being 1.04 times more likely to mention contraception as a reason for their first visit.

These regressions indicate that age is significantly related to each of the dependent variables, except for pregnancy, as a reason for first visit. Net of the other variables in each equation, older teens are significantly more likely than younger ones to have contraception as their reason for a first visit and to be consistent users of the first method of contraception that they select. Younger teens, on the other hand, are significantly more likely to revisit the clinic both within and beyond a 12-month period, to accept pills or an IUD, and to be pregnant at a second or later visit. However, the models offered predict only modest amounts of the variance in the dependent variables.

Conclusions

As previous studies and theoretical explanations for adolescent pregnancy would suggest, we have found that the youngest patients in our reproductive health care program differ in important ways from the older teens. Those who are younger at their first visit are less likely to have had prior experience with birth control, less likely to have been pregnant, more likely to leave the clinic with no method of birth control, and more likely to switch methods. These differences alone are important to service providers. Unfortunately, however, while the majority do not return pregnant, the younger teens in our program are more at risk of this than are the older ones.

Some of these outcomes are undoubtedly a function of opportunities. Younger teens, having more years of exposure, have longer periods of time in which to switch contraceptives, return to the clinic, and get pregnant. Still, service providers would do well to remember that their teen patients are indeed a heterogeneous group and that those under age 15, in particular, need special care.

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The Cuban Immigration of 1980: a Special Mental Health Challenge

LARRY B. SILVER, MD
BARBARA J. SILVER, PhD
MORTON M. SILVERMAN, MD
WILLIAM PRESCOTT, MD
LUISA del POLLARD, MA

Larry B. Silver, MD, is Acting Director, National Institute of Mental Health (NIMH), Barbara J. Silver, PhD, is Special Assistant to the Director, NIMH, Morton M. Silverman, MD, is Chief, Center for Prevention Research, Division of Prevention and Special Mental Health Programs, NIMH, William Prescott, MD, is Superintendent, St. Elizabeths Hospital, and Luisa del Pollard is Child and Youth Mental Health Specialist, NIMH.

Tearsheet requests to Dr. Barbara J. Silver, National Institute of Mental Health, Rm. 17C-20, 5600 Fishers Lane, Rockville, MD 20857.

Synopsis

The 124,769 Cubans who entered the United States from Cuba in a boatlift in 1980 included a small minority of people who needed mental health care. Some had been taken involuntarily from psychiatric hospitals, mental retardation facilities, jails, and prisons.

The National Institute of Mental Health, Public Health Service (PHS), was responsible for mental health screening, evaluation, and treatment of the Cuban Entrants. Bilingual psychiatrists and psychologists found that many Entrants given preliminary evaluations showed evi-

dence of transient situational stress reactions, not psychiatric illnesses.

Entrants who had not yet been sponsored were consolidated into one facility in October 1980, and about 100 of those with severe problems were transferred to an Immigration and Naturalization Service-PHS evaluation facility in Washington, DC. Between March 1, 1981, and March 1, 1982, a total of 3,035 Entrants were evaluated at both facilities.

Among the 1,307 persons who presented symptoms, there was a primary diagnosis of personality disorders for 26 percent, schizophrenic disorders for 15 percent, adjustment disorders for 14.5 percent, mental retardation for 8.6 percent, chronic alcohol abuse for 8.6 percent, and major depression for 7.2 percent. Only 459 Cubans with symptoms were found to be in need of further psychiatric care.

As of October 1984, many Entrants with psychiatric illnesses remained under inpatient or community-based halfway house psychiatric care as a direct Federal responsibility. A PHS program for further placement in community-based facilities is underway.

NEARLY 125,000 CUBANS ENTERED the United States between April 21 and September 26, 1980. This exodus from Cuba, known as the "Freedom Flotilla," included a small minority who needed varying degrees of mental health services. This paper will focus on the diagnostic, treatment, and legal issues involved in providing mental health care to the Cuban Entrants and will report specific diagnostic data on their psychiatric problems. The outplacement program being conducted by the Public Health Service (PHS) will also be described.

