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A balance has to be struck. Failure to prosecute in appropriate cases may lead to loss of an opportunity to establish and document dangerous behaviour. The use of part three of the Mental Health Act 1983 remains an important device in striking this balance. It acts as a permanent reminder of the patient's offending. Not only is this vital for future risk assessment, but it imports a qualitative distinction to the management of the patient as well as helping to prioritise the allocation of resources.

Implementation of the Police Case Disposal Scheme in practice involves a series of complex judgements by police officers. This is even more complex in the case of psychiatric patients. Eastman & Mullins (1999) have suggested that criminal acts committed by patients with a mental disorder or a psychiatric history have less chance of being investigated by the police. Good communication and use of opportunities for joint training between mental health staff and police officers may reduce this complexity and assist in better implementation.

Comment

The case example presented in this paper is fictional but faithfully reflects clinical reality. Any resemblance to an actual case is purely coincidental.

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***Richard Bayney** Specialist Registrar/Honorary Lecturer, West London Mental Health NHS Trust, Uxbridge Road, Southall, Middlesex UB1 3EU, **George Ikkos** Consultant Psychiatrist and Head of Medical Education, Barnet Community NHS Trust

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S. R. COLLINSON AND T. H. TURNER

Not just salsa and cigars: mental health care in Cuba

Given the marginal nature of psychiatry in terms of Western health priorities, it is always worth reviewing how countries with clearly different political systems treat their mentally ill. The 40-year economic embargo imposed by the USA on Cuba, the effects of which have been compounded by the hardships suffered during the 'Special Period' from 1989 onwards when the collapse of the Soviet Union left the island's economy in ruins (Pilling, 2001), is one of the most stringent of its kind. It prohibits the sale of food, and sharply restricts the sale of medicines and medical equipment, which, given the USA's pre-eminence in the pharmaceutical industry, effectively bars Cuba from purchasing nearly half of the new world class drugs on the market (Rojas Ochoa, 1997). Between 1989 and 1993, Cuba's gross domestic product fell by 35% and exports declined by 75% (Pan American Health Organisation, 1999). This has reduced the availability of resources and has adversely affected some health determinants and certain aspects of the population's health status. Despite this, however, Cuba has developed a system prioritised to primary and preventive care, with an infant mortality rate half that of the city of Washington, DC (World Health Organization & Pan American Health Organization, 1997; Casas *et al*, 2001). Furthermore, biotechnology and family medicine are being developed by Cuba as a human resource for other developing countries. Cuban medical schools also train physicians specifically for many developing countries around the world (Waitzkin *et al*, 1997).

The Cuban constitution makes health care a right of every citizen and the responsibility of the government. The national health system is based on universal coverage and comprehensive care, with free preventive, curative and rehabilitation services. Drugs and medical aids are charged for, but prices are low and subsidised by the state. Despite the imposition of the US embargo in 1961, Castro's Government has consistently invested both human and financial resources in the health care system. Thus, the doctor per population ratio has risen steadily during the past 25 years, with 60 000 now in practice: one doctor for every 214 Cubans, the world's best doctor–patient ratio (Garfield & Santana 1997). Family

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medicine specialists practising in the local community serve more than 90% of the population. There are currently 272 hospitals and 442 poly-clinics. New health projects for 2001 include the development of four mental health centres and a psychiatric occupational health therapy complex. In general, and in keeping with the tenets of 'revolutionary medicine' (Guevara, 1987), mental health services are oriented not only toward the bio-medical aspects of mental health, but also toward promotion of health, prevention of mental illness and, importantly, social rehabilitation. It was against this context that in January 2001 we accepted an invitation to visit the Hospital Psiquiátrico de la Habana (HPH), known locally as Mazorra, located in a western suburb of the capital, Havana.

Historical background

The original hospital was founded in 1853 and, as with European asylums, was designed to be outside the city. On our arrival, we approached the hospital along a wide avenue that led to the main building, which was dated 1930, and displayed the legend *Casa de Dementes* above the entrance door. The hospital itself covers some 7 hectares and consists in the main of single storey buildings surrounded by spacious lawns and flowerbeds. A band was playing underneath a pergola, and apparently practises there regularly, although its members are not part of the patient population. The layout of the hospital is reminiscent of the 'pavilion' system of, for example, the Bethlem Royal Hospital in England, and of colonial asylums around the world.

Until 1959, HPH was the only public psychiatric hospital in Cuba. Prior to that time the only other psychiatric facilities were private clinics. The doctors we met were reluctant to talk about the pre-1959 era, as this was considered a dark time, when the hospital was compared to a lunatic house, or even a concentration camp. We were, however, shown around an extensive archive of the hospital's history, and photographs and artefacts from this time certainly bore out these statements. The photographs of the hospital from 1859 onwards formed an anthology that moved from images of colonial paternalism, through the neglect and despair of the Batista years, to the humanitarian transformation that took place under Castro's régime. The photographs from 1959 onwards show clean, white-clothed patients helping to build their own new hospital.

