Meeting on NCD
Focus on Mental Health
Cambodia 2015

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SPECIAL REPORT
Mental Health and Human Rights in Cambodia

Leitner Center for International Law and Justice
AT FORDHAM LAW SCHOOL, NEW YORK CITY
Care needs


- Depression : 42.4 %
- Anxiety : 53 %
- PTSD : 7.3 %
- Socially impaired : 25.3 %
- High comorbidity

« This suggests that beyond psychosocial programs, the implementation of adapted clinical psychiatric care should be considered as a priority. »
Care needs


- 10.4 % of DALYs
- 2.3 % of YLLs
- 28.5 % of global YLDs = leading cause

MD + SUD :
- 7.4 % of global DALYs = 5th position
- 22.9 % of global YLDs = 1st position
Care needs


DALYs

• Mental disorders → 56.7 %
• Neurological disorders → 28.6 %
• Substance use disorders → 14.7 %
Care needs


- Treatment rates are low! Particularly in LMICs

  GAP > 90%

- HICs: treatment tends to be provided many years after the onset of the disorder
Care needs


« Although these disorders exist in all countries, cultures also influence their development and presentation. The predominantly Western-based definitions of mental, neurological, and substance use disorders can be in conflict with cultural contexts, leading to challenges in assembling data on global epidemiology. »
Care needs


« Mental, neurological and substance use disorders contribute to a significant proportion of disease burden. Health systems can respond by implementing established, cost effective interventions, or by supporting the research necessary to develop better prevention and treatment options. »

Note: DALYs = disability-adjusted life years.

Note: YLLs = years lost to premature mortality; YLDs = Years lived with disability
In 2008, WHO launched the Mental Health Gap Action Programme (mhGAP) to address the lack of care, especially in low- and middle-income countries, for people suffering from mental, neurological, and substance use disorders. Fourteen per cent of the global burden of disease is attributable to these disorders and almost three quarters of this burden occurs in low- and middle-income countries. The resources available in countries are insufficient – the vast majority of countries allocate less than 2% of their health budgets to mental health leading to a treatment gap of more than 75% in many low- and middle-income countries.

Taking action makes good economic sense. Mental, neurological and substance use disorders interfere, in substantial ways, with the ability of children to learn and the ability of adults to function in families, at work, and in society at large. Taking action is also a pro-poor strategy. These disorders are risk factors for, or consequences of, many other health problems, and are too often associated with poverty, marginalization and social disadvantage.

There is a widely shared but mistaken idea that improvements in mental health require sophisticated and expensive technologies and highly specialized staff. The reality is that most of the mental, neurological and substance use conditions that result in high morbidity and mortality can be managed by non-specialist health-care providers. What is required is increasing the capacity of the primary health care system for delivery of an integrated package of care by training, support and supervision.

It is against this background that I am pleased to present “mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings” as a technical tool for implementation of the mhGAP Programme. The Intervention Guide has been developed through a systematic review of evidence, followed by an international consultative and participatory process. It provides the full range of recommendations to facilitate high quality care at first- and second-level facilities by the non-specialist health-care providers in resource-poor settings. It presents integrated management of priority conditions using protocols for clinical decision-making.

I hope that the guide will be helpful for health-care providers, decision-makers, and programme managers in meeting the needs of people with mental, neurological and substance use disorders.

We have the knowledge. Our major challenge now is to translate this into action and to reach those people who are most in need.

Dr Margaret Chan
Director-General
World Health Organization
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« {...} The reality is that most of the mental, neurological and substance use conditions that result in high morbidity and mortality can be managed by non-specialist health-care providers. What is required is increasing the capacity of the primary health care system for delivery of an integrated package of care by training, support and supervision. »
Figure 1: Burden of mental disorders and budget for mental health

- Proportion of disability-adjusted life years (DALYs) attributable to mental disorders
- Median proportion of total health budget allocated to mental health
  (Source: Mental Health Atlas, WHO, 2005)
Figure 2: Association between specified budget for mental health as a proportion of total health budget and GDP per capita for 101 countries

Logarithmic trendline

\[ y = 1.1041 \ln(x) - 4.9884 \]

\[ R^2 = 0.2507 \]

(Source: Mental Health Atlas, WHO 2005)
Figure 3: Human resources for mental health care in each income group of countries, per 100,000 population

- **Income groups:**
  - Low income
  - Lower middle income
  - Upper middle income
  - High income

