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MENTAL HEALTH AND PUBLIC HEALTH PARTNERSHIP

by

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If I am to speak of the possibilities of partnership between mental health and public-health workers, perhaps I cannot do better than to begin by reminding you that we are unwittingly celebrating an important centenary in the history of public-health work. Exactly a hundred years ago this month cholera was raging in Britain. In London the situation was particularly grave. Indeed, in 10 days in August of 1854, that is to say in about the same period during which we have come to Toronto for our meetings, more than five hundred people died of cholera within a radius of two hundred and fifty yards of the junction of Broad Street and Cambridge Street near Piccadilly Circus. On 7 September, the parish council of St. James, Piccadilly, was meeting to consider emergency measures when a stranger, a certain Dr. John Snow, asked if he might address them. Dr. Snow told the meeting that he had come to the conclusion that the disease of cholera was transmitted by water contaminated by human sewage. He went on to explain his reasons for believing that the water of the Broad Street pump was infected in this manner and he urged the parish council to remove the handle from the pump. Although at first incredulous, the council, after discussing it, had the good sense to act on his advice. On the following day, the 8 September, by order of the parish council the handle of the Broad Street pump was removed. Four days later, on 12 September, the epidemic was evidently on the wane.

There are several aspects of this episode which merit our attention.

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Firstly, Dr. Snow's advice was not based upon a mere whim. He had spent six years painstakingly investigating, by field studies of cholera outbreaks, his hypothesis that cholera was spread by water infected with human sewage. The facts that he had collected were sufficient to convince him that no alternative hypothesis would provide as adequate an explanation. Removing the handle of the Broad Street pump was preventive action based on a tested etiological hypothesis.

Secondly, it was social action - the kind of action that only an organized society can take - in this case the elected council of the Parish of St. James.

And thirdly, the etiological knowledge on which the action was based was, as we now know, very incomplete, when we remember that even the organism concerned, the cholera vibrio, had not at that time been identified. Nevertheless, the knowledge was sufficient for effective action and to the present day the strategic significance of John Snow's incomplete etiological discovery is such that even had the cholera vibrio never been discovered, cholera as an epidemic disease would have disappeared from the world if all nations had acted on his hypothesis. Why has this not happened? The clue, I believe, lies in the fact that this etiological knowledge implies social action and social action of a very extensive nature.

The removal of the handle of the Broad Street pump stopped the epidemic of cholera in the Parish of St. James. But it did not eradicate cholera from Britain, nor even arrest the epidemics in other parts of London. To achieve that, action of a far more widespread nature was necessary which presupposed a completely new attitude to communal water supplies and to the disposal of human sewage, and new methods of handling both. It required the development of an organized public-health service and that in turn made necessary the development of new professions - the public-health physician, the public-health engineer, and his precursor the sanitary inspector. New laws were needed and, I may add, "laws with teeth in them". The original title of the sanitary inspector was, you may remember, the "Inspector of Nuisances" and in the early days he was the teeth of the law.

Nevertheless, national action ultimately did develop from the voluntary local action of the elected council of the Parish of St. James, through the evolution of a nation-wide climate of opinion which finally created new methods of handling both

drinking water and sewage and made possible legal compulsion for that minority which continued to flout, by the committing of "nuisances", the new sanitary morality which society adopted. But the law, in fact, followed public opinion; it did not create it.

I relate this somewhat lengthy parable because I think it has important lessons for those of us who are interested in the development of the mental health aspect of public-health practice.

Our local communities, our public-health services, and ultimately our nations, will act, if we can convince them that we have etiological knowledge on which to act and if we can spread that knowledge throughout the land and, to be effective, it is not necessary for that etiological knowledge to be complete.

