Community Mental Health Systems in the United States and Cuba: A Comparative Analysis

Tiffany Smith

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University of Pittsburgh

Mental illness is present across cultures, though its prevalence, prognoses, and methods of treatment vary across the world. The United States, commonly regarded as the richest country in the world, uses a capitalistic system of care that relies on insurance reimbursement (for those who can afford it), while Cuba, a small, poor communist country, operates a socialized healthcare system, where healthcare is free for all citizens. Obviously, this creates differences in the perception and treatment of all illnesses, including mental illness. This research explores the similarities and differences between the prevalence and treatment of mental illness in the United States and Cuba.

### Prevalence of Mental Illness

It is estimated that one in four adult Americans (nearly 62 million people) experience mental illness each year. Nearly 18 million live with a serious mental illness such as schizophrenia, depression, or bipolar disorder (National Alliance on Mental Illness [NAMI] 2013). Individuals experiencing or living with mental illness are at greater risk for experiencing homelessness, chronic medical conditions, hospitalization, and incarceration (Substance Abuse and Mental Health Services Administration [SAMHSA] 2011). Unfortunately, the most readily available data on mental illness in Cuba assesses Cuban-American immigrants, specifically those from the infamous 1980 Mariel boatlift. Rates of mental illness in that population are high, with about 15% having schizophrenia and 9% meeting criteria for alcohol abuse (Silver et al 1985). It was difficult to find statistics on the prevalence of mental illness in the Cuban population.

Much research on mental illness in Cuba focuses on alcohol use as the "number one problem" (Gorry 2013). With the legal drinking age set at 16 years old and the availability of alcohol at 24-hour liquor stores near an abundance of bars, it's not surprising. It is culturally acceptable to go out with your friends, grab a bottle of rum, and stay outside in Havana drinking

all night. The Ministry of Public Health (MINSAP) operates a national substance abuse hotline

that concerned family members or others may call for information about services available

(Ibid). Estimates place the prevalence rate of depression at 25% (Gorry 2013) and the rate of

suicide at 14 per 100,000 (WHO 2011). The rate of dementia is also a concern because of the

rapidly aging population; its rate is about 8% (WHO 2011).

Because mental illness often co-occurs with social problems and medical conditions,

many of which we know to be preventable, we see these factors combine to create a disability in

the person, resulting in a greater need for expensive care. In the United States, mental health care

is estimated to cost over $147 million each year (World Health Organization [WHO] 2004). In

fiscal year 2012, Cuba spent 6 billion pesos on its healthcare system (Dr. Anicia Garcia, personal

communication, 3/12/14). The longer a mental illness persists untreated, the greater the potential

for long-term disability and the greater the overall cost, both to the individual and to society as a

whole. Reduced productivity, lost employment, premature mortality, the negative impact of

stigma and discrimination, and the impact on families and caregivers are other immeasurable

costs of mental illness.

## History of Mental Health Treatment

Both America and Cuba have a legendary history of institutionalizing the mentally ill in

appalling conditions. In America, state hospitals became a place where the unwanted and the

insane were warehoused, often staying for decades. As the American public became aware of

some of the more extreme treatments being used (electro-shock therapy; lobotomy) and the

conditions of some hospitals, calls for the closing of these facilities began in force. In response,

President Kennedy signed the Community Mental Health Act (CMHA) of 1963, intended to

promote mental health & wellness by acting as a catalyst for the deinstitutionalization of the

mentally ill which occurred through the second half of the 20th century. The Act provided grants to the states in order to establish community mental health centers to serve those being discharged from state mental hospitals. While preventive and well-intentioned in nature, CMHA was not well supported and underfunded, resulting in lesser availability of community resources to those being discharged from state mental hospitals. As a result, many former patients of these hospitals ended up with their families, homeless, or in other residential facilities that were ill-equipped to deal with their mental health needs (Goldman & Grob 2006).

