THE MENTAL HEALTH NEEDS OF CUBAN ENTRANTS AND HAITIAN ENTRANTS AND PROSPECTS FOR SELF-SUFFICIENCY

Between April and November of 1980, 124,779 Cubans arrived on our shores. Castro, in an attempt to verify his claim that only the disaffected and undesirables in his country would want to leave, loaded up that immigration with persons who were mentally ill, criminal elements, and social deviants. Haitians boat people, fleeing for political and economic reasons began appearing on our shores in large numbers.

These persons just missed being included in the 1980 census by a few weeks, but we know they are here. Dr. Alejandro Portes, from John Hopkins University, is conducting a study of Mariel Entrants and Haitian Boat People in conjunction with Florida International University and Miami Dade Community College. In applying his questionnaires to the Cuban sample, it was observed that approximately 25% of the respondents manifested signs of emotional and mental disturbances. Subsequent events proved that figure to be prophetic. While serious mental disturbances consisting mainly of depression, disorientation in an alien environment, and anxiety, were less common among the Haitians in the early days, the situation has now changed and a significant proportion of those in treatment are considered severely mentally ill.

Those of us who work in the mental health system do not need a study to tell us what we already know, of course. These comments will be based on the experience in treating Entrants of four community mental health centers located in Dade County, Florida. These Centers provide the vast majority of the treatment, and fund these services primarily from Targeted Assistance dollars funneled through HRS or Metro-Dade County Criminal Justice System. The categorical funding for these services has never been enough to cover the cost of services, so centers have used other, non categorical funds to subsidize Entrant delivery.

The four CMHC's of Dade County, Florida, have treated approximately 6,000 Entrants since 1980. The center which I direct, for example, has treated 4,200 of the total amount. There is, of course, a certain but as yet undetermined number of Entrants which have received services in all or several of those centers. These CMHCs provide the bulk of the mental health services.

At any one time, there are at least 600 unduplicated clients receiving treatment at all Centers combined. In the year 1986-87, 1,397 unduplicated clients were served. (See Figure 1).

The profile of these patients is as follows:

---73% of the Cuban patients and 89% of the Haitians have been given a diagnosis of Schizophrenia, major affective disorder, other psychosis, or organic brain syndrome.

---60% of these patients have been hospitalized in a psychiatric hospital at least once.

---75% of these patients are adults between the ages of 25 and 54, with 55% of them being 25-44.

---31% of these are single and living alone.

---The vast majority are either permanently or intermittently unemployed, and therefore, of low socio-economic social levels.

Utilization of services in community mental health centers has largely stabilized. In the early days following the flotilla, utilization rates of Crisis Stabilization Unit beds, or of inpatient services ran as high as 87% by Entrants. Over the years, this rate has steadily decreased, to a point, which we believe to be an undecreasable residual rate of around 20% at any one time. Admission rates have stabilized in general, but these clients are still receiving more than 49,000 events of service per year. {See Table 1}.

Earlier it was stated that the vast majority of these patients suffer from severe and chronic mental illness. {See Figure 2 and Table 2}. As can be seen from the diagnostic categories, these clients are of a type which requires intensive help, including Crisis Stabilization (brief inpatient) services, residential services, outpatient services, chemotherapy and psychiatric monitoring in order to prevent hospitalizations, frequent acting out, antisocial behaviors, and homelessness. In other words, they use up a significant share of a treatment provider's resources to manage and control.

During 1986-87, 66 Cuban and Haitian Entrant patients resided in structured residential treatment facilities which are operated by the CMHC's. These 66 beds were utilized and full 100% of the time. An additional number of beds were partially utilized, as utilization presents peaks and valleys. Resident clients, after several years of residence and with a great deal of treatment and support, are able to behave in such a manner that allows them to remain in the community. However, the vast majority of them would immediately begin to deteriorate if they lacked such programs, since they do not, by and large, have other support systems.

It needs to be noted that a mental health service provider whose service figures are not included in this report is Jackson Memorial Hospital. To my knowledge, the amount of Targeted Assistance which is given to JMH for Entrant mental health services is so small as to be negligible and everyone knows Jackson's overall deficit in treating Entrants.

SUBSTANCE ABUSE SERVICES

Substance Abuse Services to Entrants are provided by Miami Mental Health Center and by Metropolitan Dade County's Alcohol and Drug Abuse Prevention Program.

