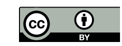

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ARTÍCULOS

Social Work and Public Health. Genealogy of a Reciprocal Relationship

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ENG **Abstract.** The aim of this study is to analyse the emergence of social work as a profession and its relationship with medicine. It is necessary to go back to the end of the 19th century to understand the context and background of the professionalisation of social work. This study uses a narrative literature review of classical texts on social work to address the origins of both social work and medicine. The interaction between both disciplines made a significant contribution to the discipline we now call public health. It is commonly known that medicine influenced social work, but a careful review of the literature shows that the influence was bidirectional. Social work is a practical and female-dominated profession, related to reform and social progress, and it may have been overlooked or co-opted by male-dominated medicine. This study reflects on the identity of social work and its contribution to the social determinants of health.
Keywords: Social Work; Public Health; Prevention; Professional Identity; Health Social Work.

ES Trabajo Social y Salud Pública. Genealogía de una relación recíproca

Resumen. El objetivo de este estudio es analizar el surgimiento del trabajo social como profesión y su relación con la medicina. Para entender el contexto y los antecedentes de la profesionalización del trabajo social es necesario remontarse al final del siglo XIX. Se utiliza una revisión bibliográfica narrativa de textos clásicos sobre el trabajo social. Se abordan los orígenes del trabajo social y su relación con la medicina progresista de la época. La interacción entre ambas disciplinas pudo suponer una contribución importante de lo que hoy denominamos salud pública. Es comúnmente conocido que la medicina influyó en el trabajo social, pero una revisión cuidadosa de la bibliografía muestra que la influencia fue bidireccional. El trabajo social es una profesión práctica y femenina, relacionada con la reforma y el progreso social, y pudo haber sido olvidada o cooptada por la medicina masculina. Este estudio reflexiona sobre la identidad del trabajo social y su contribución a los determinantes sociales en la salud.
Palabras clave: Trabajo Social; Salud Pública; Prevención; Identidad Profesional; Trabajo Social Sanitario.

Summary. 1. Introduction. 2. *Case Work* and the incorporation of the social dimension in the medical field. 3. *Hull House*, social work and health promotion. 4. Final considerations. 5. References.

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1. Introduction

There are foundational myths in all professions. In social work, Mary Richmond is considered the mythological figure par excellence, and her work *Social Diagnosis* (2008; originally published in 1917) is acknowledged as the founding act of the discipline. However, the institutionalization of different professions must be linked to specific socio-historical contexts, allowing for a better understanding of their genesis.

The professionalization of social work dates back to the first third of the 20th century. However, we must delve into the 19th century to better understand the social context that, in part, provided the conditions for the existence of a profession such as social work. This context is associated with a period of deteriorating social conditions following the industrial revolution. Thus, the emergence of social work can be traced between two key moments of worsening social issues: the crisis of the late nineteenth century and that of the 1920s, following the First World War and the Russian Revolution (Álvarez-Uría and Parra, 2014; Stuart, 2013; Abbott and Wallace, 2020).

The history of social work has consistently faced a dual tension. On one hand, there are individualizing interpretations, but on the other hand, an acknowledgment of the influence of the social environment exists. In other words, the analysis of its origins has oscillated between the psychologization and politicization of social problems. The very title of Richmond's work ("Social Diagnosis"; 2008) encapsulates this idea. Regarding this duality, reference is often made to two theoretical lines within "the most recent tradition of social work: Marxism and psychoanalysis" (Zamanillo, 2018, p. 53), or alternatively, to the latter and the mental hygiene movement (Castel, Castel, and Lovell, 1980).

These two trends are situated within two specific currents linked to distinct ways of understanding social intervention: the Settlement movement, centered on community aspects, with its primary exponent being the Hull House social center opened by Addams; and the Charity Organization Movement, focused on the social (and later psychological) needs of individuals (Ruth and Marshall, 2017). In the background, there echoes the contradiction between those who embraced the principles of *laissez-faire*, faith in self-help, and individualism (particularly associated with Anglo-Saxon Protestantism), and the growing awareness of the need for broad and profound social reform (Zamanillo, 2018; Álvarez-Uría and Parra, 2014).