The Freedom Flotilla

Sparked by the 10,000 Cubans who sought political asylum at the Peruvian embassy in Havana, Cuban leader Fidel Castro formally announced on April 20, 1980, the opening of the port of Mariel for all wishing to emigrate to the United States. Within hours of the announcement a full-fledged boatlift was undertaken by Cuban-Americans. This "freedom flotilla" continued until September 26, 1980. During this period 124,769 Cubans landed on the shores of Florida, and 90 percent, or 111,779 persons, arrived during the first 7 weeks. The term "Entrant" was established by Congress to refer to the particular group of cubans in the Mariel boatlift.

Although family reunification was the original goal of the boatlift, some of the Entrants had not volunteered to leave their country. Cuban officials at Mariel reportedly forced families waiting for departure to move aside to make room for persons brought to the port by the Government. These persons had criminal records, mental illness, physical illness, or social adjustment problems, and were alleged to have been a financial drain on the Cuban Government.

In addition to persons purported to have been brought to Mariel from psychiatric hospitals, mental retardation facilities, jails, or prisons, stories told by the Entrants suggested that the police went through Havana picking up known troublemakers and other "undesirables" to transport them to the boats at Mariel.

The unexpected landing of Cubans on American shores, as well as the increasing awareness that some were from psychiatric hospitals or legal detention facilities, demanded a new approach to the reception, processing, and resettlement of the arrivals. It became clear during the first week of the boatlift that the resources and personnel of local and Florida State agencies normally involved in refugee processing were insufficient. President Jimmy Carter designated the Federal Emergency Management Agency (FEMA) as the agency for coordinating Federal efforts in processing the Entrants.

FEMA requested the assistance of 17 Federal Departments and agencies. The Departments of State, Defense, and Health and Human Services (HHS); the Federal Bureau of Investigation; Central Intelligence Agency; Immigration and Naturalization Service (INS); U.S. Customs Service (Department of Treasury); U.S. Coast Guard; U.S. Park Police; and the Federal Aviation Administration were included. The National Institute of Mental Health (NIMH), PHS, was given the responsibility for mental health screening, evaluation, and treatment. One of the authors (Larry B. Silver, MD) was in charge of developing and implementing the NIMH initiative. The first reception facility, providing housing, screening, and processing, opened on May 3 at Eglin Air Force Base, FL. By the end of August 1980, the influx had reached 121,511 persons, almost 1.3 percent of Cuba's population of 9.6 million. Three additional recep-

'The unexpected landing of Cubans on American shores, as well as the increasing awareness that some Entrants were from psychiatric hospitals or legal detention facilities, demanded a new approach to the reception, processing, and resettlement of the new arrivals.'

tion centers—Fort Chaffee, AK, Fort Indiantown Gap, PA, and Fort McCoy, WI—were opened to handle the large influx.

Mental Health Care

The great majority of the Cubans were physically and mentally healthy. However, some were mentally ill, mentally retarded, or had a history of criminal behavior, and Castro would not allow them to return. Further, about 2,000 were unaccompanied minors, mostly between the ages of 14 and 17. The Federal goal was to seek sponsorship and settlement in communities throughout the country. Efforts to provide health and mental health care were complicated by issues involving the legal status of the Cubans, the need for comprehensive and timely clinical evaluations, and the need for coordination of the various service systems involved.

Mental health services. From the outset, NIMH developed the necessary programs to screen the Entrants, operated and monitored the comprehensive mental health services in the camps, and identified appropriate community-based outreach programs.

Each of the four resettlement camps had unique needs. They were isolated with few resources nearby. The overall response to the Cuban Entrants was an example of cooperation by Federal and State Governments and the private sector. Programs were developed at each site through a combination of service contracts with private organizations, contracts with private and State hospitals for inpatient facilities, and the use of the PHS Commissioned Corps and other mental health professionals such as psychiatrists, psychologists, social workers, and psychiatric nurses.

Within 2 weeks of opening, each camp was equipped with (*a*) an acute crisis evaluation team, (*b*) a psychiatric inpatient hospital in the camp, (*c*) a backup private or State hospital resource if needed, (*d*) an acute 72-hour observation unit, (*e*) outpatient services and, (*f*) consultation-liaison services to the camp director, security staff, and voluntary agencies. In addition, education in English as a second language was provided.

