Urban Health: A Tale of Two Cities

New York Became what Amsterdam once Was

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NYC.
Photo by
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The Dutch, or more precisely a mission from Amsterdam in search of a short route to their eastern colonies, established a settlement on an island in the mouth of a river; they are now called the Hudson River and Manhattan, New York. This article describes one aspect of the long relationship between these two cities, i.e. the issue of urban health.

In the early sixteen hundreds Amsterdam was a major European city. International trade, a harbour where ships arrived laden with goods from the colonies, and a golden age in art and architecture together with religious and political freedom made the city wealthy and dynamic. In the seventeenth century about half of the population originated from elsewhere. Immigrants were interested in the opportunities the city had to offer, and in their turn they were vitally important in enabling Amsterdam to maintain its international position. The comings and goings of foreigners in Amsterdam led to a unique development: freedom of religion and a concept we now call tolerance.[1]

'New Amsterdam' started as a trading settlement for beaver fur. The city of New York as we know it today began to flourish in the nineteenth century, long after the Dutch had left. By then Amsterdam was already in decline and had lost its international position. Now it was New York that became the city where people came to try their luck. Europeans weary of Europe's limited horizons and religious wars moved to this city of promise where the Dutch once had managed to establish a viable settlement on Manhattan Island. In the early twentieth century many African Americans from the south of the US settled in the district called Harlem. New York had become a world centre. It is still a leading city in global economics and still a centre of the arts, culture and education. Like Amsterdam in the seventeenth century, New York succeeded in integrating the various groups of newcomers. Amsterdam is now a small metropolis, but it still has the characteristics of a big city. It appears that the ingredients which determine the importance of cities have not changed much since the seventeenth century: factors like migration, international trade and a leading role in the world of education, arts and culture, to name just a few.

By 1940 New York had become the first urban area in the world to have more than 10 million inhabitants – a trend followed by many other cities in the twentieth century. As of 2008 more than half the world's population lives in a urban environment. This urban setting naturally has an enormous impact on people's behaviour, emotions, and health. Cities have become concentrations of deviant behaviour as well as of scholarship and power. We have long been familiar with the images of poverty, violence, homelessness, and the drug-addicted or mentally ill wandering the streets of urban areas. In fact, cities continue to offer two extremes: possibilities of exploiting one's talents for those with the resources and strong social networks, and the impossibility of survival for those without those advantages. Even back in the nineteenth century governments realised that these extremes had an enormous impact on the health of their urban populations, and so they founded institutions like the Department of Health and Mental Hygiene in New York City and the GGD (Medical and Mental Service) in Amsterdam. Their mission was, and still is, to promote, protect and enhance the health of their citizens. In both cities, these institutes are still active in promoting public health policies, providing health care, organising preventive programmes and conducting scientific research. An important element in their work promoting physical and mental health is the need to reflect social norms and values in the societies they serve. Many contemporary views on mental health practice, however, are not new but reflect long-standing values developed in the 1960s. In the sixties Folta and Schatzman[2] already published an article stating that good public (mental) healthcare should meet the following conditions: care should be urban based and orientated. It should be easily accessible, and outreaching, and be a part of the social structures in the neighbourhood. And it should be care for the vulnerable citizens of the city. These conditions still apply. In this article we will compare urban mental health and substance abuse care in New York and in Amsterdam. In doing so, we recognise that globalisation and its effects on mental health are crucial. However, it is impossible to give a complete picture, because public mental health is a complicated combination of medical, scientific, social, and political factors. Nonetheless, this will be a tentative sketch describing how to deal with these issues.

Urban mental health: the city as a monster?