At the origin of social work is the incorporation of the progressive ideas of the time that highlighted objective factors producing and sustaining poverty, such as inhumane working conditions, child labor, unemployment, disease, and unhealthy housing. This occurred in a context of economic and social crises, epidemics, population growth, and the advent of industrialization. The role of what we now call civil society (including trade unions, workers' associations, leagues, and federations) played a crucial role in recognizing the need for a regulatory state.

The harsh social conditions of the time were extensively documented and collected by historians, activists, and various social scientists (Hopkins, 1982; Engels, 2020; Addams, 2014; Goldman, 2014; Thompson, 2012). A paradigmatic example of the relationship between the social, historical, and political context is the text in which Engels (2020) describes the ravages produced by the industrial revolution in Manchester (*The Situation of the Working Class in England*), which was translated into English by Florence Kelley, an activist who would later be part of Hull House. Extensive social networks comprised journalists, intellectuals, activists, and various progressive associations (Álvarez-Uría and Parra, 2014).

The sociohistorical analysis of the emergence of social work as a profession and its connection with medicine enables us to correlate these trends with the genesis of the discipline later recognized as public health (Ruth and Marshall, 2017). This article employs a narrative bibliographic review based on texts now considered classics of social work. It entails a qualitative and interpretative bibliographic analysis that explores the potential bidirectionality of the relationship between medicine and social work, giving rise to practices associated with the prevention and promotion of health, and consequently, linked to the broader concept of public health. In 1920, Charles Winslow[1] defined public health as the art of preventing disease, prolonging life, and promoting health by emphasizing community organization and education. He also proposed the development of a social machinery that would permit a standard of living adequate for the maintenance of health (Winslow, 1920). In this same text, Winslow acknowledges social work as one of the "highly qualified" professions to contribute to the field of public health (Winslow, 1920, p. 30). Thus, it becomes possible to rekindle a debate about the origins and identity of social work in the health domain, especially at a time when the proliferation of biomedical technology is diminishing the focus on social aspects. The social determinants of health, closely linked to public health, occupied a significant place in the practice of the first social workers, as argued throughout this article.

2. *Case Work* and the incorporation of the social dimension in the medical field

The relationship between medicine and social work is notable and has been repeatedly emphasized (Ruth and Marshall, 2017; Stuart, 2013). These connections are evident when referring to the foundations of *case work*. Thus, Richmond established a methodology analogous to what medicine was already implementing. It is no coincidence, therefore, that the title of one of her most important books was *Social Diagnosis* (2008), published in 1917, wherein contemporary medical terminology is employed.

Even so, Richmond criticizes the "non-social attitude" (2008, p. 228) evident in some medical reports that should be employed as a source for social diagnosis. She also emphasizes the complementarity of

[1] Charles Edward Edward Amory Winslow was one of the prime movers of the discipline of public health.

information provided by both disciplines (medical and social), offering examples wherein the diagnosis can be corrected using information from a social worker, or vice versa. In this regard, she states: "There is no doubt that both groups of public servants, the social and the medical, would serve society better if they mastered all aspects of the technique of common work" (Richmond, 2008, p. 233).

Richmond (1996, p. 156) also underscores the success of social work in hospitals, noting that "the availability of qualified medico-social workers is often overwhelmed." According to this author, the social worker must act as "an interpreter between the community and the hospital, and between the hospital and the community" (1996, p. 156). Furthermore, she emphasizes that "in the mental domain even more than in the physical domain, a good diagnosis depends to a large extent on the social context, and subsequent treatment usually consists primarily of achieving greater adaptation to the environment" (1996, p. 157).