At the Fort Indiantown Gap camp, early screening identified 40 Cuban Entrants who had had some experience working with people with mental health problems. Because of their knowledge of the language and culture and their level of trust by their fellow Cubans, they were trained by the staff of a local community mental health center to work as paraprofessionals. Each went into the living areas, identified people in need of psychiatric evaluation, and helped with followup care.

By late summer most Entrants had been sponsored. Those who remained in the camps were consolidated into one facility at Fort Chaffee. Within this group there were 400–500 Cubans who needed further mental health care. Life in the camps was stressful, and the stress of immigration still existed for some people. It was not considered appropriate to establish a final psychiatric diagnosis for individual Cubans known to the mental health professionals. Instead, they were identified only as needing further mental health assessment and care. Some were diagnosed by psychiatrists as having a mental disorder but not as being dangerous to themselves or others and, thus, could not be committed to a hospital for treatment.

The majority of the Entrants who were identified as needing some mental health care but not hospitalization lived in the general living area at Fort Chaffee and received outpatient psychiatric care. Approximately 100 persons who could not handle such a placement were transferred to a special detention and evaluation facility. Because of the lack of a non-Federal facility in a community that was willing to accept such a program, the INS arranged with HHS to use a building on the grounds of St. Elizabeths Hospital in Washington, DC. PHS was asked to provide psychiatric evaluation services for the Cuban Entrants there. NIMH awarded a contract to a private health care organization to staff and operate the program. This evaluation program was later expanded to provide treatment services for those who would accept them. As of the preparation of this paper, the evaluation and treatment program is still in operation at this INS-PHS evaluation facility.

Legal difficulties of placement. According to U.S. law, illegal Entrants are to be deported back to their country of origin. However, the Cuban Entrants could not be deported, and yet they could not legally remain. The Attorney General, using his detention authority, did not approve sponsorship for persons considered dangerous to themselves, others, or the country. Those persons who were known to have committed major crimes in Cuba and to have arrived directly from prison were placed in Fed-

eral prisons. Civil rights groups questioned if a person could be placed in a U.S. prison for crimes they committed and for which they were convicted of in another country. This issue is still before the courts.

Legal issues of treatment. Some Entrants needed psychiatric treatment. Yet, there are U.S. laws stating that persons with psychiatric problems cannot be treated without their permission and that such persons cannot be hospitalized against their wishes unless specific commitment laws can be satisfied.

These legal restraints created major problems in providing mental health care. Up to 9,000 of the Cuban Entrants needed some form of mental health services, though not all had major psychiatric disorders. Few persons were dangerous to themselves or others and, unless they volunteered for treatment, they could not be placed in a psychiatric facility under the commitment laws of the State where the camp was located. Some Entrants feared that receiving psychiatric care would prevent their sponsorship or lead to deportation. Others simply refused.

Individual Cubans were brought by friends or relatives or came to the psychiatric outpatient clinic in the relocation sites because of anxiety, depression, behavioral difficulties, or dangerous or inappropriate behavior. Treatment was provided if the person voluntarily asked for and accepted it. If the mental health professional felt clinical intervention was necessary and the patient refused treatment, he or she was placed in a structured and supervised mental health unit in the camp; however, pharmacologic treatment was not given. Mental health professionals in these units had to manage psychotics who were agitated; depressives who were withdrawn, agitated, or both; and persons who were highly anxious, all with no medication or other treatments. If their behavior reached a level that a professional considered dangerous to themselves or others, one emergency order of medication could be ordered. Each episode had to be fully documented. Each action was reviewed by attorneys from the local public defender's office. Several court actions ensued.

Medical records difficulties. Because of the extraordinary nature of the situation and the immediacy with which the Federal Government had to provide both mental health evaluations and services, there was no systematic procedure for overall recordkeeping. Each Cuban who was seen by a psychiatrist or psychologist had a mental health file; many had more than one file due to the use of aliases and fraudulent INS numbers. Also, because PHS employed psychiatrists and psychologists on rotating assignments for 2 or 3 weeks, many of the Cubans were evaluated by several professionals at different times or places. In addition, time elapsed before all the records for a person were placed in a common file.

'The overall response to the Cuban Entrants was an example of cooperation by Federal and State governments and the private sector.'

