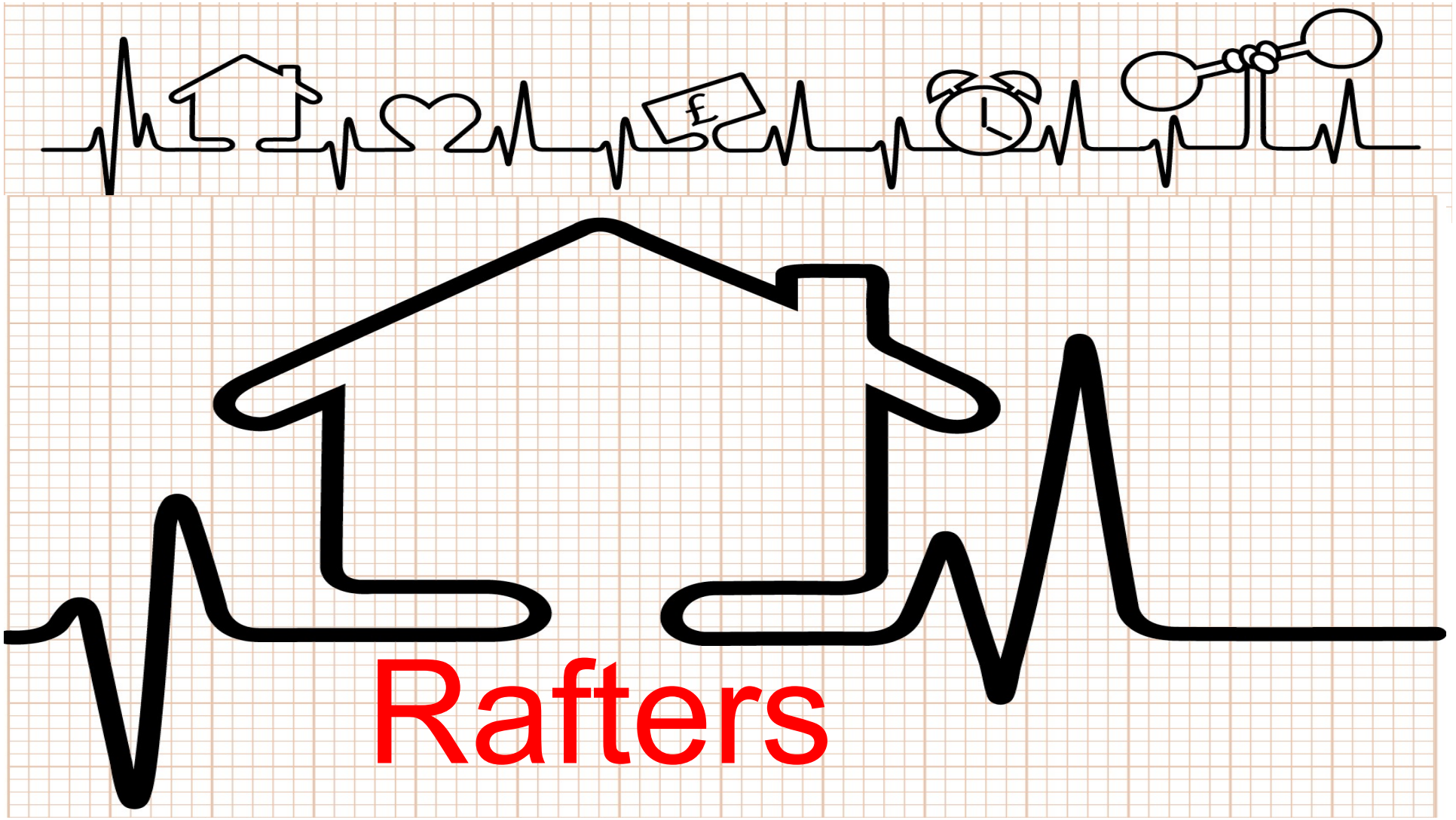
} **Firm Foundations**



3. Resources
4. Restoration
5. Resilience



Bricks and Biology
Rafters and Relationships
Dignity and Respect
Kindness & Connection
Purpose and Hope

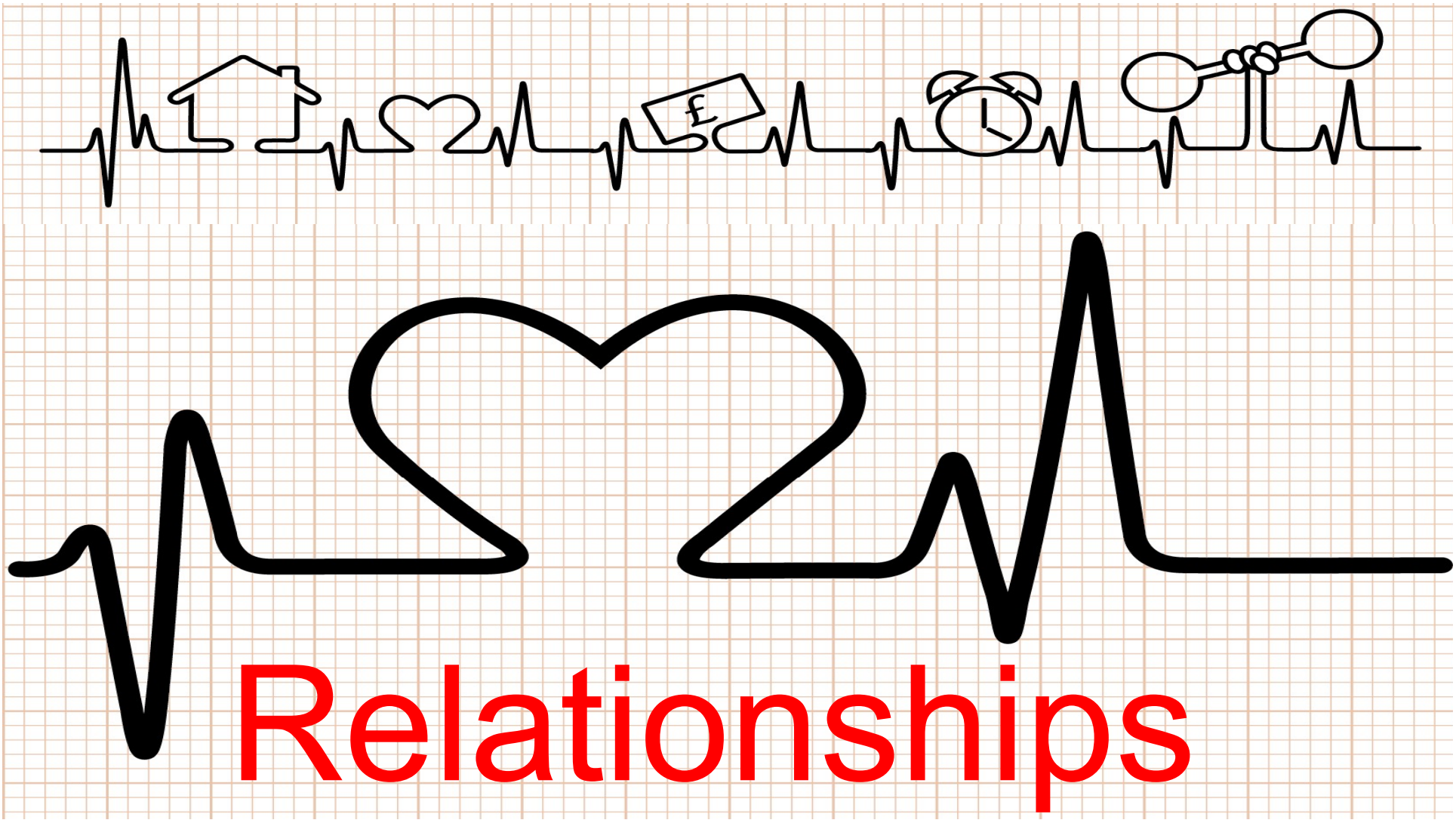

Rafters

How does housing affect health?