To discuss the origins of the interaction between social work and medicine, it is essential to mention the physician Richard Clarke Cabot and his work *Social Services and the Art of Healing* (1912). Cabot was significantly influenced by European developments in health care, which underscored the community context of disease. He was acquainted with the work of physician Charles Emerson, affiliated with the Charity Organization Society (COS) and John Hopkins University Hospital in Baltimore (1889). In this setting, a program was established for medical students and resident physicians to visit the homes of the people they cared for, gaining insights into issues related to their living conditions (Nacman, 1977).

Additionally, in London, in 1875, connections existed between the LCOS (London Charity Organization Society) and various hospitals and clinics. These institutions referred some of their patients to the LCOS offices for research purposes. As a result of these investigations, an LCOS *lady almoner* was introduced to the Royal Free Hospital in London. The program was deemed successful; however, despite this, it was not institutionalized and closed after three months. Nevertheless, the experience served to incorporate the figure of the social almoner in other hospitals, and her presence became increasingly common (Nacman, 1977; Stuart, 2004). In other experiences in France, home visits were made, connecting the homes of sick people with medical clinics focusing on hygiene, bacteria, tuberculosis, etc. (Stuart, 2004). All this background is elucidated by Cabot himself in the introduction of one of his main books: *Social Work: Essays on the Meeting-ground of Doctor and Social Worker* (1919).

With this background, Cabot made the decision to integrate a social worker into his clinic. Initially, this role was taken on by a nurse named Garnet Isabel Pelton, but she had to leave due to contracting tuberculosis.

In 1906, Ida Maud Cannon (Nacman, 1977; Stuart, 2004), a notable figure in the realm of social work in health, assumed the position.

Cannon (1877-1960) assumed the role of director for the first Social Service Department established in a hospital, having been hired by Cabot. Between 1906 and 1946, she served as the director of the Social Service Department at the Massachusetts General Hospital in Boston (Quam, 2013).

In the United States, at the beginning of the 20th century, the growth of social work emerged in a context of increased immigration (Stuart, 2013). This influx brought about the proliferation of diverse religions, languages, and ethnic groups (French, Germans, Syrians, Lithuanians, Poles, or Portuguese coexisting in the same environment), accompanied by a rise in poverty. All these factors contributed to the emergence of health-related social work (Stuart, 2004; Otis-Green, 2013).

However, it was not until 1919 that social workers were formally recognized as part of the hospital team. Their work was made possible by individual contributions from Cabot himself, along with other donations (Stuart, 2004).

Returning to Richmond's work (*Social Diagnosis*, 2008), Cabot's contribution to the specialization of diagnosis and its relationship with professions linked to psychology and medicine is explicitly highlighted: "he will render an invaluable service to medicine and psychology, and it goes without saying that the latter will continue to provide invaluable data for social diagnosis" (p. 418).

Similarly, Richmond (1996, p. 156), citing Cannon (1920), highlights issues that remain highly relevant in the Spanish context:

> Today, the social worker's administrative functions are overshadowing her social casework practice. She is too busy to visit homes and perceive with clarity and freshness the social situation underlying her cases. She thus ends up becoming institutionalized and spoiling the greatest contribution she can make to the hospital, which is to never think in a routine way and to always keep the patient's and the community's point of view in mind. (p. 156)

In this line of thought, it is worthwhile to delve into the principal contributions of Cabot and Cannon.

Cabot, in his work *Social Services and the Art of Healing* (1912; pp. VII-IX), outlines three ways of working as a team. Firstly (1), with social workers; secondly (2), in collaboration with other professionals (educators and psychologists); and thirdly (3), the need to work as a team with the *patients* themselves is established[2].

This necessity to work in interdisciplinary teams is justified by the fact that "when the doctor looks for the fundamental cause of most diseases [...], he [the physician] finds social conditioning factors, such as vice, ignorance, overcrowding, exploitation in factories, and poverty" (Cabot, 1912, p. VII). He also states that "behind most of the physical suffering is the mental torment, doubt, fear, worry, or remorse which the stress of life has created in most of the sick" (p. VIII).