In the late fall of 1980 an NIMH team of mental health professionals was assigned to Fort Chaffee to consolidate all the mental health patient records and to begin a system for coding and retrieving patient data.

Diagnostic difficulties. In retrospect, several additional issues influenced the diagnostic process. Some Cubans who were initially classified as mentally retarded were noted during followup evaluations to be illiterate persons who were depressed and withdrawn.

A second problem was cultural. One way Cuban men express frustration is by cutting themselves. Some of the Cubans took sharp objects and cut themselves four, five, or more times on their arms, legs, or stomach. When they appeared in the emergency room, bleeding from self-inflicted multiple lacerations, they were assumed to be mentally ill. Further evaluation, based on the criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM III), however, usually did not satisfy the necessary criteria to establish the diagnosis of a mental disorder (*1*).

A third difficulty was that some Entrants faked hallucinations and delusional behavior, hoping to be removed from the stressful camp environment and placed in a psychiatric hospital. Once hospitalized, the behavior stopped. Some persons admitted using this technique in Cuba to get transferred from prison to a psychiatric hospital. Thus, patients who were initially diagnosed and placed in a psychiatric hospital were found on reevaluation in the hospital to have no mental disorder. Still others would swallow metal objects in order to be transferred to a medical hospital. It was suggested that some of this behavior also reflected learned techniques for being transferred from less to more desirable settings.

Another small group presented a special mental health concern. These were Cubans in their early to midtwenties who reported having been in prison since early adolescence under charges of being a troublemaker. Their adolescence was spent in an environment that perhaps taught sociopathic behavior as a model for survival and minimized the value of feeling safe in a close or intimate relationship. Some persons had handled their forced pas-

'Few persons were dangerous to themselves or others, and, unless they volunteered for treatment, they could not be placed in a psychiatric facility under the commitment laws of the State where the camp was located.'

Table 1. Percent distributions by primary diagnosis of persons receiving inpatient and outpatient services of selected mental health facilities, United States, 1975, and for 1,307 Cuban Entrants, 1982

Diagnosis	Americans[1]		Cuban males[2]
	Total	Males	
Schizophrenia	17.7	18.9	15.3
Affect disorder	18.8	12.5	8.6
Organic brain disorder	3.4	3.6	4.6
Personality disorder	6.5	7.1	26.1
Alcohol disorders	11.7	19.3	8.6
Drug disorders	3.1	4.1	1.2
Other disorders	38.9	34.4	35.6

[1] Source of data is reference 2.
[2] 98 percent of the Cuban Entrants were males.
NOTE: Diagnoses of the U.S. population were based on DSM II criteria (3), and diagnoses of the Cuban Entrants were based on DSM III criteria (1).

sivity and adolescent identity concerns in prison by adopting overly masculine and aggressive behavior, while others yielded to a homosexual life style. Few of these former prisoners could be identified as mentally ill, yet most needed an opportunity for corrective emotional and life experiences before being able to adapt to an independent community life. The mental health professionals worked with the camp leadership to develop vocational-educational rehabilitation programs for these people.

Mental health data difficulties. At each of the four camps the mental health teams saw persons who were psychotic or who had other psychiatric disorders, as well as persons who were reacting to stress. Many of those under stress were exhibiting symptoms that reflected the circumstance of their arrival. They had wanted to come to the United States but faced the stress of leaving their home and roots and facing a new world. Others had not come of their own choice. They had been taken out of institutions in Cuba or taken involuntarily from their homes, leaving their families, friends, and possessions. These Cubans suddenly found themselves in a new country where they did not know the culture or language, and they faced a totally new and uncertain future. Many persons had, over the past 20 years in Cuba, learned to distrust or dislike the country and people upon whom they were not totally dependent.

Thus, the earliest data compiled in the camps were projections of the extent of mental disorders anticipated based on the number of persons seen voluntarily by outpatient and inpatient services. Because of the initially large number of people seen, the initial projections were high. Most of those with a psychiatric disorder who accepted the offer of treatment improved. Others who sought help became symptom free with the decrease in stress and their adaptation to camp life.