Cuba's first public psychiatric institution, Mazzora Hospital, began accepting patients in 1864. This facility housed about 3,000 patients and about 14 staff (Camayd-Freixas & Uriate 1980). Due mainly to a lack of educational opportunities for those who worked with the mentally ill, most patients did not receive any real treatment. During the Republican period of the early 1900s, education was more widely available from Europe, and psychiatry began to develop as its own discipline; however, 88% of the country's psychiatrists and 97% of its psychiatric beds were located in Havana (Basauri 2008). With the creation of the national health system after the 1959 Revolution, aggressive training of new doctors was initiated, and all were required to participate in Rural Medical Social Service for a period of six months. Thereafter came the implementation of policlinics across the municipalities, and then the system of community family physicians. Furthermore, psychiatric units were developed in the medical hospitals, outpatient programs were developed, and community mental health centers were founded by psychologists in coordination with the policlinics (Ibid). This community-based model of mental health care was derived from a biopsychosocial model with an emphasis on prevention, which promoted inclusion of all and treatment of the whole person. Due in part to the economic crisis of the "special period," community mental health treatment underwent some changes beginning in

1995. The number of available beds in psychiatric hospitals was decreased and substituted with an increase in community mental health centers. Teams at these centers consist of psychiatrists, social workers, psychologists, nurses, occupational therapists, and special education therapists (Basauri 2008). These teams work closely with the community physicians and the local policlinics.

### Community Mental Health Treatment: Systems & Outcomes

**Systems.** The mental health system in the US is extremely fragmented and difficult to navigate. While the deinstitutionalization movement of the mid-twentieth century had the best intentions of integrating individuals with mental illness into the community, appropriate support has not been provided in terms of therapy, housing, or financial support. Drop-in centers, assertive community treatment (ACT) teams, and outpatient therapy centers have attempted to fill these gaps; however, many individuals with mental illness end up homeless, in prison, or regularly present to hospital emergency rooms to meet their basic needs.

In Cuba, access to care and treatment of mental illness has been available to all Cubans since the implementation of the national health system (Dr. Jorge Ramon, personal communication, 3/11/14). This system consists of community physicians, policlinics, and psychiatric hospitals (outlined further below). In 2011, Cuba's health care budget was 617 pesos per capita (Dr. Anicia Garcia Alvarez, personal communication, 3/12/14) A National Association of Social Workers (NASW) delegation to Cuba in 2011 noted several strengths of the Cuban mental health system, including the infiltration of doctors in the community, the mandatory yearly frequency of visits between doctor and patient, and the accessibility to care. The United States spends half what Cuba does (25% of GDP) on education and healthcare (NASW 2011), and both are free to Cuban citizens.

In America, so-called "drop-in centers" are community mental health organizations where people dealing with a mental illness can come and interact with peers, access case management and basic therapy, and integrate themselves into community activities. Outpatient therapy is often provided in private practice or in designated mental health organizations, and can be difficult to access due to high cost and difficult accessibility. Assertive community treatment (ACT) teams are one service of larger mental health organizations. These teams serve chronically severe mentally ill persons in the community who may be living independently, in group homes, or in and out of the hospital. Services such as medication monitoring, case management, therapy, and community integration are provided by a psychiatrist, therapists, alcohol & drug specialists, vocational rehab specialists, nurses, and peer specialists (Allness & Knoedler 2003).

Since 1985, Cuba's healthcare system has become more integrated in the community (Dr. Jorge Ramon, personal communication, 3/11/14). The first level of public health care consists of the family doctors, who often live in the community where they work, and the "Policlinicos," which cater to specific needs such as x-rays, blood work, and physical therapy. Each family doctor is the first point of contact for issues of physical and mental health for a set number of local families. These patients undergo a "person-in-environment" assessment to determine diagnosis and a goal plan for treatment. The doctor may then refer the patient for specialized treatment at the policlinic or at a community mental health center. The first point of intervention for an individual with mental illness is that person's family. The objective is to improve community well-being, and assist the individual in functioning well in the community. Social workers, nurses, and doctors engage in community psychoeducation to determine how the family and community can assist the individual in question. The family doctor in the community is

continuously aware of which patients in his area are suffering from mental illness, as it is his/her responsibility to stay in touch with the individual and their family to ensure their well-being (Dr. Jorge Ramon, personal communication, 3/11/14). Hospitalization is a last resort, and is only considered necessary when the person is an imminent threat to themselves or others. Today, Mazzora Hospital is known as the Psychiatric Hospital of La Habana, and serves about 5,000 chronically mentally ill patients with about 1,700 staff members. The focus is on intensive rehabilitation for those who have had significant relapses in the community that were unable to be remediated by community mental health programs (Camayd-Freixas & Uriate 1980).

Since the treatment of mental illness in America has traditionally been shared unevenly by the social welfare, criminal justice, and medical systems (Mechanic & Grob 2011), coordination and streamlining of services would be a more effective means of preventing mental illness and controlling risk factors. In the 1980s, President Reagan transferred responsibility for treating the mentally ill back to the states by providing block grants (Goldman & Grob 2006). This has resulted in a broken system, one in which only one-quarter of adults with serious mental illness are served by state mental health agencies. Even though need rises during times of economic or other crisis, states usually respond by cutting the budget for mental health agencies and other services which contribute to the prevention of mental illness, such as education, housing, nutrition, and other resources. While Medicaid is the biggest provider of mental health treatment, it is burdensome for states to bill and get reimbursed for services under this program (NAMI 2009).