If we consider the "fundamental cause of most diseases" (Cabot, 1912, p. VII), the need for a preventive exercise that takes into account social conditioning factors is already apparent at the beginning of the 20th

[2] When we use the term patient it is because it responds to the terminology of the authors we quote

century. The notion of prevention becomes explicit when, speaking of social work, Cabot (1912) states that medicine deals with "cases of illness (*a case means an accident*[3])" (p. 36) and does not have time, therefore, to attend to the "*causes*" (p. 36). In other words, health is associated with preventive work in the community, making it one of the most important functions of social work.

One of Cabot's important contributions to the development and identity of social work is the book *Social Work: Essays on the Meeting-ground of Doctor and Social Worker* (1919)[4]. It is noteworthy that the book is dedicated to Richmond.

Among the functions of social work, Cabot (1920) identifies two differentiated levels of intervention: individual (casework) and community:

1. First of all, to discover to what extent the person being treated is suffering and what their symptoms mean. Cabot (1920) states the following: "the physician is often unable to decide in a certain way the importance of the symptoms he finds in the examination, the degree of suffering of the patient, the seriousness of the case" (p.40). He refers, for example, to people who have been experiencing physical discomfort for an extended period and have normalized it, considering it unimportant. Similarly, "the inspector may observe in the house a state of disorganization, lack of cleanliness, poor nutrition, displeasure in the other members of the family, showing a much more serious state in the home of the sick person than the data obtained in the dispensary consultation might lead one to suspect" (Cabot, 1920, p. 44). Cabot acknowledges the limitations of his intervention within an exclusively clinical context and, therefore, considers it important to turn to other sources of information to attend to the case appropriately.
2. Secondly, Cabot explains that one of the most important functions of the social worker is to "*discover the nests or foci* of disease"[5] (1920, p. 46) concerning the environment in which the person served lives, not just the individual served. At this point, he is referring to preventive work, related to contagious diseases, occupational diseases, or other issues that the social worker will have to investigate.

Cabot emphasizes the nature of social work as distinct, endowing it with its own identity. She differentiates it from nursing, stating that "a woman who has received a nursing education [...] becomes [...] unfit for the work of social workers, since [...] she is habituated to constant submission and to a state of mind of inferiority in relation to the physician" (Cabot, 1920, p. 54-55). The social worker must possess "character and mental activity" (Cabot, 1920, p. 55). Specifically, "an aggressive character in the face of illness, a chief mental activity, and specialized education in the face of the sick" (Cabot, 1920, p. 55).

The book written by Cannon (1913) enumerates what she terms "medico-social problems," encompassing contagious and chronic diseases, conditions requiring a period of rest, as well as issues related to employability, motherhood, "mental imbalance," neurasthenia, suicide, and other concerns such as fear, loneliness, anguish, the feeling of failure, and uselessness. In essence, it addresses issues related to both psychological and social suffering (Cannon, 1913, pp. 33-105).

For Cannon (1913), one of the factors in assessing the quality of social work in hospitals is cooperation with the patient. Thus, she states: "cooperation must be more than receptivity [of the patient], but receptivity marks the first step towards a cooperative relationship" (p. 107). One of the functions of social work would be to generate a climate of trust and reciprocity, fostering a helping relationship with people.

In 1922, a reference manual for social work in psychiatry was published, authored by the directors of the Department of Social Work at the Boston Psychopathic Hospital: social worker Mary Cromwell Jarret and physician Ernest Southard. The book is titled *The Kingdom of Evils* (1922; Bell and Spiegel, 1966; Clark, 1966), and it features an introduction by Cabot. Additionally, bibliographical references to Richmond and Cannon are found throughout the text.

This manual (Southard and Jarrett, 1922, p. 523) defines "psychiatric social work" as the "special type of social work in which psychiatric knowledge is particularly required." It further conceptualizes mental hygiene as an inclusive term encompassing "the activities of the psychiatrist, the psychologist, the psychiatric social worker, in the promotion of mental health anywhere" (Southard and Jarrett, 1922, p. 523).