The transformation of the hospital was deemed a priority by the new Castro Government, and the current Director, Dr Eduardo B. Ordaz Ducungè (now aged 78), was chosen for this task because of his 'very humane behaviour'. Originally an anaesthetist, he had been fighting with Che Guevara in the jungles of the Sierra Maestra, and the day after arriving in Havana with the victorious guerrillas, after the collapse of the Batista régime, Fidel Castro put him in charge of the hospital. When the Director and his team arrived at the hospital on 9 January 1959, they found 6000 'unclassified' patients, that is to say, none of them had a clear diagnosis. Furthermore, these 6000 patients were incarcerated in a 2000-bed hospital, with the result that many of them were living on the floors of the wards and corridors. As was evident from the photographs in the archive, conditions were clearly atrocious. Patients were tied to beds with ropes and manacles, and most of the beds were iron-framed and without mattresses. Many patients were locked away behind iron bars. Few had adequate clothing; some had none. A range of physical disorders, including leprosy, were endemic, and there was, of course, a wide mix of psychiatric presentations (learning disability, neurological conditions, psychosis, etc). There was also a special ward for the children of patients (who were actively procreating).

Under the leadership of Dr Ducungè, a team of psychiatrists and psychologists set about trying to classify the patients and reform the hospital, and in the 1960s a group went to Europe, to acquire expertise in new treatment approaches. A particular innovation they picked up on was the rehabilitation model, principally because of their experiences in France and Spain. It is clear that these are the two European countries that have developed the closest professional contacts with psychiatrists in Cuba. There is in fact a Cuban–French Psychology and Psychiatry Association, which holds regular meetings to promote exchanges between specialists in the two countries, and to encourage scientific cooperation.

The current situation

We were told that today HPH has some 2000 in-patients, and about another 2000 attending on a day or community basis. It is one of the three major psychiatric hospitals in Cuba, the others (in Camaguey and Santiago de Cuba) both having about 500–600 beds each. Each of Cuba's 14 regions also have a psychiatric unit, attached to the general hospital, and usually with about 20–30 beds. Most of the patients in HPH had long-term schizophrenic illnesses, requiring rehabilitation, and that was very much the kind of patient we saw.

Altogether, there are about 1000 psychiatrists in Cuba, about 200 of whom are child psychiatrists. The training programme involves 6 years as a medical student, 3 years of general medicine (internships), followed by 3 years of specialist psychiatric training. There are also a number of grades among the psychiatrists themselves, and presently there are eight professors of psychiatry in Cuba, with two senior 'titular' professors based in Havana. There are 150 doctors working in HPH, 50 of whom are non-psychiatrists. It was noteworthy that the hospital had its own 'somatic' clinic. Facilities included X-ray, electrocardiogram, electroencephalogram and other physical assessments, but patients needing an operation required transfer to a general hospital. The psychiatric hospital itself covers all specialities, including acute and emergency, as well as forensic and rehabilitation. It does not take older patients (over 65), but does

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quite clearly receive a significant forensic load. Our senior guide was actually a forensic psychiatrist.

In terms of the general treatment approach, it seems that most patients in the hospital were there on a non-voluntary basis (brought in under the Cuban version of the Mental Health Act), although there were some voluntary patients. The reverse is true for the psychiatric units attached to the general hospitals, in which most of the patients are voluntary. The process of bringing someone into hospital is very similar to that in the UK. It requires the signatures of two psychiatrists, one of whom must be the psychiatrist in the receiving hospital, and a family member. Initially an order is for 72 hours. A commission reviews those patients detained for a longer period every third month. The last Cuban Mental Health Act was passed in 1983, with an enhancement in 1984. Our guides mentioned that their process was modelled on the Canadian system. They also talked about the ethical background to their legislation, and referred to a list of patients' rights and the principle of consent.

Therapeutic approaches

Treatment was generally eclectic, combining rehabilitation, social therapies, occupational therapy and medication (Pan American Health Organization & World Health Organization, 1998). Our guides talked of 'social therapy linked to the pharmacotherapies', as well as socialist transformation and other Marxist accounts that informed their understanding of mental illness. They felt that their occupational therapy, for example, went beyond mere 'ergotherapy', and was aimed at generating both emotional and social benefits, a major improvement, in their view, over the more limited approaches used in North America or Europe. They also use electroconvulsive therapy (ECT), considering it to be a very effective therapy, although they agreed that the profession in Cuba was quite divided about ECT ('50/50'), not unlike the profession elsewhere.

The drugs available to them seem to be general (e.g. standard antipsychotics and antidepressants), but they have only a very limited number of atypicals. They mentioned olanzapine, but seem to have to rely on help from certain hospitals and institutions in France and Spain, who channel medications to them. They do seem to have fluoxetine regularly available as an antidepressant, as well as the usual tricyclics. It should also be noted that the hospital has a high staff–patient ratio with, in total, about 2000 members of staff. These seemed to be well-trained and interacting enthusiastically with the patients. We saw occupational therapists and nurses engaged in a range of activities, including sports, music therapy (psycho-ballet), hair-dressing, language and numeracy classes, foot massage and handicrafts. We also attended a musical show put on by the patients.