Cities not only provide numerous opportunities, they are also home to many groups of severely marginalised people.[3] Every city has neighbourhoods that are known for violence, poverty, poor health, poor housing conditions and pollution. The incidence of addiction and psychiatric disorders is higher in cities than in rural environments.[4] Rates of psychiatric disorders such as depression and psychosis are considerably higher in urban environments.[5] One might question why this incidence is so much higher. Do cities make people ill? Or are mentally ill people drawn to the cities?[6] Over the last 40 years several high-profile research projects worldwide have focused on those questions and have shown that the city is, on the one hand, a risk factor for mental and somatic illness while, on the other hand, it is also a magnet for those who are 'different.' People can live anonymously among masses of people, and there is greater tolerance of differences. Cities also have more healthcare treatment facilities. New treatments find scope to experiment more easily in cities than in rural environments. In general, the risks caused by city life are a complex combination and interaction of various factors which will be mentioned later.

From the nineteenth century on, people have had their prejudices about cities: the city as a dark uncontrollable monster or on the contrary a seducing nymph. One cliché is that cities are uncontrollable, dirty, and violent. The city doesn't care about the individual, and many people live in poor conditions with no future prospects. Cities had and still have their dark corners. As for mental health: growing up and living in an urban setting increases one's chance of experiencing a psychiatric disorder. It is not clear just why the incidence of mental illness continues to rise in urban areas and at what level it will peak, but given that humans are biological, social and psychological creatures, the answer must lie in the complex interplay of these three factors. The risk of developing schizophrenia, for example, is more than three times higher in an urban environment than in a rural environment.[7] Other disorders too, like mood and anxiety disorders, exhibit the same tendencies. Migration is another factor associated with an increased incidence of mental disorders.[8] Since most migrants move to cities, those cities have in them many people suffering from schizophrenia, depression, and other mental problems.

Although cities contain more people with psychiatric illnesses, those same cities also offer greater possibilities. The vibrant scientific, economic, and cultural life provide opportunities which do not exist in rural areas. Thus it is doing cities a great injustice to portray them only as unmanageable, cruel, and disease-promoting.

Addiction and cities: a challenge for public healthcare

Cities are the places to rock and roll, and drugs are always available. Although not everyone who uses drugs becomes a drug addict, the people who do get addicted are likely to live in cities.

In general, addiction is associated with a lifestyle that is likely to include financial problems, homelessness, criminality, and many related physical health problems. Mental illness, too, is often linked to addiction. Conditions such as schizophrenia, bipolar disease, and depression are important triggers for

drug use and make it more difficult to stop. Drug use is often a self-medication for people suffering from psychiatric disorders. Heroin, marijuana, cocaine, and alcohol are examples of the types of drugs people tend to use as self-medication. The combination of these problems in one person can result in the marginalisation of those affected. Marginalised populations in New York and Amsterdam have a great deal in common. In the 1970s, heroin became popular. Later other drugs such as speed and crack cocaine came into fashion. In the 1980s the AIDS epidemic came and hit this group hard. These patients were often marginalised, locked up, or simply died. They caused trouble in the cities through, for example, robbery, violence, and homelessness. These groups of people almost never come and ask for help. Health or government institutions are deeply distrusted and to reach them professionals have to be innovative and persistent. To solve these enormous problems, the (local) governments have had to find a way to cope with this group.

Amsterdam. Photo by Wilco Tuinebreijer.

In both cities local policy is crucially important in dealing with this problem. The GGD in Amsterdam and the Department of Health and Mental Hygiene in New York play key roles in the way the two cities cope with this problem.

In the last decade we have learned that addiction and other psychiatric illnesses arise from an interaction of biology, genes and social factors. The social factors of poverty and marginalisation have a disastrous effect. The teenage mother who has three kids by the age of nineteen is likely to be uneducated, traumatised and depressed, with few opportunities to raise her children competently. They in their turn will not finish their education, have the same genetic make up, and in the end will suffer from the same mental problems. One of the challenges for public healthcare is to break this cycle.

New York vs. Amsterdam: health as a government responsibility?