The work is composed of an exhibition of one hundred cases. Throughout it, different distinctions are made: between the public, the social, and the individual, but also between what is related to illness, ignorance, vices, and bad habits, as well as poverty or other forms of vulnerability (Southard and Jarrett, 1922). At the end of each case, a table is presented with the hours invested in its resolution, differentiating them by profession and activity. To give an example, in one of the cases, it is determined that the social worker has invested 293 hours in making 133 visits, 19 hospital interventions, 80 telephone calls, and 47 letters. All this contrasts with the number of hours spent by the other professionals, as the doctors would have invested only 4 and the psychology staff a single hour (Southard and Jarrett, 1922, p. 80).

At the same time, it is worth mentioning the moral judgments linked to the conceptions held about what is considered normal and pathological. One of the cases refers to a 43-year-old woman who dresses like a man. The text emphasizes that "she led a happy life in accordance with her own conceptions and was

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[3] The italics are in the original

[4] It is worth mentioning that the book was translated into Spanish in 1920 with the following title: *Ensayos de medicina social (la función de la inspectora a domicilio)*. The translation, ignoring the terminology proper to the profession, is indicative of the lack of knowledge that existed in Spain at that time.

[5] The italics are in the original

accepted as a man" (Southard and Jarrett, 1922, p. 133), while at the same time, the fact that she was living with another woman is described as "bisexual delinquency." It is stated, however, that in this way "she finds easier and better-paid work as a man" (Southard and Jarrett, 1922, p. 133).

Nevertheless, on the one hand, Jarrett's role has been cited as an example to illustrate the aspirations of social work in the early twentieth century and the challenges of establishing a new professional identity led by women (Clark, 1966). On the other hand, historians of psychiatry, such as Robert Castel (Castel, Castel and Lovell, 1980), view the emergence of social work in this field as part of the broader transformation occurring in psychiatry toward the adjustment of individuals to their social environment (Gabriel, 2005). This transformation is linked to the expansion of psychiatric authority beyond the confines of the hospital (Gabriel, 2005; Cohen, 1983; Castel, Castel and Lovell, 1980).

It is worth returning at this point to Richmond and the differentiation between individuality and personality. The latter is a term of greater complexity since it constitutes "not only what is innate and individual in man but also all that is acquired through education, experience, and human interrelation" (Richmond, 1996, p. 99). Therefore, it is important to explore all possible sources, compare and interpret them, in order to issue an adequate "social diagnosis" (Richmond, 2008, p. 418).

In short, it is possible to state that when speaking of Cabot, Cannon, or even Richmond, among other figures, we are not referring exclusively to the origin of social work. The concept of social determinants of health is implicit in many of the above-mentioned quotations, as is the concept of prevention. Medicine during practically the entire 19th century (with honorable exceptions) catered exclusively to the wealthy classes, not to mention the speculative and anti-empirical nature of an important part of its practices. The links between social work and medicine, together with other disciplines, seem to suggest a paradigm shift in the medical field.

Taking into account the dual tendency of social work, it remains to account for the contributions of community social workers in relation to public health. The following section is devoted to this issue.

3. *Hull House,* social work and health promotion

Jane Addams' project at Hull House was undoubtedly political in nature and sought to transform society to make it more just. Closely linked to the spirit of the suffragettes, she was always connected with social movements. Within the walls of Hull House, for example, meetings of trade unionists were frequent. Also well-known is the public lynching that the center suffered due to a lecture by Pyotr Kropotkin after a terrorist attack took place, and on which Addams reflects in a text entitled "Echoes of the Russian Revolution" (Addams, 2014, p. 429).

Addams had an affinity for poverty and the ways of working-class life in large cities. After dropping out of medical school because of a health problem, she writes, "I discovered that there were other genuine reasons for living among the poor besides caring for them medically, and I never resumed my brief foray into the profession" (Addams, 2014, p. 161).