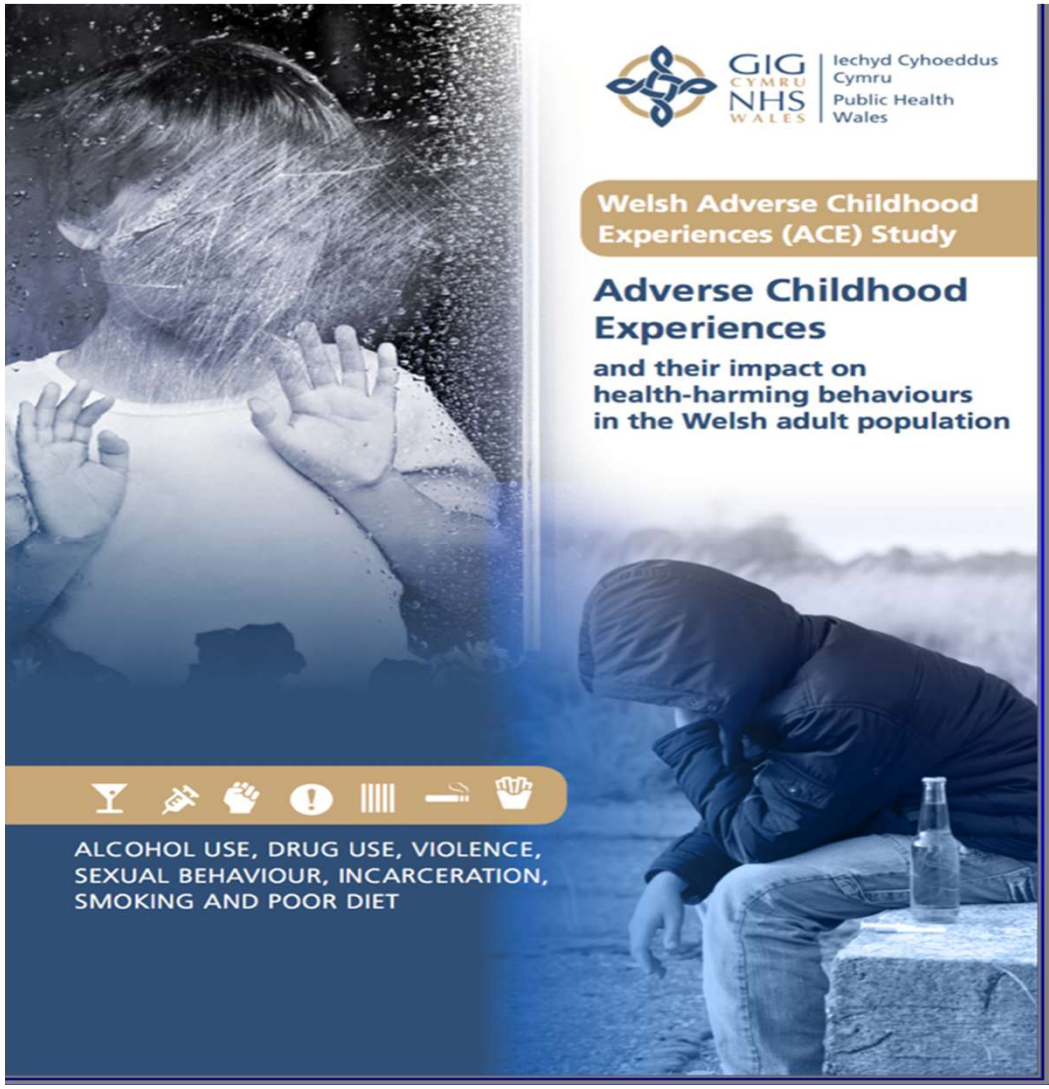
- Directly

How does housing affect health?

- Directly
- Indirectly

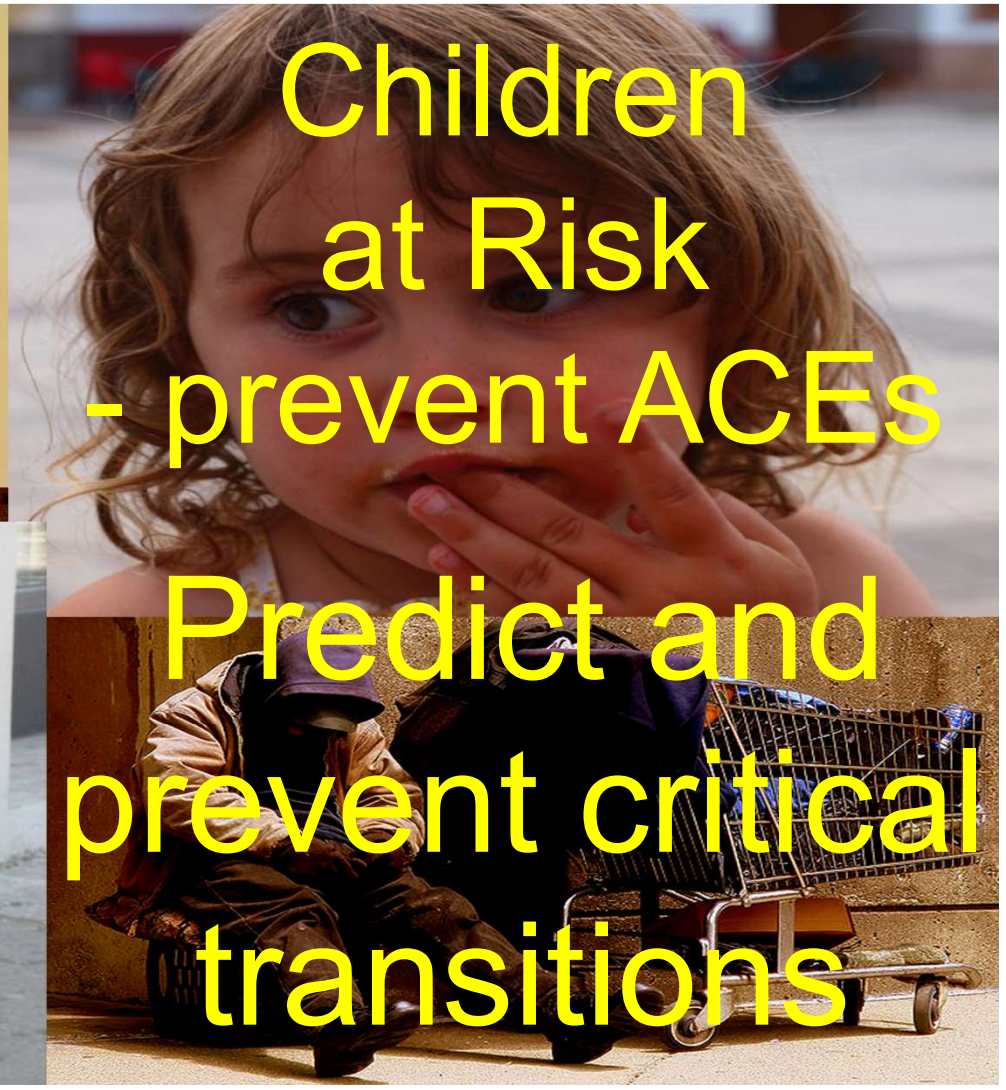

Relationships


Arguing with mum
Going missing
Night terrors
Anxiety
Drug use
Offending
Mental health difficulties
Lashing Out
Truanting