One of our principal tasks, therefore, as mental health workers must be to work to acquire such etiological knowledge, and to work to convince those in our countries who are in a position to provide facilities for it that research to win such knowledge is the foundation stone of Mental Health. It is surprising that this should be so difficult when we consider the weight of the burden of mental sickness which our societies bear; but difficult it is. All concerned, whether they be in Health Ministries, Research Councils or the governing bodies of Universities, sometimes seem to conspire to ignore the fact that nearly half the hospital beds of the Western world are filled with psychiatric patients. I suspect, for instance, that if in any Western country a single communicable disease caused hospitalization on anything like the scale that results from schizophrenia alone, a national emergency would be proclaimed. The same is true of many psychiatric problems that result not in hospitalization but in more diffuse social damage. Adult males in need of treatment for alcoholism in several Western countries, for example, outnumber those in need of treatment for tuberculosis by several hundred per cent. and yet this problem is to a large extent ignored by most of the national and private bodies responsible for the sponsorship of research.

You will note that I am flouting current fashion by speaking of the reduction of mental disease rather than the positive promotion of health. I do so for two reasons: firstly, because, although the mere absence of disease may not be synonymous with health, there is no doubt that the presence of disease is certainly synonymous with

ill-health; and secondly because I believe that understanding of the etiology of psychiatric disorders, and the etiology of their recovery, will also give us understanding of the factors which lead to positive health. For these two reasons I feel it important that we should not allow our long-term strategic aim of promoting mental health to blind us to the tactical necessity of the reduction of ill-health. If we forget the importance of the latter we may become engaged in activities as unrelated to society's current problems as would be an obstetrician who treated a pregnant woman with a contracted pelvis solely by training for active participation in childbirth.

If it is agreed that the development of etiological research and the distribution of knowledge which arises from it is one of the primary aims to which the psychiatrists who support the mental health movement should devote themselves, we must face the fact that deficiencies or biases in ourselves may handicap us in making our full contribution in this direction.

The first of these biases, which affects most of us, arises from our praiseworthy conviction that mental ill-health is a grave social problem, and mental health a state for which all should strive. We are eager that others should share this view and so perhaps devote too much of our efforts to persuading them to agree with us that "mental health is very important" and too little to the more specific task of persuading the communities in which we live to take the practical steps that arise from what etiological knowledge we have. I should remind you that in his discussion with the Parish Council of St. James, Dr. Snow's advice was eminently practical. Are we in a position as mental health workers to give such practical advice based on etiological knowledge? I believe that in a limited measure we are, but I shall leave that theme until later so that I may comment first on another of the biases of psychiatrists which I believe damages their ability to acquire, and offer to the public-health worker, tested, if incomplete, etiological knowledge on which action can be based. This bias I can best describe, perhaps, as a kind of sectarianism. One cannot help but be struck by the fact that the rarest thing in the world is a general psychiatrist - and here I should interpolate that in the realm of etiological knowledge I make no excuse for considering the psychiatrist the key member of the mental health research team, although later, when I come to consider action based on that

knowledge, I shall suggest to you that in that field his position is by no means so central.

I should perhaps explain what I mean when I describe the general psychiatrist as a rarity. I do so because I would find it very difficult to think off-hand of enough psychiatrists among my acquaintances to outnumber the fingers of both my hands who are equally interested in current developments in both psychoanalytic and neuro-physiological theory, in the study both of the psychoneuroses and the psychoses, in the study of children of both normal and subnormal intelligence, in the study both of a clinical case and the epidemiology and genetics of the same type of disorder in the community and, by no means least important, in the attempt to keep reasonably abreast of developments in the various fields both of the behaviour sciences and of mammalian biology, all of which must ultimately prove to be components of a true and comprehensive human biology of which psychiatry is, whether we like it or not, a part. There are, of course, psychiatrists who are outstanding exceptions; but they stand out by their rarity as well as by their scientific stature. Why do I consider this sectarian tendency of our profession such a handicap to our ability to contribute etiological knowledge on which public-health and social action may be based? It is because it flies in the face of the very conception of etiology itself. We no longer live in the naive and optimistic age of Koch when etiology was believed to lie in "the single specific cause". The study of etiology, as we now conceive it, is the unravelling of a web woven of many threads. Different threads within this web are most fruitfully traced in different areas of psychiatry and often by methods drawn from other disciplines. Each in turn leads to others, for the study of which the methods of yet another discipline, applied in yet another area of psychiatry, may be most appropriate.