Addams, like other committed women of the time, was treated by physician Weir Mitchell with his famous rest cures. It is likely that the success had to do with the fact that her treatment was painless, unlike those of her colleagues of the time (Ehrenreich and English, 2010; Garcia and Perez, 2017). Despite this, his practices are the paradigmatic example of medical power for the submission and adequacy of women to the domestic role socially assigned to them. It can be said that Mitchell was one of the pioneers in thinking the doctor-patient relationship or, more specifically, the "expert-woman" in the twentieth century (Ehrenreich and English, 2010, p. 186).

An example of what a *rest cure* entailed is shown in Charlotte Perkins Gilman's (2017) story *The Yellow Wallpaper* (published in 1892). It is a horror story with a high autobiographical component based on Weir Mitchell's treatment. Perkins Gilman's problem was not medical but stemmed precisely from her adaptation to the imposed feminine roles. The cure came from the separation from her husband and a life devoted to civil rights activism (Davis, 2010).

Similarly, Jane Addams' recovery does not come about as a result of Weir Mitchell's rest cure, but from the renunciation of "domestic imperatives" (Addams, 2014). It is worth noting that Jane Addams never married or had offspring, although she did maintain a romantic relationship with a woman whom she herself called marriage.

The concern related to public health can be seen in the description of the Chicago neighborhood in which Hull House was located, which was not chosen at random (Addams, 2013):

> The streets are terribly dirty, the number of schools is insufficient, sanitary legislation has not been enforced, street lighting is bad, paving is scarce and completely non-existent in alleys and small streets, and the stables are filthier than anyone could imagine. Hundreds of houses have no access to public sewerage [...] (pp. 61-62).

In relation to the location of Hull House, it is important to note the collaboration with physicians and "visiting nurses." Thus, "one of the nurses lives at Hull House, pays her board and works from here. Friends of the house are in constant need of her services, and her cases become friends of the house" (Addams, 2014, p.69). It also provided "food for invalids with orders received by visiting doctors and nurses from the district" (Addams, 2014, p. 70). It had, for example, medical dispensaries for people who could not obtain health care.

It Is relevant to highlight, on the one hand, the networking with other services and professionals and, on the other hand, the health-related work carried out from Hull House. Again, prevention and social determinants

related to migration and the working classes are taken into account. For example, Hull House had a public kitchen, as well as a service for the sale of food of nutritional quality. It also had a social café and alternative leisure spaces to the consumption of drugs or alcohol.

Addams was aware that, at times of high factory production, the working class neglected food, buying cans or ready-made products, leading to illness and poor health (Addams, 2014). Addams is also considered a pioneer of the recovery movement, providing a mutually supportive space in which difference was accepted, and in which she worked for the defense of social and civil rights (Davidson, Rakfeldt, and Strauss, 2010).

At Hull House, there was also research activity related to public health and linked to the Chicago School of sociology. There, the pragmatism of Dewey, Pierce, or Mead was taken to a more radical form, incorporating the perspectives of class and gender, and forming a distinct Chicago Sociological School of Women, perhaps closer to the presuppositions of the new Chicago School. The Hull House neighborhood and cooperative epistemology were based on an interpretive, socially situated, relational knowledge based on personal experience (especially of the oppressed classes) (García and Pérez, 2015).

Addams became a person of great relevance in the United States, even winning a Nobel Peace Prize in 1931. On the other hand, after World War I, many Hull House activists were labeled as radicals and began to be blacklisted by communism, and their prestige plummeted. For male academics, academic merit remained, linked to “pure” knowledge or “objective science” (García and Pérez, 2015; Álvarez-Uría and Parra, 2014).

One example involves the founding of the Federal Children’s Bureau in the United States, spearheaded by Florence Kelley and Lillian Wald (activists linked to Hull House). The Federal Children’s Bureau was directed by Julia Lathrop, with a focus on addressing high infant mortality. A major and sophisticated epidemiological study was carried out, including questionnaires and household interviews. Numerous reports were published, and a prevention campaign was promoted at different levels, including fundraising and legislative reforms to improve people’s social conditions (Ruth and Marshall, 2017).