...our pasts embed and express in our present

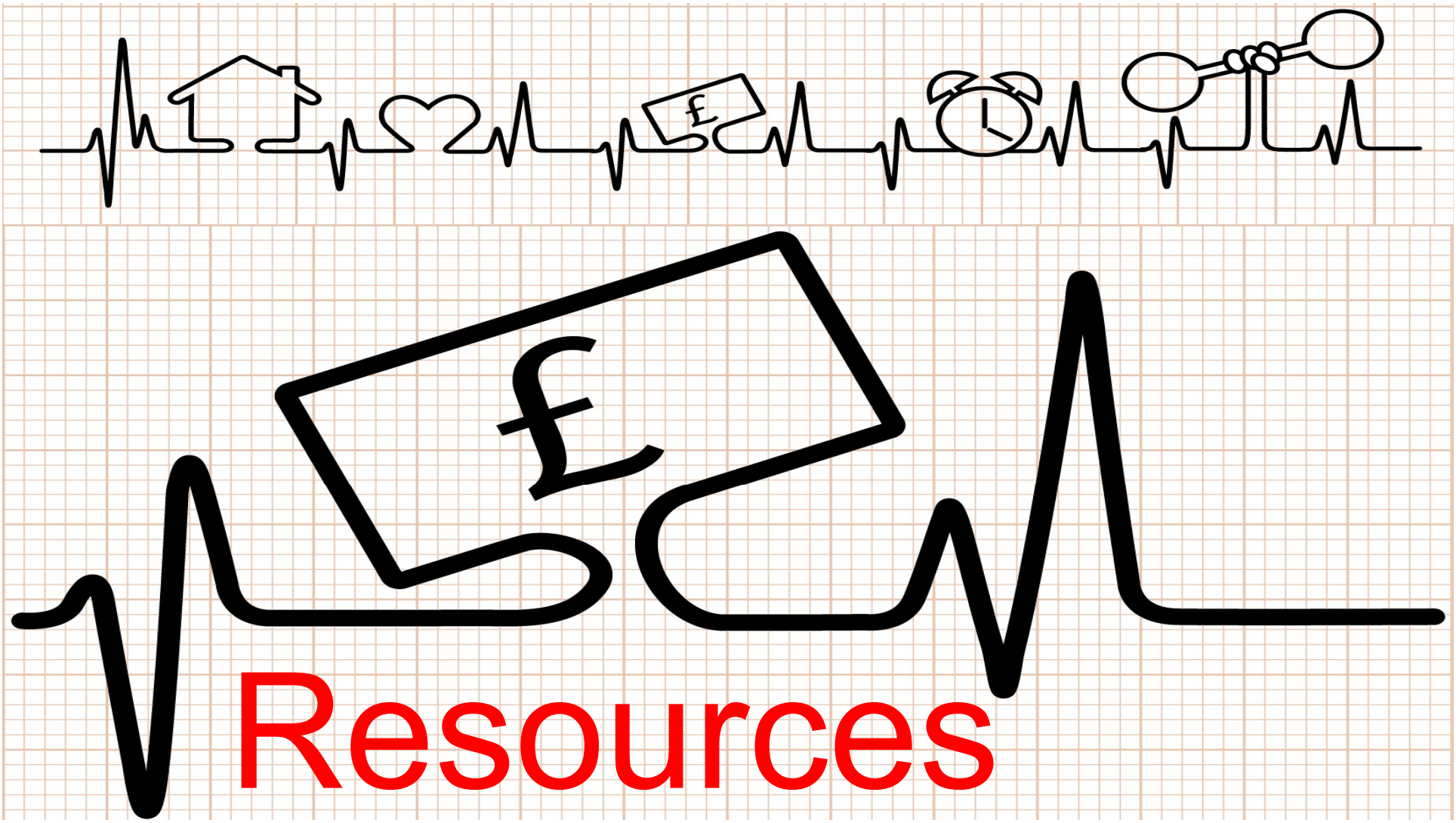

Parenting
and
Bonding


Children
at Risk
- prevent ACEs


Broken
Relationships
– Broken Lives

Predict and
prevent critical
transitions

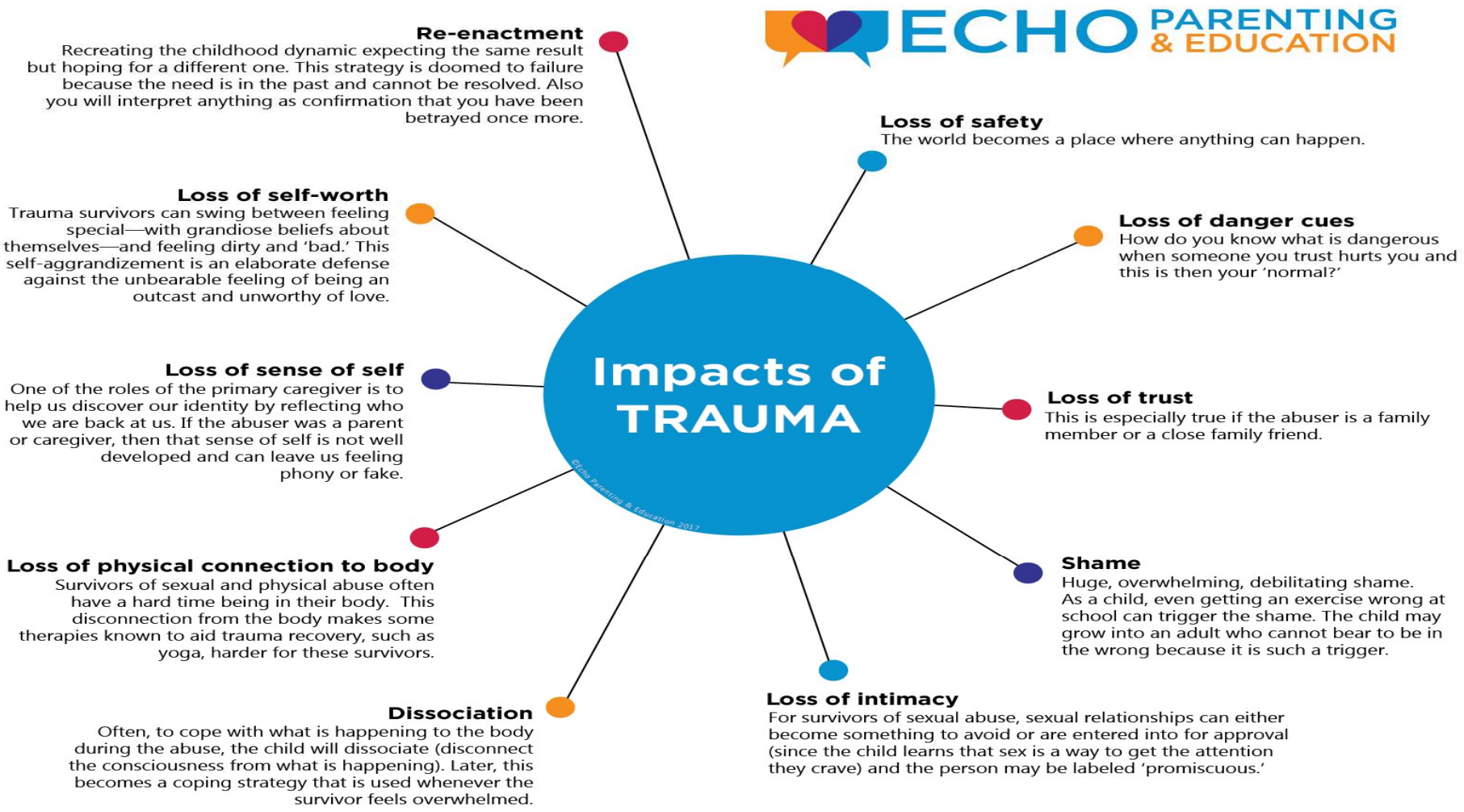

Critical Transitions
Home
Care
Leaving
Springboards
Prison
Military
House
Mind
Safety Nets
Losing
Loved One
Job

