



Mental health services in Cambodia, challenges and opportunities in a post-conflict setting



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ABSTRACT

Cambodia had suffered enormously due to war and internecine conflict during the latter half of the twentieth century, more so during the Vietnam War. Total collapse of education and health systems during the Pol Pot era continues to be a challenge for developing the necessary infrastructure and human resources to provide basic minimum mental health care which is compounded by the prevailing cultural belief and stigma over mental, neurological and substance abuse disorders (MNSDs). The mental health research and services in Cambodia had been predominantly 'trauma focused', a legacy of war, and there is a need to move toward epidemiologically sound public health oriented mental health policy and service development. Integrating mental health program with primary health care services with specifically stated minimum package of activities at primary level and complementary package of activities at secondary level is an opportunity to meet the needs and rights of persons with mental, neurological and substance abuse disorders (PWMNSDs) in Cambodia, provided there is mental health leadership, government commitment and political will.

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1. Background

The Khmer empire extended as far as Thailand, Malaysia, Vietnam and Laos during the eighth to twelfth centuries, a golden period that is enshrined in the magnificent temples of Angkor, a

world heritage monument in Cambodia. Cambodia has been a land of perennial conflict since Angkorean times. Following the independence from French colonial rule, the country deteriorated to become the poorest in the region, a 'victim of its geography and political underdevelopment' (Shawcross, 1994). The spillover of Vietnam War and the social engineering and pogrom of Pol Pot regime in the 1970s resulted in collective trauma of the entire population. A million and a half died due to starvation and sickness, half a million were eliminated in the name of agrarian revolution and about two million people were internally displaced between 1975 and 1978. Studies in the refugee-sites along the Thai border revealed the impact of war and internecine conflict on the mental health of the Cambodian population (Mollica et al., 1997). The end of the Cold War and the Paris Peace Agreement of 1991, followed by UNTAC-intervention (United Nations Transitional Authority in Cambodia) brought an uneasy peace and stability but the country continues to suffer from political instability and the impact of chronic conflict (Deth, 2009). The people of Cambodia are in the process of reconciling with the trauma of war and conflict of the past whereas lack of institutional structures remains to be a challenge for the growth and development of the nation, particularly health services

Abbreviations: ATS, Amphetamine type of stimulants; CCAMH, Center for Child and Adolescent Mental Health, Cambodia; CMHTP, Cambodian Mental Health Training Program; HICs, High Income Countries; HTPC, Harvard Training Program in Cambodia; IMCI, Integrated Management of Childhood Illnesses; IBSA, India Brazil South Africa Trust Fund; IOM, International Organization for Migration; KRT, Khmer Rouge Tribunal; LMICs, Low and Middle Income Countries; MNSDs, Mental, Neurological and Substance Abuse Disorders; NIMH, National Institute for Mentally Handicapped, Secunderabad; NIMHANS, National Institute of Mental Health and Neurosciences, Bangalore; NORAD, Norwegian Aid; PNES, Psychogenic Non-Epileptic Seizures; PWE, People With Epilepsy; RQC, Reporting Questionnaire for Children; TPO, Transcultural Psychosocial Organization; UNCRPD, United Nations Convention of Rights for People with Disability; UNTAC, United Nations Transitional Authority in Cambodia.

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(Bockers et al., 2011). Deva et al. (2009) outlined the development of mental health services in Cambodia and the challenges ahead in the backdrop of sparse human resource and meager allocation of national health budget to the mental health program. Research and development of mental health services in post-conflict countries such as Cambodia, had been trauma focused and there is a need to move beyond post-traumatic stress disorder (PTSD)-paradigm to address the range of common mental and neurological disorders (de Jong et al., 2003; Murthy and Lakshminarayana, 2006). This article, a follow-up to the update on the mental health situation of Cambodia by Deva et al. (2009), underscores the importance of epidemiologically sound, public health model of mental health service delivery, with an emphasis on integration of mental health services with the primary, secondary and tertiary health care systems in Cambodia.