In Cuba, there are 115 dedicated community mental health clinics (Dr. Jorge Ramon, personal communication, 3/11/14). Clinics in different municipalities have different priorities; however, their main goals are community psychoeducation, as well as individual social &

occupational rehabilitation, and daily living skill training for the patients. They employ nurses, social workers, and psychiatrists who attempt to involve local social institutions in the care of community members. Social workers or nurses may visit schools to identify children at risk for emotional or behavioral problems, or educate teachers about illnesses children may have and work with them to help the children take their prescribed medications (Ibid). Social workers and nurses may also work to educate community members about illegal drugs, as well as the health detriments of alcohol and tobacco use. Staff of the mental health clinics are encouraged to further their education and hone their skills. Empathy and caring are important facets of care emphasized and taught to all healthcare staff.

The World Health Organization (WHO, 2011) has data on the number of mental health facilities available in Cuba, but not on how many patients have been treated, other than in outpatient clinics. According to WHO's Mental Health Atlas, Cuba has 1,151 psychiatric beds in its medical hospitals and 6,505 beds in its 24 psychiatric hospitals. A publication by the Cuban Ministry of Public Health reports that there are 17 psychiatric hospitals in the country, with 0.3 per 100 persons admitted (Anuario Estadistico de Salud, 2012).

In general, citizens come to the mental health clinics for counseling and information about a variety of concerns, including parenting and marital relationships as well as psychiatric symptoms. The family doctor in the community refers any patient with psychosis to these mental health centers for treatment. The psychiatrist at the clinic works with the patient's family to create an action plan for treatment. Psychopharmacologic treatment is very basic, as access to drugs is limited. Electro-shock therapy is rare. Basic antipsychotics, antidepressants, and anti-epileptic drugs are available in limited quantities. An injectable antipsychotic, such as fluphenazine decanoate (Prolixin) is available and is ideal to use because the patient only has to

come to the clinic every few weeks (Dr. Jorge Ramon, personal communication, 3/11/14).

Mediations are only used in the most severe of cases; otherwise, homeopathic remedies are

sought.  The mental health clinics do not provide formal therapy or group treatment, nor do

patients usually have access to peer support in the same sense as in the Unites States. Most

therapy is provided in the form of art, music, yoga, and other cultural activities. The only

exception is in the case of alcohol treatment; clinics often have mutual help groups, such as

Alcoholics Anonymous (AA) for patients who voluntarily seek treatment. However, family

therapy and psychoeducation, as well as vocational rehabilitation, are effective in supporting the

individual in the community in terms of mental health and substance abuse treatment. The family

is responsible for the quality and amount of social interaction the individual partakes in.

Furthermore, the government provides paid employment for symptomatically stable individuals

with mental illness. If the patient lacks family support, the government will provide a food and

housing subsidy, though housing in this case will usually come in the form of a psychiatric

hospital (Dr. Jorge Ramon, personal communication, 3/11/14). Most communities also have

dedicated centers for the elderly, which hold day programs to encourage social interaction,

exercise, and participation in the arts.

Forty-five percent of American suffering from mental illness cite cost as a barrier to

seeking treatment, even when they had health insurance (Kliff 2013). Until around the turn of the

21st century, people with mental illness had many additional barriers to obtaining care. The

Wellstone-Domenici Mental Health Parity and Addiction Equity Act passed in 2008,

representing the most significant federal effort to create mental health parity. This means that

insurance benefits for mental health services can only be restricted or financially limited to the

same extent as physical health services; there cannot be less coverage for mental health services

than physical health services. Under the Wellstone-Domenici Act, deductibles and copayments, as well as treatment limitations such as frequency of services or number of visits to behavioral health providers, cannot be limited more than the same benefits for physical health. Additionally, access to mental health services will become even more widespread over the next five years thanks to the Affordable Care Act (2010). This health care legislation ensures that consumers will have access to health plans that cannot deny people with "pre-existing conditions," such as mental illness or a substance use disorder. These health plans will also be more accessible to people with mental illness who do not already receive Medicaid, as they will not have to be obtained through an employer, and there will be a marketplace of more affordable options. Marketplace health plans will cover counseling, psychotherapy, inpatient treatment, and medications (Healthcare.gov). These changes go a long way to helping people with mental illness obtain treatment; however, prevention would still be the ideal way to reduce healthcare costs related to mental illness, both for individuals and for the general population.