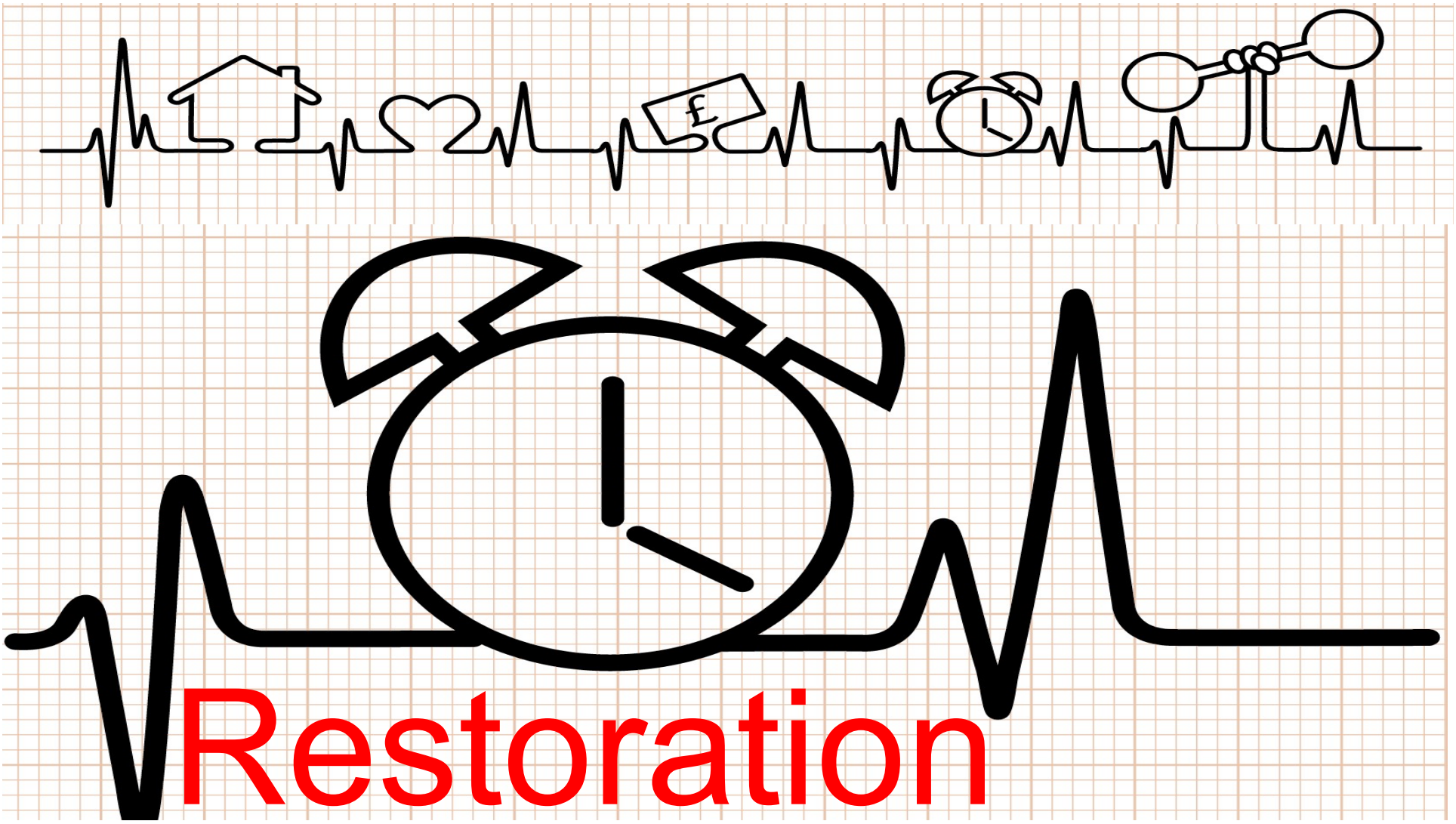

Resources

Children in poverty more likely to have problems with friendships, study shows

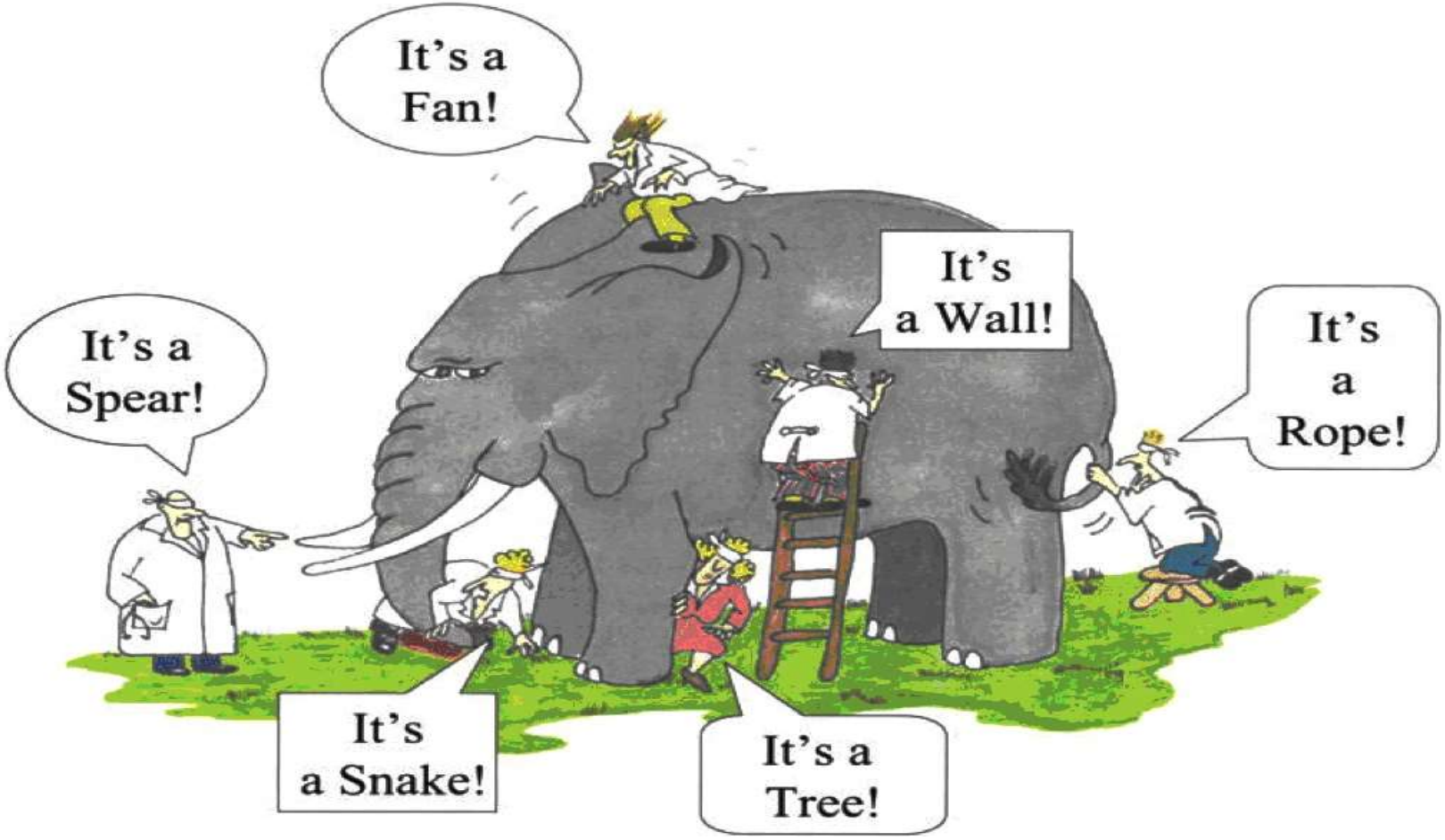
Children who live in poverty are more likely to be solitary and to fall out with friends or be bullied, the National Children's Bureau says