The Dutch have enjoyed an open and tolerant society for centuries, and there is a long tradition of democratic discussion on important religious and societal themes. When drugs and HIV infection rates started to become serious, politicians and doctors quickly tried to control the damage.

Various strategies were followed. One example: the GGD opened outdoor clinics for addicts. People could get methadone and, later, prescription heroin in these government-financed clinics. The primary aim in these treatment strategies was harm reduction, which means that abstaining from drugs was not the main goal of the treatment.

In the United States similar initiatives were set up. However, in the US harm reduction is not embraced as it is in other parts of the world. For example, federal money cannot be used to support syringe exchange programmes. Additionally, many local municipalities have outlawed syringe exchange. Consequently harm reduction programmes such as this are thin on the ground even in New York City (it has eight syringe exchange programmes to serve a population of 19 million people).

Over the past few years, professionals from the GGD and Montefiore Medical Center/Albert Einstein College of Medicine in the Bronx, New York, have been visiting each other to learn from each other's programmes. There are similarities, but also enormous differences.

One striking difference is the scale: Amsterdam is a city of slightly over one million people while the Bronx is a neighbourhood of almost two million inhabitants within New York City, which itself has 19 million residents. The Bronx is a poor neighbourhood with a concentration of the problems described above. It is the epicentre of many epidemics, including drug use, violence, joblessness, frequent imprisonment, young single mothers, and HIV/AIDS. The concept of harm reduction has been accepted and implemented more in New York City than in many other parts of the US. Here, for example, one can see cases of opioid addiction, HIV and mental illness all being treated within one clinic or medical facility. Additionally, many healthcare facilities also work together with community-based organisations in an effort to address the complex needs of marginalised individuals. Visit the clinics that care for such marginalised humanity and you will find the waiting rooms packed with people, from young mothers to the elderly, all waiting to see their nurse, social worker or doctor.

If you drive, walk, or take the subway through the South Bronx, you are likely to be impressed by the energy and liveliness all around. Music with its roots in South America, Africa, and the Caribbean can be heard everywhere. The atmosphere is reminiscent of Latin countries around the world. You'll find cultures and people from South America, Central America, the Caribbean, Spain, Portugal and Africa blended together into a culture that is typically Bronx.

When you see the endless expanse of red-brick buildings containing small apartments packed with people you realise that behind those windows there must be enormous numbers of people with problems like addiction, mental illness, poverty, and violence. There is no way you can register every sufferer, every woman violated by her boyfriend or husband, or every youngster who drops out of school only to embark on a criminal career. And for a young person from a subculture that provides few opportunities, becoming a doctor, scientist,

or politician is almost unthinkable and unattainable. And yet behind much of the pain and problems in the South Bronx, one finds people who have incredible strength and survival skills. Watching these people navigate or 'work' the streets, the welfare system or the healthcare system shows how those survival skills have allowed them to survive what many would succumb to – poverty, violence, mental illness, and drug abuse.

In Amsterdam, the neighbourhood most comparable with the Bronx is the Bijlmer. Built in the seventies; cheap but nice apartments inhabited by incomers, people who came to the Netherlands for a variety of reasons. People from Surinam came after that country became independent and then became embroiled in an economic and political crisis. But it was not only people from Surinam who came in an attempt to make a living; people from all over the world who came to try their luck settled in this neighbourhood, and multiculturalism is its hallmark.

On a hot summer day the atmosphere of both neighbourhoods is much the same; the same food-smells, music, endless large apartment buildings, and of course the same drugs. In both neighbourhoods opiate addiction is a major problem, possibly more than psychiatric illness. Because of this, the focus of health-care tends to be on addiction and deviant and criminal behaviour, with psychiatric problems being overlooked.

Despite the similarities between New York City and Amsterdam, there are also many differences between the two cities. In the Netherlands, considerable efforts are made to prevent individuals from becoming marginalised. There is a rigorous public health system responsible for individual healthcare. It starts with paediatric care, the vaccinations children have to receive, compulsory education and the amount of help offered when things go wrong. Another example is the collaboration between the police and the GGD. Twenty-four hours a day, the police can request the assistance of a health professional. General practitioners and trained psychiatric nurses see anyone the police wants seen. Psychiatric screening and admission to hospital are also available around the clock.