Once order had been established at each camp, the mental health professionals were able to move out into the general camp living areas. They found additional persons with stress reactions, psychiatric disorders, and mental retardation. Some of the Cubans who had been placed in detention areas because of behavioral difficulties were found to have psychiatric disorders, to be mentally retarded, or both. Thus, the data had to be revised to reflect these newly found cases.

Specific Diagnostic Data

By March 1982, after nearly 18 months in detention, 1,307 Cuban Entrants in the resettlement programs were receiving inpatient or outpatient psychiatric care, had been diagnosed through the psychiatric screening programs as needing further psychiatric care, or both. Ninety-eight percent were male. Because the initial screening sessions by the psychiatrists and psychologists were conducted under extremely difficult circumstances and the presenting clinical picture was compounded by the situational stress, it was decided not to use a formal diagnosis from the DSM III initially, but to place individuals into one of two major categories—absence or presence of evidence of mental illness.

The final psychiatric evaluations used DSM III criteria. The evaluations in these tables were based on generally long-term observation, repeated clinical evaluations, psychological testing to confirm mental retardation or organic brain disorder, and, when necessary, a neurological evaluation. All of the psychiatric evaluations reported in this paper were conducted by bilingual psychiatrists and psychologists employed by the Public Health Service.

Between March 1, 1981, and March 1, 1982, all remaining Cuban Entrants at Fort Chaffee or the INS-PHS evaluation facility in Washington, DC, were evaluated. These evaluations were based on the criteria set forth in the DSM III for disorders on axis I and axis II. Axis I disorders consist of all mental disorders and conditions not attributable to a mental disorder that are a

focus of attention or treatment exclusive of the conditions in axis II. Axis II disorders are the personality disorders (primarily in adults) and the specific developmental disorders (primarily in children and adolescents).

Of the 3,035 Cubans evaluated, 1,307 received at least one DSM III diagnosis: 557 had only an axis I diagnosis, 337 had only an axis II diagnosis, and 413 had diagnoses on both axes. No evidence of mental illness was presented by 1,728 persons.

The percent distribution by primary diagnosis of the Cuban Entrants in March 1982 was compared with a United States inpatient and outpatient population from selected mental health facilities in 1975, the latest date for which data were available. These data indicated that the two groups had similar rates for schizophrenia, organic brain syndrome, and drug abuse and markedly different rates for alcohol-related disorders, affect disorders, and personality disorders (table 1).

The relatively low rates for substance abuse, particularly alcohol abuse, can be attributed to the fact that alcohol and drugs were not permitted in any of the camps and, therefore, by DSM III criteria, the diagnosis of acute substance abuse could not be established.

The most frequent primary DSM III diagnostic group was personality disorders, encompassing 26.1 percent of the 1,307 Cubans (table 2). Antisocial personality disor-

Table 2. Frequency of occurrence and placement recommendations, March 1982 final evaluations

DSM III primary diagnosis	Frequency	Percent of total	Percent of subgroup	Placement recommendations					
				Voluntary agency	Psychiatric inpatient	Psychiatric halfway house	Shelter for mentally retarded	Federal Bureau of Prisons	ORR [1] special program
Personality disorders	341	26.1	...	284	0	21	0	15	21
Antisocial	229	...	67.2	193	0	3	0	12	21
Narcissistic-borderline	27	...	7.9	18	0	7	0	2	0
Avoidant-passive aggressive	18	...	5.3	17	0	1	0	0	0
Paranoid	13	...	3.8	10	0	3	0	0	0
Schizoid-schizotypal	13	...	3.8	11	0	2	0	0	0
Other personality	41	...	12.0	35	0	5	0	1	0
Schizophrenic disorders	200	15.3	...	15	106	77	1	1	0
Undifferentiated schizophrenia	102	...	51.0	1	67	34	0	0	0
Paranoid schizophrenia	47	...	23.5	5	23	19	0	0	0
Residual schizophrenia	32	...	16.0	6	8	17	1	0	0
Disorganized schizophrenia	11	...	5.5	0	5	5	0	1	0
Catatonic schizophrenia	4	...	2.0	0	3	1	0	0	0
Paranoid disorders	4	...	2.0	3	0	1	0	0	0
Adjustment disorders	190	14.5	...	158	4	20	0	3	5
Mental retardation	113	8.6	...	29	4	6	74	0	0
Mild	105	...	92.9	29	4	6	66	0	0
Moderate	7	...	6.2	0	0	0	7	0	0
Unspecified	1	...	0.9	0	0	0	1	0	0
Alcohol abuse, chronic	113	8.6	...	104	3	4	0	0	2
Major depression	94	7.2	...	57	8	29	0	0	0
Organic mental disorders	60	4.6	...	27	6	25	0	2	0
Conduct-impulse control disorder	58	4.4	...	40	2	9	0	3	4
Anxiety disorders	30	2.3	...	23	1	6	0	0	0
Paraphilias	19	1.5	...	6	2	9	0	2	0
Bipolar depression	18	1.4	...	3	8	7	0	0	0
Drug abuse, chronic	16	1.2	...	14	1	0	0	1	0
Developmental disorders	13	1.0	...	10	0	3	0	0	0
Schizoaffective disorders	12	.9	...	1	3	8	0	0	0
Atypical psychosis	12	.9	...	2	3	7	0	0	0
Other disorders	10	.8	...	10	0	0	0	0	0
Sexual identity disorders	8	.6	...	6	0	2	0	0	0
Total	1,307	[2] 99.9		789	151	233	75	27	32