- Financial poverty
- Poverty of education
- Poverty of choice & opportunity
- Poverty of access & participation
- Poverty of power & influence
- Poverty of status & dignity
- Poverty of 'belonging'
- Poverty of HOPE


ECHO PARENTING & EDUCATION
Impacts of TRAUMA
Re-enactment
Recreating the childhood dynamic expecting the same result but hoping for a different one. This strategy is doomed to failure because the need is in the past and cannot be resolved. Also you will interpret anything as confirmation that you have been betrayed once more.
Loss of safety
The world becomes a place where anything can happen.
Loss of self-worth
Trauma survivors can swing between feeling special—with grandiose beliefs about themselves—and feeling dirty and 'bad.' This self-aggrandizement is an elaborate defense against the unbearable feeling of being an outcast and unworthy of love.
Loss of danger cues
How do you know what is dangerous when someone you trust hurts you and this is then your 'normal?'
Loss of sense of self
One of the roles of the primary caregiver is to help us discover our identity by reflecting who we are back at us. If the abuser was a parent or caregiver, then that sense of self is not well developed and can leave us feeling phony or fake.
Loss of trust
This is especially true if the abuser is a family member or a close family friend.
Loss of physical connection to body
Survivors of sexual and physical abuse often have a hard time being in their body. This disconnection from the body makes some therapies known to aid trauma recovery, such as yoga, harder for these survivors.
Shame
Huge, overwhelming, debilitating shame. As a child, even getting an exercise wrong at school can trigger the shame. The child may grow into an adult who cannot bear to be in the wrong because it is such a trigger.
Dissociation
Often, to cope with what is happening to the body during the abuse, the child will dissociate (disconnect the consciousness from what is happening). Later, this becomes a coping strategy that is used whenever the survivor feels overwhelmed.
Loss of intimacy
For survivors of sexual abuse, sexual relationships can either become something to avoid or are entered into for approval (since the child learns that sex is a way to get the attention they crave) and the person may be labeled 'promiscuous.'
©Echo Parenting & Education 2017


Restoration

SYSTEM RETRAUMATISING THE INDIVIDUAL

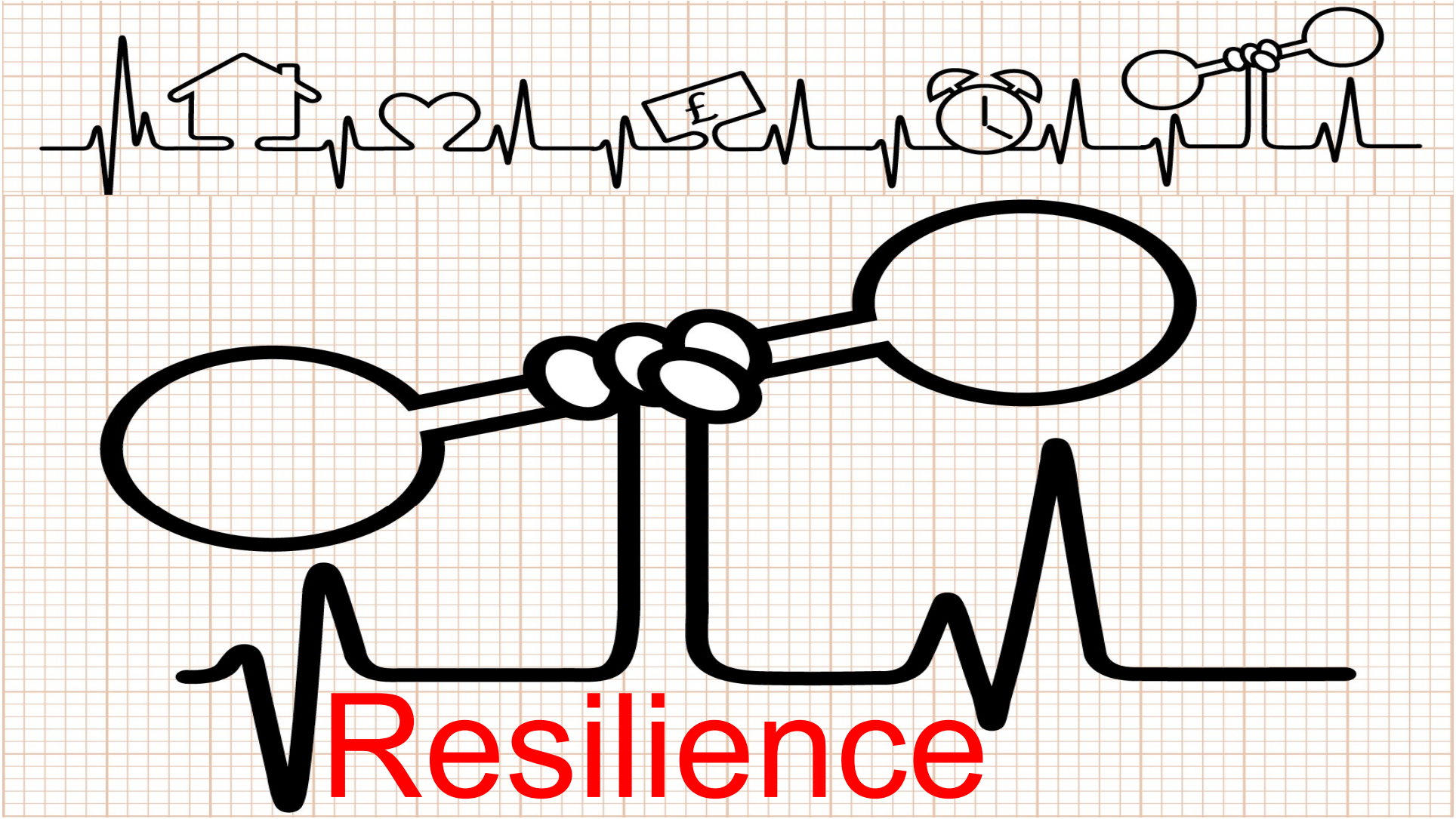


do involve greater numbers of people. However, for these wider definitions, the arguments about people making 'bad choices' do not apply in the same way. What this wider array of definitions and measures do show is that a larger number of people are touched and affected by SMD, or by at least one of its key components, taken over a lifetime. Particularly striking was the long-term negative impact of mental ill-health, and of homelessness, on economic as well as personal wellbeing.