This sectarianism to which I have referred may be no handicap to the psychiatrist who restricts himself to clinical work in a specific sector of the psychiatric disorders - although I would be tempted to challenge that assumption had I the time - but for the psychiatrist interested in the mental health field, in the pursuit of etiological knowledge and in the preventive action that must be based upon it, it is, I believe, a form of crippling myopia.

In reminding you of Dr. Snow and the Broad Street pump I pointed out that on the basis of partial etiological knowledge it was possible for him to advise, and for the community to undertake, local action which was both rapid and effective. But I indicated also that the national implications of that knowledge were so widespread that they reached into every corner of the nation's social life. To act nationally on those implications needed many simultaneous changes, a widespread modification of popular beliefs on drinking water and human sewage, the evolution of new methods of handling both, the passing of new laws, the creation of a public-health service and the training of completely new types of workers for that service. Each of these changes at every step needed the vigorous advocacy and support of a group of devoted public-health reformers. I believe the same to be true in the mental hygiene aspects of public-health work. So that whereas, in the local community, action based on etiological knowledge may be comparatively easily achieved, this is far from true of action on the national scale, for the latter will entail radical revision of many aspects of the social fabric and practices of the whole society.

Perhaps one might illustrate this by taking a single hypothesis regarding a factor which it has been suggested makes a significant contribution to the prevalence of certain types of psychiatric disorders and by following through all the implications of that hypothesis for action on the national scale.

Let us take as our example the hypothesis that an infant between the ages of six months and three-and-a-half years needs a continuous relationship with a mother or a mother figure and that children deprived of such a relationship during that period will show, more frequently than those who are not so deprived, a degree of permanent damage of personality development - damage particularly to the capacity to form relationships with others and to the cognitive capacity we call abstraction. If we were to accept such a hypothesis as valid, and if we were called upon to collaborate with our public-health colleagues in acting upon it, we should have to start by considering two questions. Do the practices of the public-health services tend to bring about such separations and, if so, how can they be avoided? Secondly, what are the other social causes of such separations and what must be done to prevent them?

In considering the first question we are, I think, forced to admit that we in the medical profession are responsible for many of what I might call the "elective" separations of young infants from their mothers. We have given far less consideration than it merits to the devising of domiciliary care for many chronic maladies for which we are accustomed to put infants into hospital. We advocate the advantages of wholesale hospitalization for childbirth without weighing in the balance its disadvantages. We deal with the problem family by the radical surgery of removing the infant from it to an institution. As these few examples show, to take seriously the implications for action of the hypothesis of the noxious influence of the separation of the young infant from the mother demands a wholesale reevaluation of many of our public-health practices. Nevertheless, as is now being shown in many different places, changes in public-health practice which reduce the frequency of these "elective" separations can be achieved at the local level. For, as Dr. Snow found in his meeting with the Parish Council of St. James, face to face discussion with those who have a direct responsibility for the health and welfare of their immediate community can bring about understanding of the need for change in that community and, understanding once reached, action can be prompt. But the effects of such local action are limited. The removal of the handle of the Broad Street pump had no immediate effect on the cholera that spread from the many other infected sources of water in other parts of Britain. And yet, in time its wider effect ultimately began to be felt, chiefly through the spreading appreciation that arose from it of the general proposition that the radical prevention of cholera depended on keeping sewage out of drinking water. But this, as is evident, demands far more comprehensive action than the removal of the handle of a pump. The latter was within the competence of a Parish Council but the former required the concerted action of the whole health organization of a nation. In this respect we are luckier than Dr. Snow and the early public-health workers who followed him. They even had to create the national public-health organization.

But to return to our hypothesis of the etiological significance of the infantile separation experience. Even supposing that we and our public-health colleagues prove successful in so modifying public-health practices on the national scale that they no longer contribute their present considerable proportion of the separation experiences that are inflicted on infants, we would still only have begun our task of acting on the

implications of this etiological hypothesis. For looking round our societies we shall immediately see a large variety of social phenomena, beyond the bounds of public-health practice, from which such separations arise. Illegitimacy is an obvious example.