**Outcomes.** Research has found significant differences between people diagnosed with schizophrenia in the United States versus Cuba. Vandiver (1998) found that Cuban patients were more likely to live with a family member or a spouse (and thus have social support), and were more likely to be employed than patients in the United States. Cubans also reported a higher satisfaction with their quality of life than Americans. However, Cuban men were more likely to indicate high levels of support and satisfaction than Cuban women; this was hypothesized to be due to the extra societal pressure put on Cuban women to maintain the household and family, as well as their own health (Ibid).

In Cuba, about 58% of psychiatric hospitals patients stay more than 5 years; 21% stay between 1-5 years; and 21% stay less than one year (WHO 2011). Comparable rates in the

United States are unknown (Ibid). Comparison with the United States is best achieved by looking

at the rates of treatment per 100,000 persons. The number of patients treated in outpatient

facilities in Cuba is about 7,617 per 100,000 compared with about 932 per 100,000 in the United

States. The rate of admissions to psychiatric hospitals in the United States is about 257 per

100,000; the comparable rate in Cuba is unknown (WHO 2011). However, Cuba has about twice

the available outpatient facilities that the United States does, and nearly 23 times the available

beds or spaces in community residential facilities (Ibid).

### Lessons the U.S. & Cuba Could Learn From Each Other

Cubans have greater access to healthcare and community mental health treatment than

Americans, both in terms of cost and accessibility. The greatest detriment to those suffering from

mental illness in Cuba is their lack of integration into mainstream society. In the most basic

sense, public facilities in Havana are not accessible to people with disabilities. There are not

usually ramps available to easily cross the street or enter buildings. Rarely does one encounter a

person with a physical disability on the street. Most people experiencing mental illness or

disability are sheltered in their family homes where they can be safely cared for (Dr. Jorge

Ramon, personal communication, 3/11/14). Much as there is already advertisement in the Cuban

media about vaccinations for children and the dangers of tobacco use, so there needs to be

advertisement about the signs of mental illness. Just as there is community advocacy about the

proliferation of illegal drugs, there needs to be advocacy for community members to step

forward to acknowledge their neighbors living with mental illness or addiction and help them

integrate into the community at large.

Both Cuba and the United States could benefit from a reduction in stigma against the

mentally ill. Two types of mental health stigma have been identified by research: public stigma,

which includes prejudice and discrimination among the general population; and self-stigma, which is the internalized prejudice a person with mental illness may experience (American Psychiatric Association 2012; Corrigan & Watson 2002). Both can cause harm to people experiencing mental illness. Corrigan and colleagues (2012) published a report about stigma based on 72 studies representing 14 countries and nearly 40,000 people. They found that three strategies are effective in reducing stigma: education to reverse stereotypes; protest or activism targeting stigma; and contact with individuals with mental illness. Furthermore, the study found that direct contact was more effective for adults, whereas education was more effective for youth. Both were more effective than media interventions.

The United States could benefit from a media awareness campaign similar to those already used in Cuba for chronic medical conditions. Mental health advocacy organizations need to promote in-person educational initiatives, both in school settings for youth and in public settings for adults. While many organizations now provide diversity trainings, mental illness is not often included along with issues such as culture, religion, ethnicity, or sexual orientation. Recently, there has been an emergence of training programs in Mental Health First Aid (MHFA), appropriate for family members, teachers, emergency workers, human resources professionals, managers, and community human services professionals (National Council for Behavioral Health, 2013). And MHFA certification provides training in substance-related disorders, mood disorders, psychosis, eating disorders, and self-injury. It also provides crisis intervention training for issues like panic attacks, overdoses, psychotic episodes, or suicidal behavior. Large cities such as New York and Philadelphia have already trained public service and emergency workers in MHFA, and legislation providing funding for MHFA training is being passed in many states. At the federal level, the Mental Health First Aid Act of 2013 (S. 153/H.R. 274) would authorize

$20 million to fund training programs across the country. Though it would only provide a simplistic training on the signs, symptoms, and impact of mental illness, it would increase public awareness and contribute to stigma reduction in the public sphere.