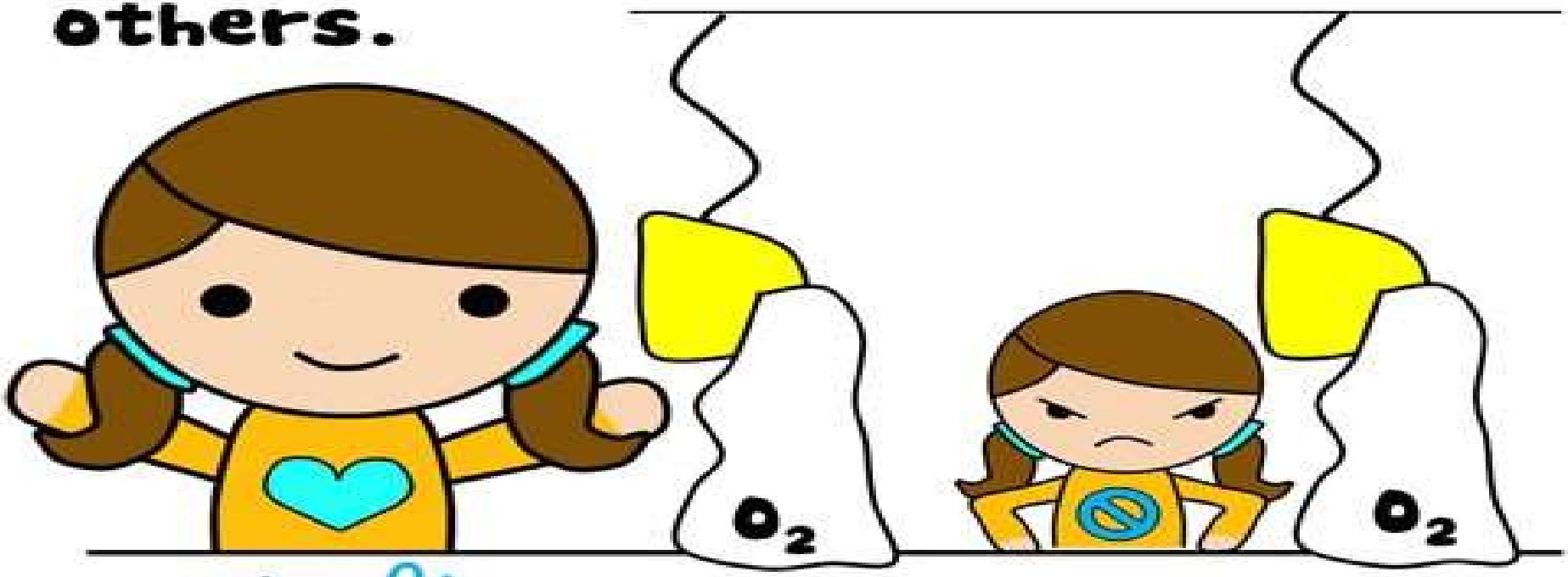
We would argue that there is a moral imperative for society to try to help people experiencing SMD to 'recover' and move forward to a more positive situation. At the most basic humanitarian level that obligation stems from the suffering which people are experiencing. However, as the accounts of 'routes in' make clear, there is a strong social justice case for helping people whose early life contained so many damaging experiences over which they themselves had no control. Further, the array of quantitative as well as qualitative evidence on the current quality of life of people with current or past SMD, as presented in this report, shows that people are being 'punished' many times over for transgressions whose roots were largely in childhood and not their responsibility as adults.

In addition, there is a more utilitarian case to be made, once one counts the sheer financial and economic excess costs of SMD in terms of healthcare, crime and justice, benefits, and so forth; costs which were documented more selectively in this study but on a more comprehensive basis in the original *Hard Edges* study in England (Bramley et al, 2015). We would further argue that there is a common public interest in tackling conditions which contribute significantly to antisocial behaviour and lowered levels of trust and social capital in communities.

Sociologists sometimes talk of the 'symbolic violence' that certain classes in society


Resilience

Life Lesson: Put on your own oxygen mask before assisting others.



seriously.
you can't help anyone if you're dead.

A system that understands toxic stress

- Understands the impact of toxic stress on service users and on staff
- Recognises that stress causes us to revert back to old habits that may have been overcome in the past.
- Learning about the psychobiology of toxic stress is liberating.....

  .... it provides an explanation for some puzzling, often destructive behaviours we engage in and feelings that can come to dominate us.

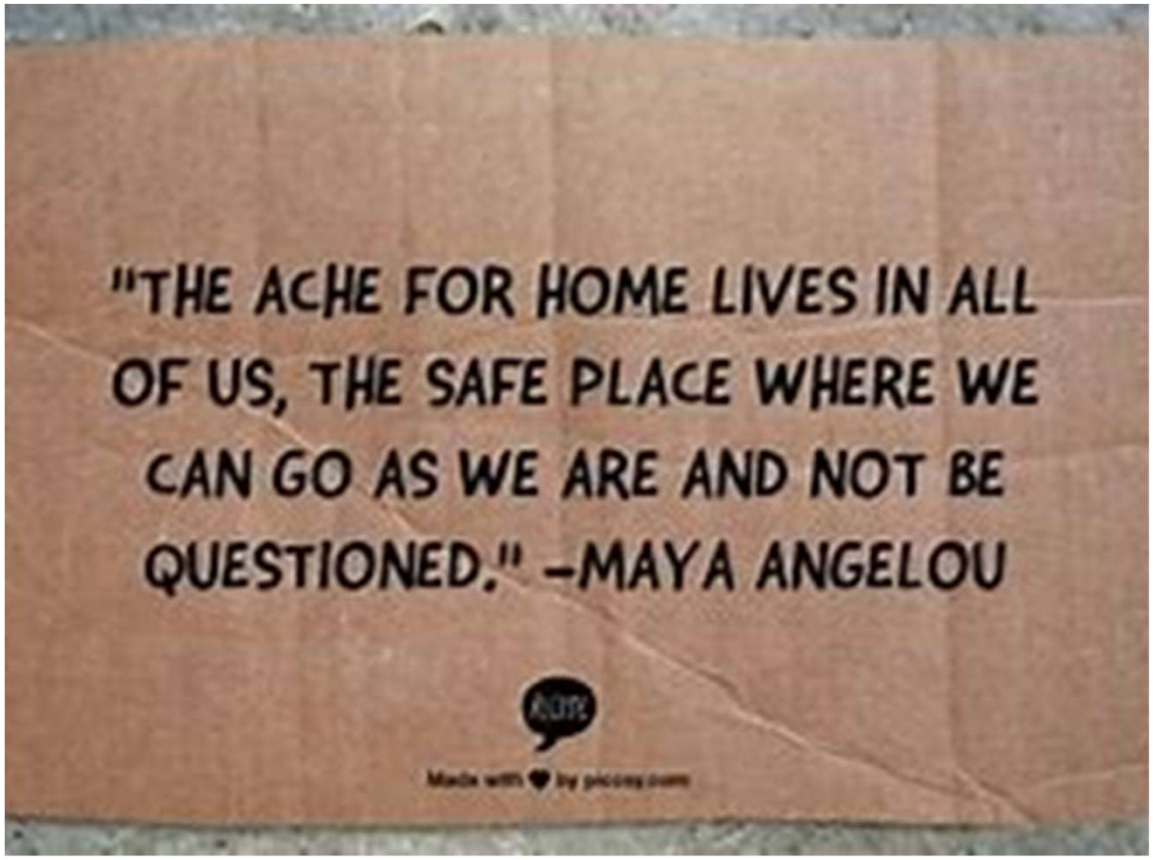

Making Fife a great place to live, work, visit and invest
Tackling climate change
Increasing employment
Reducing inequalities
Adapting to climate change
Reducing carbon emissions
Growing businesses and employment in key sectors
More dynamic businesses
Developing a modern business infrastructure
Improving the knowledge and research base
Extending employment and skill opportunities
Reducing low income households
Improving early years development of children in Fife
Raising educational attainment and reducing educational inequality
Strengthening communities through regeneration
Increasing the capability of Fifers to take action and make a difference to their communities
Making Fife's communities safer
Improving the health and wellbeing of older people in Fife and maintaining their involvement in their local communities
Improving the health of Fifers and narrowing the health inequality gap
Meeting the need for suitable housing choices