There is clearly an etiological problem here and it is extraordinary how little serious research work has been done on the socio-psychological etiology of illegitimate pregnancies. Radical prevention of separations arising from this cause must await such etiological understanding. But, in the meantime, even though we lack that knowledge, we do know what usually happens to illegitimate children unless we take steps to prevent it happening. They form, in many countries, the largest single group of "separated" infants. It is they, rather than orphans, who fill the orphanages. How can such children, having been born, be provided during the period which the separation considers important with a continuous relationship with a mother figure if their natural mother cannot care for them? Adoption seems to be one obvious answer and yet the recent survey of adoption legislation by the United Nations shows that the laws of many nations, far from facilitating the provision of a maternal relationship at this critical age, in some cases actually forbid it. In fact, one is tempted, when one studies the laws on this subject, to conclude that they are framed to protect adoptive parents against the awful potential dangers of adopting a child, rather than to fill the infant's biological need for mothering. In another large group of unmothered infants, we shall find that divorce is the factor which led to the separation and we shall be forced again to note an extraordinary absence of research on the etiology of the breakdown of marriage. Even without that knowledge, however, many separations arising from divorce would not occur if in some countries the divorce laws did not include the perverted notion of using removal of the child as a punishment for the so-called guilty party, or his custody as a reward for so-called innocence.

We shall be forced, too, to consider other influences of an economic nature which force the mother to leave her young infant in order to work. Among these I would quote as an example the influence of a conscious national policy which sets out to put pressure on such a mother to work in a factory in the interests of an increased labour force. The income tax policies of many countries also are such that inadequate

tax allowances for children force many mothers of young infants whether they wish to or not to work to supplement the family income, while the childless married woman, free of the economic pressure of a family, can stay at home. The policy of "equal pay for equal work" has the same effect, unless generous children's allowances for those who wish to mother their own infants balance the pressure to go out to work. Equal pay for equal work - in the absence of such children's allowances - means that the woman who stays at home to mother her infant considerably reduces the family's income. Those are only a few of the ramifications of the problem. If time permitted, we could follow its implications much further.

I have taken this one etiological hypothesis and tried to trace a few of its implications for action throughout a nation. I hope I have demonstrated that they are quite as far-reaching as those which ultimately arose from John Snow's hypothesis about the effects of sewage in drinking water.

At this point you may be provoked to interject "I don't accept the validity of the separation hypothesis". In that case, rather than pursue the attractive red herring of attempting to decide whether you reject it because of its implications or as a result of a scrutiny of the evidence offered in support of it, I would invite you to take any other item of etiological knowledge you may choose and follow through all its implications for social action. They will prove equally far-reaching. And you will see that the implications for action may reach not only throughout the direct activities of the public-health services but, far beyond, into every corner of national social organization and policy. They will lead you even to consider matters of legal and fiscal policy which at first sight might seem very remote from mental hygiene. We should not be daunted, however, by the immensity of the range of these implications. However difficult it may be to bring about immediately the action they call for on a national scale, we are certainly not powerless to bring about some appropriate action locally in the communities of which we are members from which ultimately will spread the general understanding which leads to national action.

When earlier I spoke of the need for etiological knowledge, I suggested that the psychiatrist was probably the key member of the research team to which we must look for the acquisition of that knowledge, although I indicated my belief that many of the

techniques of study he must use would probably have to be drawn from disciplines far beyond the bounds of clinical psychiatry. I do not believe the psychiatrist plays anything like such an important role in the preventive action that arises from the etiological knowledge he acquires.

