



## Research paper

## Prevalence and correlates of psychological distress among drug users in Phnom Penh, Cambodia



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## ABSTRACT

**Background:** Compared to the general population, drug users are at increased risk of both poor mental health and HIV infection. The aim of this study was to determine the prevalence and correlates of high psychological distress among drug users in Cambodia.

**Methods:** In April 2014, a two-stage cluster sampling method was used to randomly select 169 drug users from hotspots in Phnom Penh. Psychological distress was measured using General Health Questionnaire (GHQ-12). Bivariate and multivariable analyses were conducted to identify factors associated with levels of psychological distress among this population.

**Results:** Our study found high prevalence of attempted suicide (15.3%), drug related arrests (46.2%), and incarceration (31.4%). Of the 169 participants, 42.0% were found to have high levels of psychological distress, indicating poor mental health. After adjustment, high levels of psychological distress were independently associated with suicidal ideation ( $p < 0.001$ ), higher frequency of drug use ( $p = 0.02$ ), sharing of needles or syringes ( $p = 0.005$ ), and having been sent to a rehabilitation centre ( $p = 0.02$ ). In addition, participants who perceived their overall health as being poor or very poor were more likely to have high levels of psychological distress ( $p = 0.002$ ).

**Conclusion:** Integration of mental health within HIV and needle and syringe exchange programmes is required to address psychological distress among drug users in Cambodia. Health system interventions, such as screening, referral, and training of health providers, need to be strengthened. In addition, interventions addressing social determinants of mental health and mitigation of frequent arrests and improving conditions in rehabilitation centres are required.

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## Introduction

Poor mental health is a source of significant public health burden globally (Whiteford et al., 2013). In 2010, mental health was the 11th most important cause of morbidity and mortality globally (Murray et al., 2012). Mental health conditions are also among the most difficult to treat (Stein & Seedat, 2007). In many contexts, people with severe mental disorders are also the most vulnerable and socially excluded (Funk, Drew, Freeman, & Edwige, 2010). Although prevalence of poor mental health differs by

contexts and sensitivity of screening methods (Charlson, Diminic, Lund, Degenhardt, & Whiteford, 2014), evidence suggests that, compared to the general population, drug users are more likely to have mental disorders (Armstrong, Nuken, et al., 2013; Brienza et al., 2000; Conner, Piquart, & Duberstein, 2008; Knowlton et al., 2001).

Research has shown that the relationship between mental disorders and drug use is complex and either can proceed, reinforce, or be the consequence of the other (Buckingham, Schrage, & Cournos, 2013). Drug use is often a behavioural mechanism for coping with mental health symptoms (Loue, Sajatovic, & Mendez, 2011). While understanding the causation sequence remains relevant, evidence suggest that severity of poor mental health is often correlated with the extent of drug dependence, unmet service needs (Li et al., 2015), and in some

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cases, adverse childhood experiences (Kang, Deren, & Goldstein, 2002) of drug users. In addition, while the direction of the effect may differ, gender is also an important mediator of the way in which poor mental health is experienced or coped with among this population (Loue et al., 2011; Pettes et al., 2015; Shaw et al., 2015; Springer, Chen, & Altice, 2009).

HIV is often overlaid within this complex situation: poor mental health, particularly depression, is often linked with an increased uptake of high-risk behaviours and ultimately, HIV infection among drug users. Various studies have shown that drug users with severe depressive symptoms and suicidal thoughts are more likely to share needles and syringes (Armstrong, Jorm, et al., 2013; Mackesy-Amity, Donenberg, & Ouellet, 2014). Those with severe depression and suicidal thoughts have a greater frequency of unsafe drug injection (Li et al., 2013; Pilowsky, Wu, Burchett, Blazer, & Ling, 2011), more sexual partners, and greater frequency of unprotected sex (Armstrong, Jorm, et al., 2013; Pettes et al., 2015).

Once infected with HIV, poor mental health can lead to poor treatment outcomes among drug users, including poor adherence to antiretroviral therapy (Carrieri et al., 2003; Palmer, Salcedo, Miller, Winiarski, & Arno, 2003), faster disease progression (Bouhnik et al., 2005), and increased hospitalisation (Marimoutou et al., 2003). In addition, improvement in mental health has been noted following initiation of antiretroviral therapy among drug users. Standard interventions in HIV treatment, such as motivational counselling, adherence counselling, peer-based support, and case management, often have a positive psychological impact, which in turn reduces substance use (Springer et al., 2009). These observations suggest that better linkages between mental health, HIV prevention and treatment, and needle-exchange programmes could be beneficial.