Thirty-nine (39%) percent of Miami Mental Health Center's Entrant clients over the past three years have had a serious alcohol and/or drug abuse problem and have received treatment. The center operates 6 residential beds for rehabilitative substance abuse services, and approximately 25% of the total outpatient services to Entrants are for substance abuse problems.

ADAP provides, through Metropolitan Dade County's Criminal Justice System Targeted Assistance funding, 20 beds at the stockade for severe and chronic alcoholics. In addition, at any one time, they serve 10 Entrant clients in detoxification services, and 30 outpatients at their Education and Treatment Program.

It has been observed by both programs that this population is much more difficult to treat than the non-Entrant population. Of the total numbers served, only about 25% of the clients present a picture similar to the dominant population and to non-Entrant Hispanic clients; that is, persons who have a more or less "pure" substance abuse problem, have a reasonable employment history and other factors which are usually present in the lives of "normal" people.

The remaining 75% present a multi-problem picture, including substance abuse, emotional disorders in many cases, no employment history, no English language skills, no support systems, and many other negative factors for their prognosis for recovery in this society. In addition, many of the traditional approaches of substance abuse treatment, such as the confrontational group techniques of therapeutic communities are counterproductive, because they remind the clients of Castro's neighborhood community meetings.

It is also interesting to note, that the incidence of substance abuse in these clients has increased by about 20% over the past three years, over all, as represented within agency caseloads.

All of this leads to an examination of the needs of these clients in the present, and in the future.

RESIDENTIAL PROGRAMS:

At any one time, we project that 100 clients will need mental health and substance abuse residential services. If these services are not available, these clients will most definitely deteriorate. Those under the care of CMHC's will face an immediate housing crisis with which they are ill equipped to survive. Others will fall victims to the cumulative effects of daily stresses, and will join the ranks of the homeless. About 20% will require hospitalization, and, speaking for Dade County, Florida, this will create a severe demand on the public inpatient system (Baker Act), which is under unbearable stress. Our local state hospital is in effect closed, with long waiting lists. Crisis Stabilization Units and hospitals which provide indigent care are full and operating at deficit levels. Referrals from the Criminal Justice System will increase, since there would be some Entrants who will resort to anti-social behavior due to either mental deterioration, hunger, or despair.

For the above reasons, it is imperative that residential and basic management psychiatric and chemotherapy services be maintained at the very least, in order that the demand for other, institutional services not increase.

SHELTERED WORKSHOP PROGRAMS:

Severely impaired clients can, with the appropriate programming and support systems, contribute to their own support. An increase in the funding for these programs, <u>if they are attached to the community mental health system</u>, can be made to work. Priority contracting for services with these systems would further help.

DAY TREATMENT PROGRAMS:

Residential programs work best in preventing hospitalization among the acutely and chronically ill when accompanied with day treatment programs. It is in Day Treatment programs that acculturation skills, English, job seeking skills, etc. are taught to the clients. Vocational rehabilitation

programs very frequently are best attached to day treatment, and will maximize the clients' potential for competitive employment, albeit sporadic and bolstered by treatment support.

FAMILY SUPPORT PROGRAMS:

Both Cuban and Haitian Entrant populations present diagnoses of chronic mental disorder, and in addition, problems that are typical of persons who have suffered losses. For example, severe depression is a common complaint. Not only have these people left behind a homeland, but in many cases have found a much less than welcoming reception here. From the extremes of sequestration at Krome, to the prejudice of their Black American brothers, they have certainly not found the streets of Florida paved in gold.

Especially in the case of Haitians, economic hardships, even in those where family members are together, have resulted in the breakdown, in many cases, of traditional Haitian family values, resulting in those symptoms of social disintegration typical in this country. Haitian teenagers, for example, have begun to be documented as exhibiting a rapidly increasing rate of runaway behavior, substance abuse, and teenage pregnancy.

In addition to access to mental health programs for those who do have severe mental disturbance, there need to be programs aimed at preventing family disintegration, and educational programs similar to those needed by the non-Entrant population, but with a Haitian cultural emphasis.

SUBSTANCE ABUSE SERVICES:

Substance Abuse services are needed by both the Cuban and Haitian Entrant population. The easy availability of drugs on the streets as well as the traditional use of substances as escape mechanism can be added to the stresses of immigration and the individuals' biochemical make up to produce a high incidence of abuse in both population. As referred to earlier, these programs must be culturally sensitive in order to be effective.