[1] Office of Refugee Resettlement Special Program.
[2] Total does not equal 100 due to rounding.

NOTE: Leaders (. . .) indicate not relevant or applicable.

Table 3. Age distribution of 650 Cuban Entrants with personality disorders, schizophrenia, and mental retardation primary diagnoses

DSM III diagnosis	No age given	Under 20 years	20–29 years	30–39 years	40–49 years	50–59 years	60 years and older
Personality disorders:							
Antisocial disorders	11	3	155	53	5	2	1
Narcissistic-borderline disorders	0	0	21	4	2	0	0
Avoidant-passive aggressive	0	0	12	3	3	0	0
Paranoid disorders	0	0	4	5	2	0	0
Schizoid-schizotypal disorders	0	1	6	5	0	0	1
Other disorders	0	0	23	8	4	3	0
Schizophrenia:							
Undifferentiated schizophrenia	4	2	47	30	15	3	1
Paranoid schizophrenia	3	2	23	12	5	1	1
Residual schizophrenia	1	0	23	4	3	1	0
Disorganized schizophrenia	0	1	4	4	1	1	0
Catatonic schizophrenia	0	0	4	0	0	0	0
Paranoid disorders	0	1	1	2	0	0	0
Mental retardation:							
Mild	8	3	54	30	8	2	0
Moderate	0	0	6	0	0	1	0
Unspecified	0	0	1	0	0	0	0

der represented 67.2 percent of all personality disorder diagnoses. The placement recommendation for the majority of Entrants with the primary diagnosis of personality disorder, 83 percent, was selective, supervised sponsorship into the community through a voluntary agency. Only 20 Cubans, or 6 percent, in this group required placement in a psychiatric halfway house, and none required inpatient care. Over two-thirds of those with this diagnosis were between 20 and 29 years of age, and approximately one-fourth were between 30 and 39 years of age (table 3).

The relatively high rate for personality disorders can be attributed to the fact that the Cuban Entrants in this detained population were those for whom placements were not forthcoming due to their histories of mental illness, antisocial behavior, or both. Therefore, the sample was biased and overrepresented with problem cases.

The second most frequent primary DSM III diagnosis, schizophrenia (15.3 percent), was divided into its six components. The most frequent diagnoses of schizophrenia were undifferentiated, 51 percent; paranoid, 23 percent; and residual, 16 percent. Inpatient psychiatric care was the placement recommendation for 52 percent of this group, while 38 percent were recommended for placement in a psychiatric halfway house. Half of the Entrants in this group were between 20 and 29 years of age, while one-fourth were between 30 and 39 years of age (table 3).

Adjustment disorders were the third most frequent DSM III diagnosis (14.5 percent). The relatively high rate of diagnoses in this category can be attributed, as it was for personality disorders, to the biased population sent from Cuba and the biased sample remaining for long-term observation. The traumatic effects of the departure from Cuba and detention in the United States may have also contributed to a higher incidence of adjustment disorders. The latter attribution gains support from the fact that 83 percent of the Cubans with this diagnosis improved enough after observation and care to be recommended for sponsorship within the community.