In particular, it is important to identify how the already defined packages of mental health services (Patel & Thornicroft, 2009) can be delivered to drug users in low- and middle-income countries. In countries such as Cambodia, limited progress has been made in the understanding patterns of mental health among this population. In response to this gap, this paper documents the prevalence and correlates of high psychological distress among drug users in Phnom Penh, Cambodia.

## Methods

### *Study sites, sampling, and training*

In April 2014, data used for this study were collected as part of an impact evaluation of the Sustainable Action against HIV and AIDS in Communities (SAHACOM) project implemented by KHANA, the largest national non-governmental organisation providing integrated HIV prevention, care, and support services at the community level in Cambodia. The details of the SAHACOM project have been published elsewhere (Yi, Chhoun, Brant, Kita, & Tuot, 2014; Yi et al., 2015). The study participants were randomly selected for face-to-face interviews from a list of hotspots obtained from KHANA's partners who implemented the SAHACOM programmes in the capital city of Phnom Penh.

A two-stage cluster sampling method was used to select the study sample. At the first stage, the probability proportional-to-size sampling method was used to select hotspots from the list. At the second stage, because of the small number of reachable participants who use drugs in the programmes, all drug using clients in the selected hotspots were invited to participate in the study. A person would be included in the study if they: (1) were at least 18 years of age; (2) had used any form of illicit drugs in the past three months; (3) were able to present themselves on the day

of the interview; and (4) were able to provide informed consent to participate in the study.

All research team members were trained for three days on the study methods, interview techniques, privacy assurance, and confidentiality. The training also addressed quality control strategies, such as rechecking and reviewing the questionnaires after administration and resolving issues that might arise during the fieldwork. Data collection team leaders were encouraged to perform regular reviews on the progress of the data collection and communicate any issues that may occur during the data collection.

### *Questionnaire development and measurements*

A structured questionnaire was first developed in English and then translated into Khmer, the national language of Cambodia. The Khmer questionnaire was back-translated and pretested with a sample of 10 drug users to ensure that wording and contents were culturally suitable and clearly understandable for the respondents. We also received comments from experts working on HIV and mental health in key populations in Cambodia and the questionnaire was finalised based on their feedbacks and findings from the pilot phase.

Standardised tools were adapted from previous studies in the same population (Heng & Tuot, 2013), the most recent Cambodia Demographic and Health Survey (National Institute of Public Health National Institute of Statistics and ORC Macro, 2010) as well as from other studies in Cambodia (Yi et al., 2010). Socio-demographic characteristics included age, marital status, completed years of formal education, average monthly income, and living situations. In addition, we also collected information on self-perception of level of HIV risk compared to the general population, self-rated overall health and quality of life, suicidal thoughts and suicide attempts in the past three months.

Regarding illicit drug use, participants were questioned about types of illicit drugs and frequency of use in the past three months, duration since the first use and age at the first use. For those who reported injecting drugs, they were also asked whether they had used needles or syringes that had been used by someone else in the past three months. In addition, respondents were questioned about whether they had been arrested because of drugs-related acts, sent to a rehabilitation centre, or incarcerated. These rehabilitation centres are community-based treatment centres that are meant to provide care and treatment services (including access to HIV prevention, treatment, and care resources), as well as vocational training for drug users.

Adverse childhood experiences were measured using five questions adapted from the brief screening version of the Childhood Trauma Questionnaire (Bernstein et al., 2003). The questions collected information on the experience of physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect with five response options ranging from (1) 'never' to (5) 'very often'. Participants who responded 'never' or 'rarely' were grouped together as those without adverse childhood experiences and those who answered 'sometimes', 'often', or 'very often' as those with adverse childhood experiences.

We also adapted five items from the brief screening version of the Childhood Trauma Questionnaire to enquire about family dysfunction (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997; Bernstein et al., 2003). The items collected information on 'witnessing violence against a family member', 'having an alcoholic or drug user family member', 'having a family member who was depressed, mentally ill, or who has attempted suicide', 'having parents who had been separated or divorced', and 'having a family member who has been to prison'. The response options for all the items were 'yes' or 'no,' except for 'having parents who had been separated or divorced'. For this item, another response option was

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