The United States could most certainly benefit from a more socialized healthcare system and the implementation of a biopsychosocial model of treatment. It would be easier to begin with small steps, such as integrating a routine mental health screening in primary care. The Surgeon General's National Prevention Council (2011) recommends that Americans attend an annual checkup with their primary care physician, the purpose of which is to assess and prevent major medical illness. However, there is no standard in the United States for a routine assessment of mental health and illness. Most Americans present physical and mental health problems to their primary care physicians (PCP) or family physician. In fact, nearly 20% of the patients a PCP sees has symptoms of a mental illness, but only 50% of these are properly detected in the primary care setting (Baca et al 1999). Furthermore, a study by Luoma, Martin, and Pearson (2002) found that 75% of suicide victims had contact with their PCP within the year of suicide, and 45% had contact with their PCP within a month of suicide. This clearly indicates the need for integration of mental health services into primary care.

The Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ; Primary Care Evaluation of Mental Disorders; Pfizer Inc, New York, NY) is a questionnaire developed to assist primary care physicians in screening for mental illness. The questionnaire can be read aloud by the physician, or self-administered by the patient in about eight minutes. It assesses for eight DSM-IV diagnoses, including major depressive disorder, anxiety disorders, panic disorder, and bulimia nervosa (Spitzer et al 2000; Hahn et al 2000). One problem identified in using the PRIME-MD/PHQ is the lack of follow-through. While it has

been found to be useful in identifying patients with mental illness, it does not often lead to

therapeutic intervention or referral (Spitzer et al 2000). Other problems with screening for mental

illness in primary care include time limits of the PCP visit, competing medical/health concerns to

be addressed at the visit, and the payment structure for completed mental health screenings or

interventions. Natural obstacles such as unwillingness of patients to discuss mental health issues,

cultural differences and stigmatized perceptions of mental illness, even among physicians, could

be obstacles to implementing this type of care.  One suggestion to address these issues would be

to integrate social workers into primary care settings. They would be able to perform a quick,

comprehensive screening, provide necessary referrals, and ensure that physicians and nurses still

have time to complete their necessary assessments. This would also influence the

implementation of a person-in-environment perspective in American healthcare.

The United States could also learn from Cuba's system of intervention in schools to

identify children at risk and educate teachers about mental illness in children. The "Student

Support Act" (HR 320) is a bill designed to create additional mental health support for children

in public schools by providing at least $1 million in additional state grants for schools to hire

additional school mental health providers and supports. This act will amend the Elementary and

Secondary Education Act of 1965. The goal of this legislation is to reduce the minimum

provider-student ratio in schools to (1) one school counselor for every 250 students; (2) one

school psychologist for every 1,000 students; and (3) one school social worker for every 250

students. The insertion of more mental health professionals into schools is intended to increase

feelings of safety for students, teachers, and parents, as well as to increase the likelihood that a

child's mental illness (or symptoms thereof) will be recognized and treated before adverse

consequences, such as violence, occur. The bill text also states that the program hopes to result in

"reduced school suspensions, reduced referrals to the principal's office, reduced the use of weapons, force, and threats" to address the issue of school safety in general. Furthermore, mental health support may increase students' learning capacity, to assist teachers and other personnel in recognizing warning signs, and to encourage parents to be involved in the provision of mental health services. Having more mental health providers in schools could reduce the burden on parents to find outside counseling or intervention as well; those families who may have trouble affording help for their at-risk children would be able to more easily access the care they need for their children.

Finally, the United States could benefit from a greater emphasis on family as a support system for the mentally ill. With a reduction in stigma and increased support, more family members may be willing to care for their ill relatives and realize there are resources available to assist them. Parents especially play a key role in early intervention and prevention of mental illness in children and youth. For those who can afford to obtain prenatal care and regularly visit a pediatrician, it would make sense to provide information on "early warning signs" of mental illness to parents in a nonthreatening manner. Offering further resources, such as parenting classes, screening tools, and referrals to mental health programs for children would be beneficial. Furthermore, postnatal care is an appropriate time to assess parents for signs of mental illness (Elliot et al 2000). As with primary care settings for adults, it would be beneficial to integrate social workers into pediatric and obstetric/gynecological practice. What must also be considered is the effect of life circumstances on health and mental health. Cuts to public assistance programs such as SNAP or TANF do more harm to families than good; poor nutrition, unsafe living conditions, limited access to healthcare, and poor education can all contribute to the development or worsening of mental health (Prince 2007). In short, mental health and physical health are

intrinsically related.  In greatest part, this comprehensive approach to treatment of the person

would take a radical shift of consciousness in our country to an all-inclusive, humanistic

perspective that emphasizes the inherent dignity and worth of all people.

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