Despite the success of the reforms, including the National Maternity Act of 1921, also known as the Sheppard-Towner Act, there were many entities that opposed it, primarily anti-suffragist and anti-communist groups, but also the American Medical Association. The result of these criticisms was the elimination of the Sheppard-Towner Act in 1929 (Ruth and Marshall, 2017, p. S238).

Another example in terms of public health and social determinants of health has to do with the Mental Hygiene movement and the figure of Adolph Meyer.

Meyer was responsible for the introduction of Freud’s thought in North America. He was linked to the origins of occupational therapy and social work, working with his wife, Mary Potter Brooks (considered the first social worker in psychiatry), but also with other well-known figures such as Julia Lathrop. In addition, he was a promoter of the Mental Hygiene movement. Institutionally, he headed the American Psychiatric Association and the American Neurological Association (In memoriam: Adolph Meyer, M. D., 1950).

Castel (Castel, Castel and Lovell, 1980) uses this figure to refer to the progressive changes in the psychiatric field that were taking place:

> a parallel network is being set up which, not by chance, has a representative who is not an alienist but someone who is a bit psychiatrist, a bit psychoanalyst, a bit social worker, a bit hygienist: a new figure with a rich future (p. 38).

Meyer’s importance lies in the fact that he was involved in practically all the new developments in the psychiatric field at that time. Like Addams (whom he knew and worked with), he was linked to the Chicago school, relating to philosophers such as Dewey, Pierce, or Mead (Castel, Castel and Lovell, 1980; Miranda, 2015).

In 1905, Meyer hired his wife as a social worker, and in the following years, there was an exponential increase in the number of social workers included in hospitals. By 1915, every hospital in Massachusetts had a female social worker (Miranda, 2015).

The Mental Hygiene movement emerged in response to the publication of the book *A Mind That Found Itself: An Autobiography* (Beers, 1908). In this autobiography, Beers, a person who had experienced various psychiatric services, critically discussed the flaws of asylum institutions. Beers, who had been a patient in a private clinic, a charitable foundation, and a state hospital, did not deny the existence of mental health issues but advocated for less dehumanizing forms of intervention. He emphasized the significance of biographical and contextual factors in mental health, stating that the book “is an autobiography, and more: in part it is a biography; for, in telling the story of my life, I must tell the story of another self” (Beers, 1908, p.1). The narrative describes the period of “unreason” he experienced between the ages of twenty-four and twenty-six (Ehrenreich, 2014).

Beers’ book received support from many progressive psychiatrists of the time, including Adolph Meyer, who wrote a review shortly after its publication. Meyer expressed that “through the knowledge of what he [Beers] himself experiences, observes, and hears, he hopes to obtain action to improve a system that is considered good enough” (Meyer, Johnston, and Chambers, 1908, p. 612).

A year later, under Meyer’s advice, Beers founded the Mental Hygiene movement. The movement’s statutes emphasized prevention through educational, research, and dissemination activities, as well as the networking of all existing means (Castel, Castel, and Lovell, 1980).

Meyer was critical of hospitalization and institutionalization, advocating intervention in the environment. The Mental Hygiene movement was considered a public health movement that sought adjustment between the individual and their environment, facilitating good mental health (Cohen, 1983). It took into account

the context and the social dimension, as well as the living conditions of modern society resulting from the industrial revolution (Cohen, 1983).

In spite of this, it was not until after the First World War, with the challenges associated with the return from the front, that the rise of this movement began (Castel, Castel, and Lovell, 1980).

These pioneering experiences allow us to glimpse the relationship between the field of public health and its preventive nature, highlighting the influence of social work in addressing the non-medical aspects of the disease. In the following section, we establish a series of considerations with the aim of emphasizing the role of social work and its contributions in the preventive and public health field.