Psychological testing, which included the Escala de Inteligencia Wechsler para Adultas (EIWA), was used to evaluate the Entrants suspected of being mentally retarded. The results indicated that less than 9 percent of the screened group, many fewer than suspected, were mentally retarded. Of these, 93 percent were diagnosed as having mild mental retardation. Only seven people were classified in the moderate mental retardation category, and there were none in the severe group. Sixty-five percent of the Entrants with this diagnosis, including all in the moderate group, were recommended for placement in a sheltered home for the mentally retarded while one-fourth were recommended for special sponsorship in the community. More than half of Cubans with the diagnosis of mental retardation ranged in age from 20 to 29 while one-fourth were in the 30–39 age group.

In total, 459 of 1,307 Cubans with at least one DSM III diagnosis had a placement recommendation that involved further psychiatric care: inpatient care was recommended for 33 percent; outpatient care, 51 percent; and sheltered homes or programs for the mentally retarded, 16 percent (table 2).

The distribution of the 2,287 persons screened with ages known was as follows: under 20, 1.8 percent; 20–29, 54.3 percent; 30–39, 29.1 percent; 40–49, 9.1 percent; 50–59, 4.5 percent; and 60–69, 1.1 percent.

Chi-square analysis of this age data indicated no significant differences between the total screened population, and the psychiatric inpatient and the sheltered home for the mentally retarded placement groups (beyond the .01 level of significance). The age distribution of persons recommended for psychiatric halfway house placement did differ significantly from the total screened population (chi-square = 28.6). This difference appeared to be due to overrepresentation of persons in the under 20 age group in this placement category (14 persons or 63 percent).

The Outplacement Programs

Efforts were started in January 1981 to seek programs for the Cuban Entrants who would need long-term psychiatric care. The goal was to place those needing inpatient psychiatric care or special mental retardation programs in State or other facilities and those needing halfway house or specially staffed group home care in appropriate programs. The Federal Government agreed to bear all costs for care and to maintain full responsibility for the long-term welfare of each entrant, freeing the State or local communities from such responsibilities. If any person did not succeed in the program, he or she would be returned to a Federal facility.

This initial outplacement effort resulted in about 100 persons moving to carefully selected and supervised halfway house or other specially designed programs. By the winter of 1981, this approach had to be modified because each outplacement effort was met with unanticipated levels of State and local opposition.

Fort Chaffee was closed in October 1982, and the Bureau of Prisons within the Department of Justice assumed responsibility for all federally detained Cuban Entrants. The Bureau of Prisons transferred Cubans with serious psychiatric symptomatology to the Medical Center for Federal Prisoners, Springfield, MO; Cubans with apparent psychosexual disorders to the Federal Correctional Institution, Lexington, KY; and Cubans who appeared to be in need of inpatient care to the INS-PHS evaluation facility, Washington, DC. The remainder of the Fort Chaffee population was transferred to the Atlanta penitentiary.

Also, in October 1982, the INS-PHS evaluation facility in Washington, DC, was expanded to become a more permanent facility that could accept those Cuban Entrants with psychiatric problems from other Federal programs; for example, PHS-sponsored halfway houses, as well as persons with selected cases whose sponsorship broke down. Each Entrant would be reevaluated, treated if such treatment was accepted, and reassessed for special needs or future placement.

The INS-PHS evaluation facility has an admission unit; several specialized treatment units; and a combination transition board-and-care unit designed to prepare the person for the anticipated placement. Vocational evaluation and a course in English as a second language are also provided.

Between October 1982 and October 25, 1984, a total of 2,327 Entrants who had been identified on arrival, or in the camps, or returned from parole as socially dysfunctional or in need of mental health services were housed in the Atlanta penitentiary. At Atlanta a process was initiated to conduct a full psychiatric, psychological, and neurological evaluation of each Entrant not yet evaluated, using bilingual psychiatrists and psychologists. By October 25, 1984, 385 Entrants had been transferred to psychiatric halfway house programs developed by the PHS.

Between August 21, 1981, and October 25, 1984, 1,528 Entrants who had been evaluated as having no mental illness or a nonsevere mental illness but had social dysfunctions were placed in special structured programs developed by the Community Relations Service (CRS), U.S. Department of Justice.