2. Trauma-led research and mental health care, a legacy of conflict-ridden Cambodia

The socioeconomic situation, health and development of the people of Cambodia, particularly the mental health, had been adversely affected, either directly or indirectly due to border disputes which remain a source of conflict between neighboring countries (Sothirak, 2013). There are an estimated 400,000 migrant workers in Thailand and the enormity of their mental health challenges in the background of poverty, migration and lack of access to services is a cause for concern (Meyer et al., 2014; Van de Put and Eisenbruch, 2004). The recent regime change in Thailand led to the influx of more than 200,000 migrant workers back to Cambodia within the brief period of a week, indicating the fragility of the psychosocial situation and the challenge for mental health service providers. The recurring mental health crisis and reliving of trauma by the people of Cambodia was exemplified by the study among the survivors of Pol Pot regime in the backdrop of ongoing Khmer Rouge Tribunal (KRT) (Field and Chhim, 2008). A mental health survey among landmine-victims in Siem Reap province of Cambodia reported high prevalence of mental health problems, 62% anxiety disorders, 74% depressive disorders and 34% PTSD, and recommended 'mental health services embedded within the primary health care system' (Lopes Cardozo et al., 2012). The study that looked at lifetime events and PTSD in four conflict settings, viz. Algeria, Cambodia, Ethiopia and Gaza, found 28.4% Cambodian survivors suffering from PTSD, next only to the respondents from Algeria (de Jong et al., 2001). Many epidemiological studies in post-conflict countries such as Libya, and among war-refugees of Rwanda, Somalia and Vietnam highlighted the impact on the mental health of the population well beyond the period of conflict, that is further worsened by poverty, health and human resource constraints (Charlson et al., 2012; Onyut et al., 2009; Steel et al., 2002). The geopolitical situation, the chronic and recurrent upheavals in Cambodia and the international focus on PTSD led to many trauma related studies, and it is time common mental, neurological and substance abuse disorders (MNSDs) were given equal importance if not more (Van de Put and Eisenbruch, 2002). A study by Somasundaram et al. (1999) underscored the need for 'culturally informed approach in finding solutions to psychosocial problems' and the importance of establishing community based interventions to meet the huge mental health needs of Cambodia. The World Health Organization emphasizes the importance of evidence based intervention and recommends guidelines for management of MNSDs and neurodevelopmental problems that include epilepsy, and child and adolescent mental health and related conditions to reduce the burden of mental morbidity in low and middle income countries (LMICs) (Dua et al., 2011; Thornicroft, 2012).

3. Prevalence of mental, neurological and substance abuse disorders (MNSDs) in Cambodia

Until recently, most of the published studies on mental health situation of the people of Cambodia are from the immigrant population living in high income countries (HICs) (Fazel et al., 2005; Marshall et al., 2005) and there are a few population based prevalence studies on MNSDs in Cambodia. Most of the rural areas were inaccessible due to poor infrastructure in terms of connectivity and landmines, a legacy of war, which may explain the lack of nationwide prevalence study of MNSDs in Cambodia. A study among the clinical population in an out-patient setting revealed the following profile: anxiety 18%, depression 15%, epilepsy 15%, psychosis 15% and schizophrenia 18% (Somasundaram et al., 1999). The authors reiterated the need for community based care and integration of traditional healers in the mental health service delivery in the background of inadequate number of trained mental health personnel and non-availability of essential medicines in Cambodia, a scenario common to most LMICs. A recent survey among 2600 adults aged 21 and above in nine provinces of Cambodia reported high prevalence of suicide attempts, post-traumatic stress disorder (PTSD), and anxiety disorder in the general population (Schunert et al., 2012). According to this survey, there were 42 suicides per 100,000 of the population per year, which is high but comparable to countries in transition such as Belarus, Estonia, Hungary and Kazakhstan (Hoven et al., 2010). The most common reported stressor leading to suicidal thoughts in this study was poverty and indebtedness, similar to the travails of the cotton farmers of India (Grùère and Sengupta, 2011). This is of serious concern, particularly when 23% of the population in Cambodia is below poverty line (Ministry of Planning, 2013). In the study by Schunert et al. (2012), 27.4 and 16.7% of the respondents reported anxiety and depression, respectively, and 2.7% experienced symptoms of PTSD, which were overall higher than in other post-conflict countries such as Ethiopia and Palestine, with the exception of Algeria (de Jong et al., 2003). Epilepsy adds to the mental health burden, as it is considered a mental illness and it is referred to as "Chikoot Chiruk" in Khmer (Cambodian language), a derogatory expression, which literally means 'pig madness'. It is important to understand the cultural belief system and stigma around MNSDs in order to improve help seeking behavior, as 70% of the people with epilepsy (PWE) seek help with the traditional healers or monks before reaching a hospital (McLaughlin and Wickeri, 2012; Eisenbruch, 1992).

Epilepsy is a global problem affecting 2–3% of the population and 80% of the burden of epilepsy is among LMICs (Barragán, 2012). Anxiety, mood disorders, psychosis, attention deficit hyperactivity disorders and autism are most common comorbidities, having 'bidirectional relationship' with seizure disorders (Gaitatzis et al., 2004). Therefore, it is important to consider management of epilepsy as part and parcel of mental health treatment package in LMICs, particularly in Cambodia where there are not many trained neurologists. A population based study of epilepsy in Cambodia reported a life-time prevalence of 5.8/1000, slightly lower than that in other countries in the region but the treatment gap was 65.8%. Among those treated, only 30% had access to antiepileptic medication and about 60% were reported to be using herbal products. Furthermore, 54% of the respondents considered epilepsy to be contagious and the prevailing stigma was associated with type of seizure and quality of life (Bhalla et al., 2012). In a door-to-door universal survey in 15 villages among 2564 children ($M = 1261, F = 1303$) in the age group of 2–16 years using Reporting Questionnaire for Children (RQC), 7.6% of the parents responded 'yes' to the question, 'Did the child ever have fit or fall to the ground for no reason' (Ahmad et al., 2007; Center for Child and Adolescent

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