In analyzing the needs of this residual population of Entrants, the best analogy to be considered is that the non-Entrant population which is chronically mentally ill. We must ask ourselves, why at this time, are there myriads of homeless individuals on the streets?

Why is there an estimated 50% of the total homeless population mentally ill and living on the streets? The obvious answer is, of course, that those programs which were designed to provide for their care in the deinstitutionalization movement were either improperly designed, grossly underfunded, or non-existent at all.

The residual mentally ill Entrant will be with us forever, unless this country adopts a stance of rounding them and shipping them back where they came from, if that ever becomes possible, and I won't get into that subject. From my point of view, this is not a solution that I care to dwell upon. I hope that this country never joins rank with those that treat the mentally ill as political pawns to be disposed of without regard to their humanity.

The state of Science/Art in psychiatry is such that we will not be able to cure them. We can, at best, control their symptoms and train them to live in relative harmony with their immediate environments. This is, after all, all that can be done at this time for this non-Entrant population that is chronically mentally ill.

And now, a word about funding. A study of the mental health treatment system of District XI of the Department of Health and Rehabilitative Services which was released recently, and which was conducted by Marlowe and Nutter, of the University of Florida, at Gainsville, documents Dade County as being grossly underserved both in relation to the rest of the state, and relative to its own needs. It describes the problems of funding for mental health services for Entrants as one of the most crucial problems facing the District. It categorically states that the loss of Entrant mental health funds would be catastrophic for the community.

During the current year, (State fiscal year, July through June), the mental health system of Dade County is providing services on $2,143,211 of targeted assistance, administered through the Alcohol, Mental Health, and Drug Abuse Program Office of the Department of Health and Rehabilitative Services, and through Metropolitan Dade County. (See Table 3). We face once again the uncertainty of whether we will have any Targeted Assistance dollars for services in Federal fiscal year 1988. If these dollars are not available,then the cuts which will result will be absolutely crippling to a system which already limps.

The non-renewal of Targeted Assistance funds will mean that a tremendous amount of service will not be provided. In the case of Miami Mental Health Center, the loss of Entrant funds and other factors will mean a 15% cut in programs and staff layoffs beginning on July 1, 1987. Other mental health centers will be hit at different times, depending on how they have distributed their allocations of Targeted Assistance dollars.

At the Miami Mental Health Center, programs to be cut have not been designated yet, since our Board of Director have approved a three phase cutdown in order to allow a little more time to elapse to see the outcome of the present budget hearings. They may decide to eliminate services to Entrants, or may decide to push more tax paying Americans off the service ladder. If they eliminate Entrant services, these persons will wind up on the streets, on the tax payers' lawns, or in the tertiary treatment system, composed of the state hospital, Jackson Memorial Hospital, or the County Jail, at a much higher cost than is being incurred now.

We will most definitely have to eliminate residential services, resulting in the effects already described. {See Table 4}. We will not be able to serve those countless others who are now being kept relatively well and independent because there have been Crisis Stabilization Services, Case Management, and Medication Services available to them.

The Office of Refugee Resettlement view that targeted assistance dollars should be spent on programs which target employment skills development is characteristic of the view held by many congressmen, etc., who do not understand that for the next 50 years or so we will have a residual number of mentally ill Entrants among us. We cannot invent support systems or families where there are none, or when it rejects the client. A long term system for funding Entrant mental health services will be crucial for effecting the improvement that can be made in this population and in safeguarding the safety of the community. One possibility is to attempt to get the amounts being spent nationwide on mental health and substance abuse services added to the Community Mental Health Block Grants, not as set-asides, but as new monies.

A crucial problem this year is that the State of Florida's Legislature , as of about a week ago, had only approved a 2% price level increase for the mental health system. At the same time, certain expenditures will be incurred by the system (the astronomical increases insurance rates, repairs and renovations pursuant to the new licensing laws for residential facilities) which renders that increase totally inadequate, and creating deficits. For these reasons, centers such as ours cannot any longer afford to subsidize these services as we always have in the past.