Third Sector
Public Sector
Private Sector
Communities
Communities
Communities
Communities
Communities
Communities
Communities
Communities
Employment & Training
Attitudes to Offending
Education
Lifestyle
Neighbourhoods
Person with Offending Background
Families
Victims
Living Arrangements
Emotional / Mental Health
Family Circumstances
Physical Health
Substance Misuse

The engineering of shared wellness across society

Gearing effect

Oil in the system


"THE ACHE FOR HOME LIVES IN ALL OF US, THE SAFE PLACE WHERE WE CAN GO AS WE ARE AND NOT BE QUESTIONED." -MAYA ANGELOU


SAFE PLACE

Safety = Good Home

A good home is a safe place, a sure place, a right place;
a good home is a warm place, a nice place just to be.
A good home is a fine place, a firm place, a true place;
a good home is a kind place, a good place to be free.

A good home is a strong place, a place to come for help;
a place to welcome others, a place to be yourself.
A place where things are shared, a place to reach out from;
a place of understanding, a place to build upon.
A place to face your fears, a place to grow and thrive;
a place where love is shown, where it's good to be alive.

Ruth Buckley

Figure 11.1a: An increase in health activity precedes the first homelessness assessment for **males.** Son after this date, particularly for drug-related and alcohol-related acute admissions, and for repeat homeles admissions (SMR04) and mental health prescriptions.

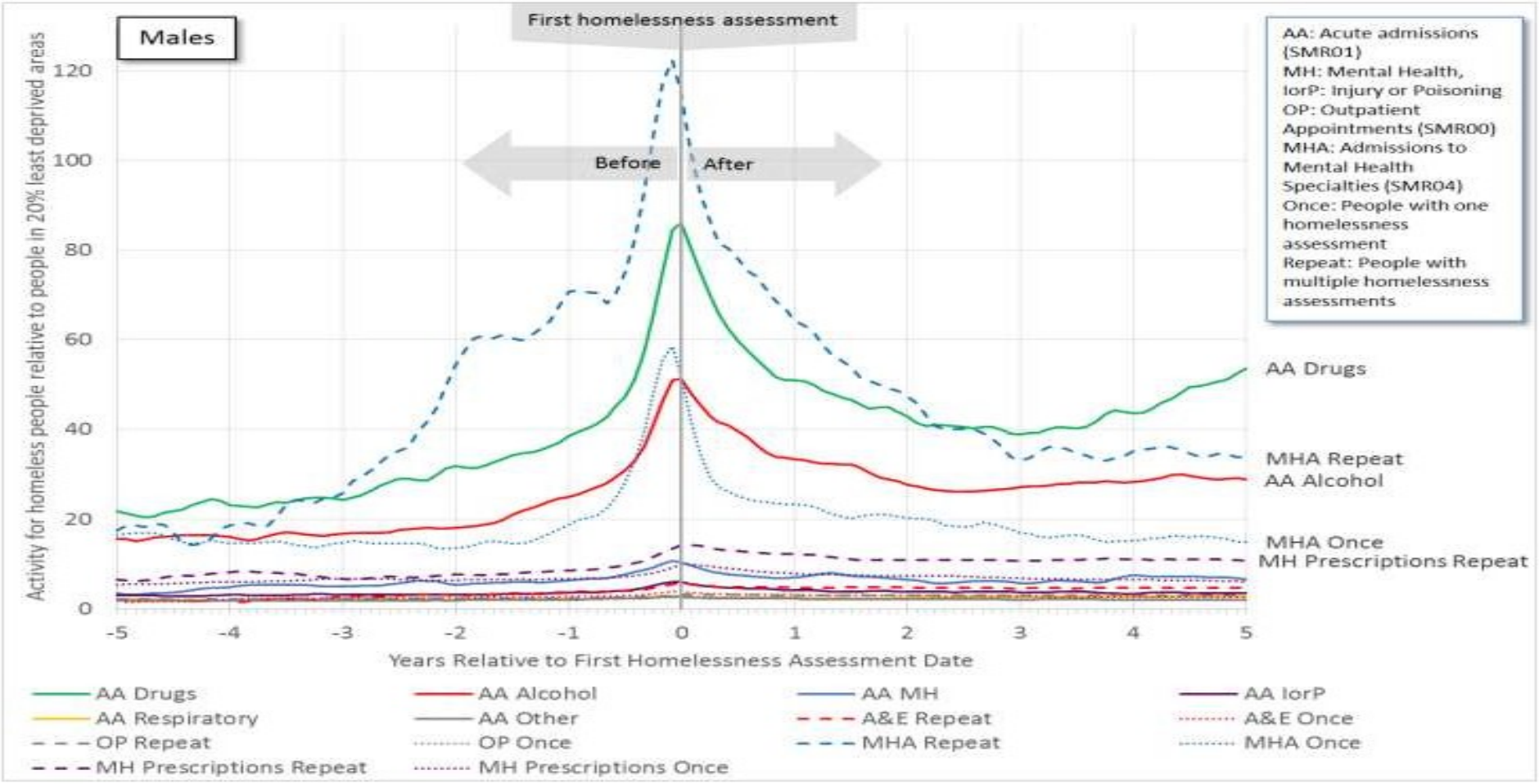
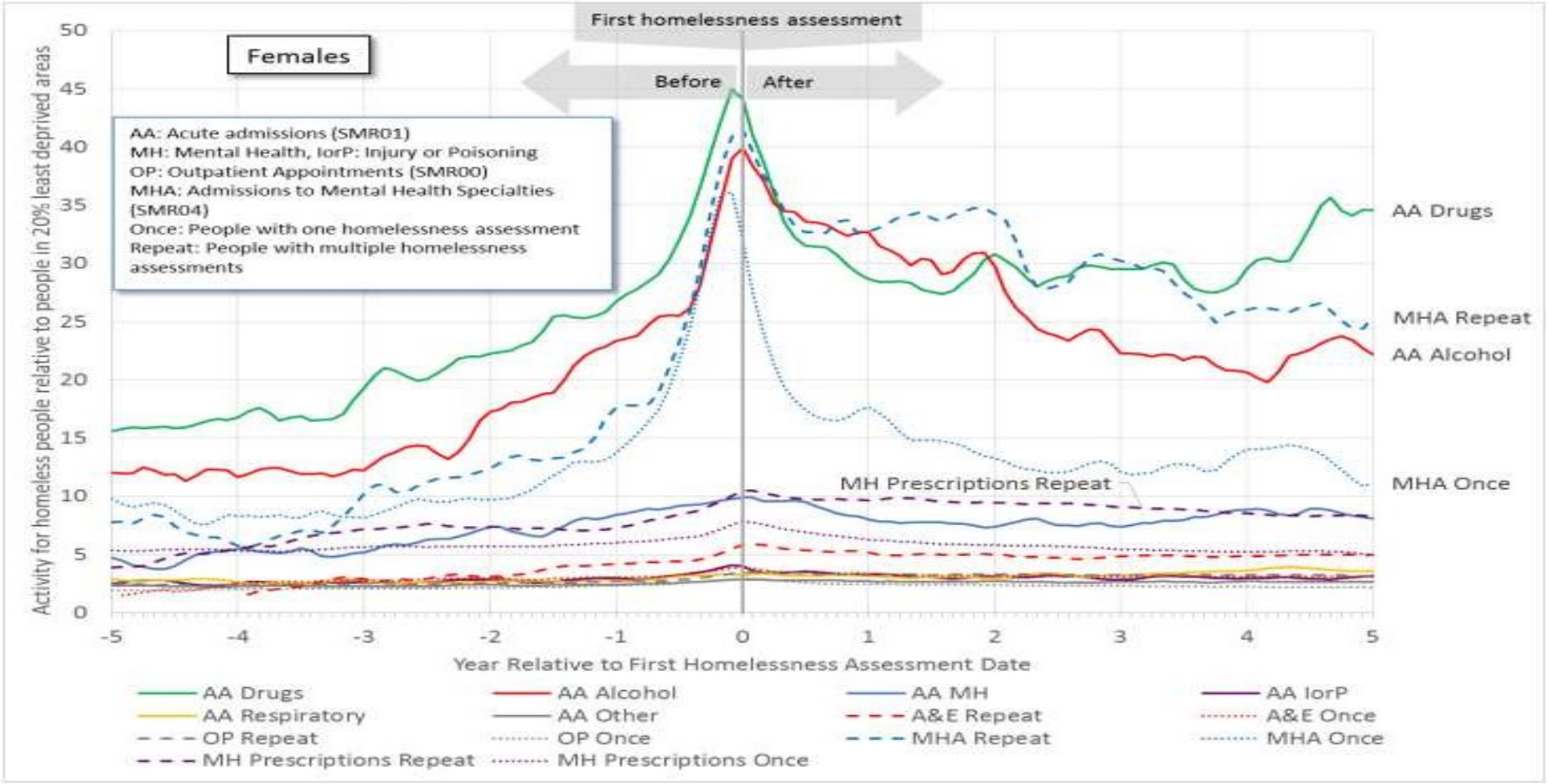