It is important to realise that these services are part of the GGD and as such part of the municipality. Nurses, doctors and psychiatrists are civil servants, the budget is funded partly by the government and partly by the health insurance companies. It is all part of the conviction that public (mental) health is a government responsibility.

Attitudes and policies in the U.S., and specifically in New York City, are quite different. Given its history and economic characteristics, much less support is provided to prevent individuals from becoming marginalised. There are clear demarcations between the healthcare, criminal justice and education systems. Problems often arise that concern more than one of these systems, but these have to be formally addressed in just one arena – with the result that they are never properly resolved. For example, drug use is frequently treated as a criminal justice matter, with no offer of medical intervention. Similarly, psychiatric problems are dealt with in different locations and by different medical professionals from other medical fields. This is most apparent when we consider how treatment for substance abuse, mental illness and medical problems is financed and structured – they are all covered separately and in different ways by health insurance companies, treated by different doctors, and treatment takes place in geographically different locations.

In recent decades advances in the medical sciences have been enormous. New information has become available on the relationship of the individual with his/her external world and the interaction between genes and environment as it relates to mental illness. Increasing neurobiological medical and sociological knowledge provides us not only with a more scientific view of the development of addiction and mental illness but also with new evidence-based treatments.

If you visit a city on a number of occasions you will never visit the same city twice, because we live in an age of speed, in which new information affects all our lives. Given our new knowledge of the gene-environment interaction and the effects of marginalisation, modern communications and the internet in particular make it possible to share new findings rapidly and to exchange information easily. These findings are important to allow us to develop methods of care which are based on scientific knowledge instead of prejudice or (political) trends. In a fast-moving society, the notion of 'ideal care' for those who are vulnerable does not exist.

NYC. Photo by Annaleen Louwes.

An example of this is the enormous amount of paperwork which has to be done if you want to provide financial assistance to a patient. In Amsterdam the collaboration between healthcare and social services is simplified by locating programmes that address these services together in one building. In New York this is not the case; different offices work independently of each other, with little or no communication between agencies. An interesting recent development is that both cities are now investing in housing for those who are marginalised by reason of addiction or mental disorder, or by a history of detention which is

often linked to the previous two. Research shows us that people in accommodation are more able to accept and continue with their recommended healthcare, and therefore housing facilities are made available in both cities. The difference is however still the scope. In Amsterdam, housing facilities have been developed on a large scale. In New York, the recent focus has been on developing short-term solutions. That city, for example has special programmes that provide designated housing for homeless people with HIV. Other marginalised individuals often receive no support.

Sharing knowledge

New York and Amsterdam have a long relationship. In the twenty-first century they are both metropolises, with all the advantages and disadvantages of big cities. We have seen some of the similarities and differences between them in the field of public (mental) health. Each has found its own ways of creating solutions for those of their inhabitants with mental health and/or addiction problems. Some of them are strikingly similar, others very different. With globalisation now a major phenomenon in our world, regional solutions are becoming obsolete. Sharing knowledge and practical experience of what seems to work and what doesn't can be useful for healthcare providers, scientists, and politicians; and this is one of the reasons why these two cities should enjoy, profit from and nurture of their relationship. ■

NOTES

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9. Since several years the Montefiore Hospital, part of the Einstein College of Medicine in The Bronx, New York City, exchanges knowledge and experience concerning urban health issues with the GGD. In the year 2009, the Hudson celebration year, a conference will be organised to celebrate both: the 400 year-old relationship between the two cities and the exchange concerning urban health issues. Experts from New York and Amsterdam will present the similarities and differences in the challenges this subject poses (www.henryhudson400.com).

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