I think that it is safe to say that at community levels all over the United States, the reasons for supporting the position that the Entrant situation is the product of federal policy or actions is understood. It is further understood that local and state governments aggressively look to the federal government to provide a long term solution to this problem. Up to last year, the State of Florida's governor has taken quite a firm stand on this issue. We are grateful to all levels of government for whatever support there has been for taking care of Entrant mental health needs. However, the fact remains that the effort to put the responsibility where it rightfully belongs, because of the immigrational nature of the issue, is resulting in the community providers and its clients being treated like Ping-Pong balls.

It must be understood that the prospects of self-sufficiency for a residual group of Entrants is absolutely nil. Furthermore, it must be recognized that while the present state of funding is barely holding the fort, it is doing so at the expense of the non-Entrant population. And finally, any reduction in funding, or elimination of funding will be catastrophic to those communities that have large groups of mentally ill Entrant clients.

In the era of Gramm-Rudman-Hollings, the message given may well be swallowed up in the din on many groups making similar claims, but we must go on record as standing up for the rights to treatment of perhaps one of the most needy and perhaps even despised of populations, the chronically mentally ill Entrant.

TOTAL ENTRANT CLIENTS

FISCAL 1984 TO 1987

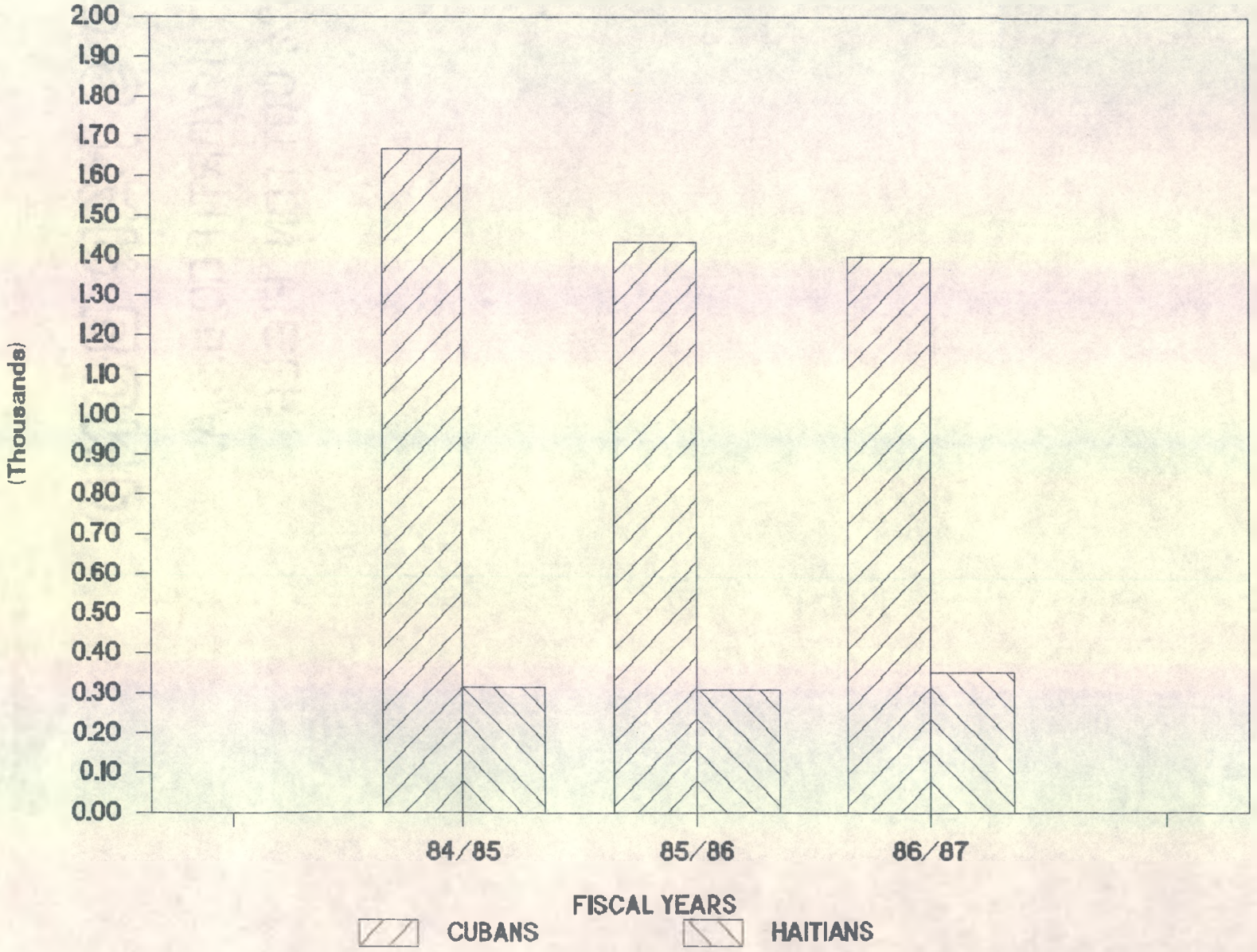

Figure 1

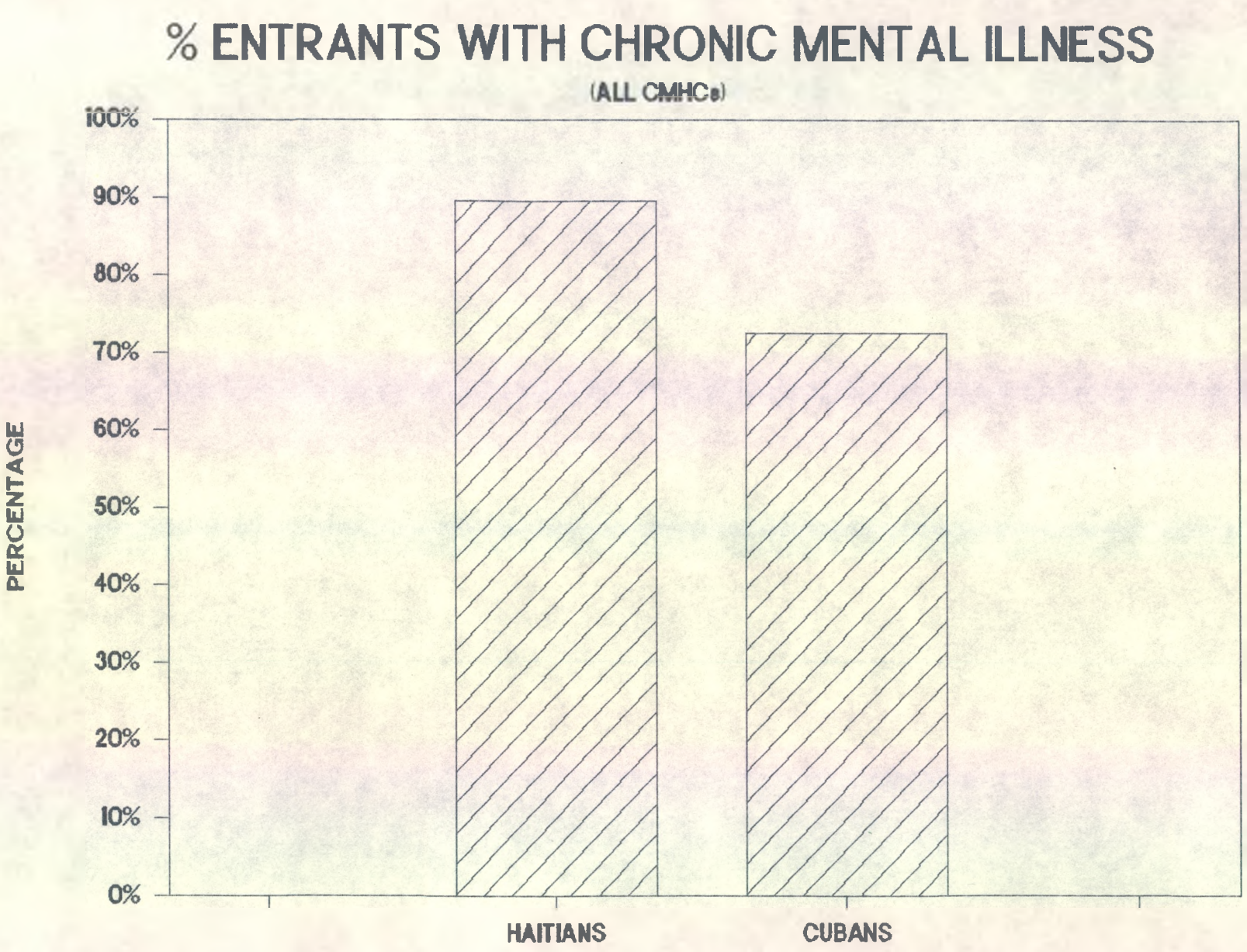
% ENTRANTS WITH CHRONIC MENTAL ILLNESS
(ALL CMHCs)
PERCENTAGE
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
HAITIANS
CUBANS