Figure 11.2a: An increase in health activity precedes the first homelessness assessment for **females.** Sor higher after this date, particularly for drug-related and alcohol-related acute admissions, and for repeat hor health admissions (SMR04) and mental health prescriptions.



Data – Linkage as driver for:

Improvement in:

- **service design**
- **joint working**

Improvement in understanding:

- **causes**
- **consequences**
- **interventions**

Root Causes

Consequences → Interventions

How can we ensure that hidden populations are represented in data linkage projects?

Criminal justice - the last resort safety net?

- Service users committing offences and/or requesting custodial sentences in order to gain access to a **'safe place' in prison** and to 'care' of various kinds.
- Service providers **seeking to have vulnerable people arrested** simply in order that they could access the mental health and other services they needed.
- The existence of a court order appeared to be the necessary **'passport' for access** not only to an array of health and other support services, but also the main route through which any kind of **coordination of care** occurred for people facing SMD, if it occurred at all.
- **Criminal justice social workers were praised** by some service users as the most consistent and helpful service they had encountered. Frontline service providers, too, generally acknowledged that criminal justice teams provided the **'stickiest**' and most **pro-active** support that adults with SMD could expect.
- **But pre- and post-release support for prisoners far from perfect** - with many still being released straight into homelessness

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Homelessness services - 'carrying the can'

- In the absence of a court order, local authority statutory homelessness services were the next most likely service to 'lead' on SMD cases, but this presented a host of issues.
  - No command over addictions/ mental health services, nor the necessary authority to coordinate timely multi-sectoral interventions
  - Unlawful practice in some areas: routinely turning people away without the temporary accommodation to which they are entitled, use of 'local connection' as a bar to homelessness assistance
  - The highly variable quality of hostels and other forms of temporary and/or supported accommodation
  - Disappointingly "light touch" and short-term nature of floating support offered to some people with SMD

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The missing mental health services

- Gaping hole - extreme rationing applied by these services operating under acute pressure, meant that even getting to the point of achieving an assessment could seem an insurmountable hurdle

- The “one/two/three strikes and you are out” policy operated in many areas could almost be designed to eliminate the chances of those with chaotic lifestyles from ever gaining access to the help that they need

- Even for those who managed to access mental health services, the overreliance on prescription medication was widely criticised

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Substance misuse services in retreat

- Sense that the availability of services had declined in recent years, particularly residential rehabilitation facilities
- For those who managed to access residential services, there was often said to be a lack of ongoing support to aid their full recovery once they were back in the community
- For community-based treatments, too, there were often substantial waiting periods, meaning ‘windows of opportunity’ to get people on the road to recovery were lost
- Nonetheless, some service users reported a positive experience of rehabilitation and/or community-based substance misuse services, successfully stabilising or even overcoming their addictions, while others felt ‘stuck on methadone’ for long periods without the support they needed to come off it.

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Crisis-focussed systems that can't cope with the effects of trauma

- Only limited evidence (in the larger urban areas) of the development of trauma-informed services/PIE
- The crisis nature of service interventions militated against 'strengths-based' approaches, focussed on future hopes and potential for a better, more socially productive life
- Little emphasis placed on helping people (re)build positive family relationships, even though that was the overriding motivation for recovery identified by most service users

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A lack of 'sticky' and coordinated services

- Service users appreciated frankness, accessibility and reliability in frontline workers, and also 'stickability', not giving up on them if 'they failed to engage'.
  - ➢ but assertive, pro-active services that reached out to, and stayed with, service users were hard to come by
  - ➢ emphasis instead on the service user taking the initiative or 'being left to their own devices' to seek and secure help
- General lack of clarity around co-ordination/case management (unless social work or criminal justice have a clear statutory duty).
  - ➢ in some areas the 'lead professional' model was considered an important step forward, with early evidence of success when implemented well
  - ➢ but more often it was unclear who should/will lead, though this was something that some Health and Social Care Partnership were said to be actively trying to address.

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The Financial Truth

- £37,059 annual cost to keep a person in prison
- £34,000 annual cost of a prisoner released reoffending
- £156,250 cost of residential care for a young person annually.
- £315.57 average cost per day for a psychiatric bed.

- £1909 cost of a community payback order
- £25,666 average cost of an early and effective intervention implementation

We have attempted an approximate analysis of the excess healthcare costs associated with the homeless cohort in the Waugh et al (2018) HHIS study. The largest extra costs are in mental health prescriptions (£311m per annum) and acute in-patient and day cases (£306m), followed by substance prescriptions at £150m. The smallest items are actually drug treatment and out-patient appointments. The total excess cost of health for people who have ever been homeless is £900m, which seems a big figure, compared with the annual Scottish Health budget of c. £13bn, although it should be recalled that 'Ever Homeless' in Scotland are about 10% of the whole adult population[27]. This analysis also suggests that the excess costs for poverty and deprivation affecting people in the general population who have not been homeless amounts to £2.3bn. The total (2.3+0.9=£3.2bn) is roughly in line with Bramley et al (2016) estimates of the excess health costs in Scotland associated with poverty broadly defined (i.e. about a quarter of the health budget).

Housing

We have already referred in the section on poverty to the higher incidence ousing deprivations among the SMD groups. In this section we consider mo ualitative aspects of housing which may contribute to or impair quality of life.

gure 20 looks at two key measures: not being warm enough in winter (often lin fuel poverty); and the home being in a poor state of repair. In this instance