This relative insignificance of the clinician is a characteristic of preventive medicine in action - and it may be one reason for the hostility felt toward that branch of medicine by those clinicians who overvalue the privileged and priestly origins of their profession. Although it was the clinician and his colleagues in the clinical laboratory who won the etiological knowledge that makes, for instance, the prevention of typhoid possible, they play little part in preventing it. For our freedom from this disorder in the Western world we rely on the generalship of the public-health physician, not the clinician, and equally on the unending campaign fought by the men who operate our water filtration plants and our sewage systems, on those who handle and distribute our food supplies and many other groups of non-medical workers in our society; and last but by no means least we rely on the mothers and teachers who transmit to each generation of children the personal habits which our societies adopted, rather recently, as one of the long-term results of the startling hypothesis which John Snow first put forward that faeces in drinking water can give rise to ill-health.

You may wonder why I again flout the present day fashion in speeches on mental health by putting mothers and teachers last on the list. I do so because in the earliest stage of preventive medicine, at which mental hygiene now stands, mothers alone cannot take the action which is needed. I believe we have done a disservice to mental hygiene by repeatedly telling mothers that they are predominantly responsible for the mental health of their children.

It is as if John Snow had advised the mothers of Broad Street to stop the epidemic by teaching hygienic habits to their children. Not only would the epidemic have continued but in addition the mothers would have been blamed, and would have blamed themselves, for their failure to arrest it.

It was far more important that the women of Broad Street should understand and accept the reason why they had to walk further to fetch their water when the handle

of the pump was removed. In other words, at that stage of the problem their understanding and action as citizens was needed, not their action in their personal capacity as mothers.

It was later, when communal action had removed the all-pervading threat to health of an infected water supply, that their action as mothers became more important than their action as citizens. Once safe water was available, the mothers' personal action in teaching to their children the new sanitary morality played an important part in combating the "person to person" infections which still remained.

The way in which this new sanitary morality of the 19th century was spread throughout the community prompts me to reflect that we in the mental health movement sometimes seem to feel that we are the first discoverers, and the most skilful practitioners, of the health education of the public. It is not until we see the sensitive community health education experiments of present-day workers in public health in different parts of the world, let alone some of the educational ventures in the field of agricultural extension, fundamental education or community development, that we realize that we are not the only partner to bring to this enterprise the capital of knowledge and experience in this field. In addition, we must realize that the partnership can only be successful if we set out to understand and share the traditions, the methods and the aims of the public-health worker, and it is here that so often we as psychiatrists have failed; our failure has rested as much on an absence of humility and of understanding of what preventive medicine is and does as on the relative paucity of our etiological knowledge. Our future contribution to the partnership will depend on our determination to remedy both these deficiencies.

When it comes to wider changes in society beyond the actual conduct of public-health practice, we shall find again that such changes are far easier to achieve in partnership with the organized service of preventive medicine than they are by mental health workers alone, for from its outset, 100 years ago, preventive medicine has been concerned, not merely with direct public-health action, but with the promotion of health through social changes which remove noxious influences from the human environment or provide for biological needs which were previously unfilled. In the past the great successes of preventive medicine have concerned the physical health of the individual

and it has been the improvement of the physical environment and the filling of physical needs to which the public-health worker has devoted his efforts. As the frontier of preventive medicine moves on to the problems of mental health, his attention must turn, indeed it is already turning, to the psychological and social environment, and needs, of the human being. If preventive medicine is to be as successful in this new territory, as it has been in the old, it will need from us etiological knowledge on which to act and a true working partnership in that action.

Some of the main supporters of preventive medicine, as it began to develop a hundred years ago, were physicians, but so, I must remind you, were many of its principal opponents. I have no doubt that the profession of psychiatry will display the same two-faced attitude toward preventive medicine as it begins to occupy itself with the problems of mental health. Nevertheless, I am sure that there are leaders in the practice of public health who will be as little deterred by the sneers of those who belittle their efforts in this new field as was John Snow by the almost unanimous rejection by his medical contemporaries of his ludicrous hypothesis regarding the ill effects of faecal contamination of drinking water; I am equally certain that there are, and will be in the future, other psychiatrists who will enter into a partnership with their public-health colleagues which will ultimately result in victories over mental ill-health as great as those over physical disease which stemmed from John Snow's advice to the Parish Council of St. James, a hundred years ago, to remove the handle of the Broad Street pump.