Figure 2

TABLE 1

SERVICE DELIVERY TO CUBAN AND HAITIAN ENTRANTS
FISCAL 1986-1987

(Patient Hours and Patient Days)

SERVICE CATEGORIES	*	CUBANS	HAITIANS	*	TOTAL
A. INDIVIDUAL THERAPY:	*	3275	56	*	3331
B. MULTI-CLIENT THERAPY:	*	3469	4	*	3473
C. PRELIMINARY SERVICES:	*	1454	12	*	1466
D. CASE MANAGEMENT:	*	5269	292	*	5561
E. PSYCH EVALUATIONS:	*	177	16	*	193
F. ASSESS EVALUATIONS:	*	166	0	*	166
G. PSYCHIATRIC EXAMS:	*	50	0	*	50
H. CHEMOTHERAPY:	*	1761	136	*	1897
I. RESIDENTIAL SERVICES: *	*	21031	2780	*	23811
J. REHAB DAY TREATMENT:*	*	3291	2712	*	6003
K. CRISIS TELEPHONE:	*	102	0	*	102
L. CRISIS INTERVENTION:	*	732	20	*	752
M. CRISIS STABILIZATION:*	*	1791	72	*	1863
N. PREVENTION/CONSULTATION:	*	450	0	*	450

* patient days

TABLE 2

FREQUENCY COUNT AND PERCENTAGE OF VARIOUS DIAGNOSTIC CLASSIFICATIONS FOR CUBAN ENTRANT CLIENTS AT THE MIAMI MENTAL HEALTH CENTER

FREQUENCY COUNT*	84-85	85-86	86-87	TOTALS
ORGANIC DEMENTIAS:	21	13	17	51
CHRONIC MENTAL ILL:	271	245	412	928
NEUROSIS:	143	78	54	275
ALCOHOL/DRUG ABUSE:	310	444	274	1028
OTHER DIAGNOSES:	200	73	31	304
TOTALS:	945	853	788	2586

*UNDUPLICATED CLIENTS

PERCENTAGE	84-85	85-86	86-87	TOTALS
ORGANIC DEMENTIAS:	2.22%	1.52%	2.16%	1.97%
CHRONIC MENTAL ILL:	28.68%	28.72%	52.28%	35.89%
NEUROSIS:	15.13%	9.14%	6.85%	10.63%
ALCOHOL/DRUG ABUSE:	32.80%	52.05%	34.77%	39.75%
OTHER DIAGNOSES:	21.16%	8.56%	3.93%	11.76%
TOTALS:	100.00%	100.00%	100.00%	100.00%

TABLE 3

SOURCES OF FUNDING FOR MENTAL HEALTH, ALCOHOL, AND DRUG ABUSE SERVICES RENDERED THROUGH FOUR CMHCs IN METROPOLITAN DADE COUNTY

FUNDING CATEGORIES	84/85	85/86	86/87	TOTALS
ALCOHOL, DRUG ABUSE AND MENTAL HEALTH*	$1,829,774	$1,105,733	$1,205,831	$4,141,338
METRO-DADE CRIMINAL JUSTICE SYSTEM*	$533,487	$607,373	$708,938	$1,849,798
CENTER SUBSIDIES**	$156,442	$345,505	$228,442	$730,389
TOTALS:	$2,519,703	$2,058,611	$2,143,211	$6,721,525

* Targeted Assistance

** Other Agency Revenue: HRS, General Revenue, Local Funding, etc.

TABLE 4

RESIDENTIAL AND CRISIS STABILIZATION SERVICES

SERVICE CATEGORY	CUBANS	HAITIANS	TOTAL
A. RESIDENTIAL BEDS:			
ADAMA BEDS:	34	8	42
CRIMINAL JUSTICE BEDS:	23	0	23
TOTAL BEDS:	57	8	65
B. CRISIS STABILIZATION:			
ADAMA CLIENTS:	259	8	267
CRIMINAL JUSTICE CLIENTS:	8	0	8
TOTAL CLIENTS:	267	8	275