4. Final considerations

By way of conclusion, different elements are presented to reflect on some of the current challenges of social work:

1. Firstly, it should be noted that the influence of medicine on social work is noticeable. Similarly, owing to the reciprocal influence of social work on the medical field, new models of care related to public health, prevention, and social determinants have been developed.
   The need to work in multidisciplinary teams and to intervene with the individual and their environment in all its complexity would not be possible without the contributions and influence of social work. The existence of a public hygiene movement, for example, would not have occurred without the presence of social workers. However, this optimism of medicine and psychiatry in social work may be attributed to the still rudimentary development of medical science and technology (penicillin would not be discovered until 1928) and the prospect of expanding its field of action to other non-medical areas of social life (factories, schools, etc.).
   Social work, since its origins, has been engaged in issues related to public health from a community and preventive perspective. No one would doubt Jane Addams' concern for the health of the neighborhood in which Hull House was located and the work developed around prevention and public health. From this perspective, it is essential not only to advocate for social work in health (developed, therefore, in health services) but also for a social work in health (understanding this concept in a holistic way) across various levels of intervention: individual, group, and community.
   It is pertinent to emphasize the necessity for more extensive and improved research in social work. This should be dedicated to enhancing understanding regarding the impact of structural factors on health, as well as to the implementation and advancement of community strategies for prevention and health promotion. If a discipline like social work neglects what were, at least in its origins, its distinct domains, other professions inevitably step in to assume these responsibilities, as has been the case for an extended period.
2. Secondly, and conversely, the advancement of medical technology since the late nineties of the twentieth century, coupled with an increasing predominance of the biomedical model, poses a significant challenge for professions associated with the social realm, relegating them to the periphery (Healy, 2016). The biopsychosocial model emerges as a response to address all those dimensions that are overlooked by the biomedical model (Engel, 2003). The interest that the initial social workers placed on the individual and their surroundings, on social determinants, public health, and prevention, is more imperative than ever. There is a trend toward medicalizing social problems, concentrating on individual pathology while marginalizing the root causes and social determinants. The emphasis placed by the early social workers on the environment and prevention can serve as a guiding principle for contemporary social workers intervening in the health sector.
   Paradoxically, the neglect of psychological and social aspects by medical science represents a failure in terms of the efficacy and efficiency of health services. In the North American context, for instance, where there is notable technological advancement, growing concerns arise regarding the inaccessibility of certain vulnerable populations to health services due to factors such as income, ethnic or cultural origin, age, sexual orientation, or geographic isolation. Many individuals still lack health insurance, facing challenges in accessing health services. Moreover, new contexts, such as those related to "diseases of affluence" (Pickett and Wilkinson, 2015) such as overweight, hypertension, diabetes, etc., further complicate the landscape.
   Despite the significant advancements in biomedicine, the perspective of the first social workers becomes increasingly crucial, creating new scenarios for intervention. In this context, social workers must undergo training in matters related to the biomedical technology revolution. This is essential for acquiring a critical stance towards these advancements and maintaining the ability to sustain a holistic and ethical model of social intervention (Healy, 2016).
3. Thirdly, we should reflect on the administrative and welfare drift of social work and reclaim the traditional role of the profession in the field of health. This drift could go hand in hand with a deprofessionalization of social work (Healy and Meagher, 2004).
   Healy and Meagher (2004, p. 245) use the term deprofessionalization to refer, first, to the fragmentation and routinization of direct care, affecting the use of creativity and reflexivity of practice. Second, to refer to the growing loss of professional categories, which are occupied by other less qualified and less well-paid qualifications. And, third, in relation to "paraprofessional" jobs where social work skills and knowledge are not required or fully utilized.

One of the elements that can help combat this deprofessionalization is to return to the origins and reclaim a professional identity that was at the forefront of new models of social care. Again, if social work abandons its specific areas of intervention and is unable to point out its professional potential and specificity, other professions will take over, as has historically been the case.

5. References

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