As of October 25, 1984, there were 1,512 Entrants still housed in the Atlanta facility; many returned from parole. Psychiatric evaluations had been completed on 1,052 Entrants, and evaluations were pending for 460. The responsibility for caring for 304 of the Entrants has been delegated to the Public Health Service while CRS has the responsibility for 748.

Of those determined to be releasable, based on a Department of Justice review, 118 Cubans are awaiting placement in a PHS facility and 42 Cubans are awaiting placement in a CRS facility. Of the 304 Entrants who are the responsibility of the PHS, independent of those determined to be releasable, 60 need psychiatric inpatient care, 14 need care in a forensic unit, and 230 need care in psychiatric halfway house or board and care facility. The Atlanta facility residents who have not been declared appropriate for release for outplacement are reevaluated on a regular basis by the Attorney General's Cuban Status Review Panel.

Contingency Plans

Based on the experiences with providing services for the Mariel boatlifts NIMH has proposed a three-stage contingency plan for a future mass influx of people. Specific staffing needs have been developed for each stage.

Stage one would be at the point of entry and would consist of a brief mental health screening of each individual. The staff would consist of PHS Commissioned Corps professionals plus interpreters.

Stage two would take place at the relocation facilities and consist of a more indepth psychiatric evaluation. The staff at this stage would be recruited through contracts with private individuals, organizations, and State mental health programs.

Any person considered to have evidence of significant emotional stress, mental illness, or mental retardation at the time of the stage two assessment would be referred for a more extensive study including any necessary testing. This stage three evaluation could be repeated subsequently. Professional services would also be provided by contracts with private individuals, organizations, and State mental health programs.

Conclusion

The Mariel boatlift of 1980 brought to the United States nearly 125,000 Cubans, A small minority of them needed special attention, usually of a psychiatric nature. The cost of the psychiatric evaluations and subsequent treatment in the inpatient units at Fort Chaffee and in Washington, DC, approximated $14.8 million, excluding the costs related to the services provided by the cadre of PHS medical officers and staff.

Despite the great amount spent on a relatively small group of Cubans it is important to remember that the great majority of the Cuban Entrants have adjusted to life here. This theme was exemplified in an editorial in the Washington Post on January 8, 1982.

> Between April and October 1980, more than 125,000 Cubans arrived in south Florida via the Mariel boat lift . . . .
>
> The surprising and impressive fact is that all but two percent have been settled and are quietly earning a living and becoming Americans. This unheralded achievement is due in large measure to the efforts of the Immigration and Naturalization Service and the Departments of State, Justice and Health and Human Services. Credit also is due to the many voluntary agencies that worked to find sponsors for the Cubans and that provide continuing support. Unfortunately, the remaining two percent of the Cubans—those who have not been resettled—are the ones we read about. . . .
>
> Fidel Castro undoubtedly thought he would embarrass and discredit our government by unloading his undesirables on the beach at Key West. He must be disappointed. Americans have accorded the migrants both charity and justice.

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Analysis of County-Level Data Concerning the Use of Medicare Home Health Benefits

JOHN HAMMOND, MBA, MA

Mr. Hammond is a health economist with the Contract Health Services Branch of the Indian Health Service, Health Resources and Services Administration.

Tearsheet requests to John Hammond, Rm. 5A 27, Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857.

Synopsis

A multiple regression analysis was undertaken of variables identified in the literature as underlying the relationship between community characteristics and the availability and use of home health services. The literature on social science and health care administration was reviewed to identify the variables that theoretically underlie different rates of home health care use among communities. County statistics then were used to quantify many of those variables that, when considered in combination, should explain much of the use of home health services.

Three categories of variables—general community characteristics, health sector characteristics, and service availability—contribute roughly equal amounts to the total explained variance of 25 percent. Viewed from the opposite perspective, 75 percent of the use of Medicare home health benefits remains unexplained despite the purported strong association between the variables employed in this analysis and the use of home health services. These findings abase the long-held belief that substitution of inpatient services for home care is commonplace, and they suggest the potential effectiveness of community-level strategies to promote the use of home health services, particularly efforts to increase their availability.