In relation to other diagnoses apart from the psychoses, they see little anorexia or bulimia nervosa. The hospital has a drug dependency unit (DDU), but this is largely for foreigners. Most of the patients in the DDU are Spanish speakers, from countries such as Venezuela and Colombia. This seems to be a way of bringing in an additional income. There is apparently not much drug misuse in Cuba (antidrug laws are very severe), but recently the doctors have begun to see cocaine-dependent patients. Inevitably, their biggest problem is alcohol, as rum is widely available and quite cheap. The regimen in the DDU is based on intensive group therapy, a model used elsewhere in the world.

Social impact

In terms of community outreach, a number of patients go home at the weekends, and many others come in as day patients, for occupational therapy and other activities. There was also a 'night ward', where patients who went off site during the day – often because they had jobs – would return to sleep. It seems that there are community-based teams throughout the Havana region (consisting of some 3 million people) who do most of the community care. Each patient does have an assigned social worker, but it was difficult to clarify the actual training of these. It is also of note that medical students come and live on site for 2 months, in one of the pavilions, when they do their psychiatry firm. Typically, however, psychiatry is not a high status specialism within the medical profession.

When asked about 'untoward incidents' in the community, the doctors said that these were not really a problem for psychiatrists. They said at first that this was because 'we don't have lawyers to attack the psychiatrists'. They conceded that there might be a problem if a forensic patient was let out without full consultation with the whole team, and in defiance of the legal ruling. They mentioned the notion of a patient not being evaluated correctly, and of the importance of ethical practices. They felt there was a difference between their approach and that of psychiatrists in a capitalist society, in so far as in the latter any decision about discharge implied some sort of 'responsibility'.

They discharge patients into the community, and the community organises follow-up and tries to prevent relapse in the usual way. They mentioned a recent famous case that had involved a well-known actress killing her daughter and then killing herself while actually being 'evaluated' (presumably while in hospital). She was, it emerged, suffering from a psychotic illness. However, these tragic events did not provoke a huge outbreak in the press. They gave as reasons for this: first the fact that their press 'does not want that, and it's not a big scandal'; but also that there was a sense that they did not let 'the media take power' in terms of what happens. Thus, it simply was not 'a matter of news'.

Health tourism

While at HPH, we walked past a half-built building, originally planned as a new forensic unit. The money for this had, however, run out, and the building was

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going to be completed, at a reduced cost, as a theatre for the patients' use. There is a visible lack of resources throughout Cuba, but the Cuban government has begun to address this with great resourcefulness. It has realised the marketable value of a highly trained medical workforce situated in a beautiful location. Cubanacan, the state tourism company, has openly developed a thriving health tourism service, which has turned into a tourist sub-system in itself. It provides primary care in the form of physicians at hotels and international clinics; secondary care in clinics and hospitals offering specialised medical care in a wide range of disciplines, including surgery and dentistry; and a large number of goods in the field of medical products, pharmacology and optics.

Among the clinics and centres promoted by Cubanacan are several that specialise in the treatment of drug and alcohol misuse; and of degenerative and neurological conditions. The health tourism industry also offers 'centres to improve the quality of life'. These include 'thermal centres, aesthetic centres and thalassotherapy centres, where tourists can receive 'executive checkups, stress control, general biological restoration, and sleeping disorders control'. Although a majority of the health tourists are from Spanish speaking countries, an increasing number are arriving from North America.

Summary

Our general impression from the visit to HPH was of a positive attitude towards mental health, with much work being done in order to destigmatise those with mental illness. However, it was agreed by the doctors that some families did still cover up mental illness, and that others would resort to traditional remedies if they felt that conventional medicine was not working. The doctors themselves were enthusiastic about their work, although biologically orientated. The sceptical Westerner might consider whether we were being presented with a 'show piece', but the overall feel of the hospital was of a caring and well-organised institution. Fidel Castro's 42-year régime has been notable for its drive to eradicate poverty, hunger and disease through a comprehensive social welfare programme. For this psychiatric hospital, having one of Castro's oldest comrades as Director may well have further ensured that vital resources were forthcoming. A lesson perhaps in *realpolitik* for mental health workers of the world?

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***S. R. Collinson** Lecturer, Bartholomew's and the London Medical School, West Smithfield, EC1A 7BE, **T. H. Turner** Consultant Psychiatrist and Honorary Senior Lecturer, Homerton Hospital

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GIANETTA RANDS

Fear of flying, reviewed

An example of evidence-based old age psychiatry

'Doctor, would it be alright to take mum to Cyprus for a family wedding?' In a cosmopolitan city such as London hardly a month goes by without hearing a similar sort of query. If 'mum' has dementia I tend to advise the family against flying. This advice is based on anecdotal observations from past clinical practice. I have witnessed a number of patients experience significant deterioration in cognition following flying. While disorientation in unfamiliar environments may explain some of the difficulties in travelling for a person with dementia, as illustrated by John Bayley in *Iris* (1998), this may not be the only explanation. On this occasion, I decided to use evidence-based practice to review the situation.

The clinical picture

Mrs P. presented at 67 years of age with a history of intermittently progressive, global cognitive impairment,

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