- **Numbers of personnel per 100,000 population**

- **Psychiatrists**
  - Low income: 2.70
  - Lower middle income: 10.50
  - Upper middle income: 2.70
  - High income: 0.05

- **Psychologists**
  - Low income: 0.05
  - Lower middle income: 0.60
  - Upper middle income: 1.80
  - High income: 0.04

- **Psychiatric nurses**
  - Low income: 1.05
  - Lower middle income: 2.70
  - Upper middle income: 1.05
  - High income: 32.95

- **Social workers**
  - Low income: 0.04
  - Lower middle income: 0.28
  - Upper middle income: 1.50
  - High income: 15.70

(Source: Mental Health Atlas, WHO 2005)
Care needs

Patients
Families
Caregivers
Civil society
Which patients?

- Definitions: variability; cultural context
- Disease process / distress feeling / healthcare-seeking... 1, 2, 3 different people...
- Diagnosis
  - Multi-axial system
  - Dimensional approach
  - Clinical severity / functional impairment
- e.g. Psychosis
Psychosis


- Incidence of schizophrenia: 15.2 (7.7-43.0) / 100 000
- M/F ratio: 1.4 (0.9-2.4)
- Migrant/native-born ratio: 4.6 (1.0-12.8)
Psychosis


Prevalence of schizophrenia

• Point : 4.6 (1.9-10.0) / 1 000
• Period : 3.3 (1.3–8.2) / 1 000
• Lifetime : 4.0 (1.6–12.1) / 1 000

« {...} prevalence estimates from “least developed” countries were significantly lower than those from both “emerging” and “developed” sites (p = 0.04) »
Healthcare-seeking behaviour


- Traditional medicine: 56.7%
- Western medicine: 22.1%
- Religious medicine: 20.2%
- Not psychiatry: 77.3% (Mental problem? Mental Health services?)
- Patients' education = only sign. factor for HCSB

«This suggests that the development of psychiatry in Cambodia will be facilitated by a better spreading of knowledge on mental health and will have to take traditional and religious medicine into account.»
Caregivers


“Schizophrenia caregivers reported worse HRQoL than non-caregivers and caregivers of other conditions. Providing care for an adult relative with schizophrenia is important to caregivers, but caregivers need more resources to provide adequate care. Providing informal schizophrenia caregivers with support services to help better manage patients may improve their health status.”
Who is in charge of mental health?

- General practitioner
- Psychiatrist
- Psychologist
- Social worker
- Monk
- Traditional practitioner
- Ethnologist
- Physiotherapist
- Nurse
- Politician
- Patient
- Ethnologist
- Physiotherapist
- Psychologist
- Family
- Politician
- Monk
- Pharmacist
- Lawyer
- Philosopher
- Traditional practitioner
- Police
- Artist
- Judge
- Spiritual guide
- Anthropologist
- Nurse
Mental Health

- In the scope of many professions → transversal thinking
- No worldwide consensus
  Open concept
  → each program will contain an uncompleted part
  → concept must be comprehensive, not exhaustive
  → place kept for discussion, debate, dialogue, deliberation
- 3 lines of work:
  1. Reduce symptoms
  2. Welcome distress, relieve distress, accompany
  3. Reduce disability, increase capability, improve social participation
Mental health

« Negative »
Mental health

« Positive »
Mental health
Mental health

Mental disorders

Psychological distress

Positive Mental health
Children with epilepsy can go to school.
Children with epilepsy can go to school
Intellectual Disabled children have equal right to play and recreation
Intellectual Disabled children have equal right to play and recreation
Cambodia – our observations

- Counseling
- Psycho-education
- Village Health Volunteers
- Monks
- Home visit – alcoholic patient
- Home visit – psychotic patient
- General hospital
- Child psychiatry
- Social work
Cambodia – our proposals

- Training
  - Education & continuous training
  - Support
  - Supervision
- Medicine supply
- Mental Health system information, action research capitalization
- Reduce the gap...

« Scientific publications do not fully match with health priorities. Gaps remain regarding NCD, implementation studies, and health system research. A health research agenda would help align research with health priorities. We recommend 1) that the health authorities create an online repository of research findings with abstracts in the local language; 2) that academics emphasize the importance of research in their university teaching; and 3) that the researcher teams involve local researchers and that they systematically provide a translation of their abstracts upon submission to a journal. We conclude that building the bridge between research and public health requires a willful, comprehensive strategy rather than relying solely on publications. »
13 July 2015

« NGO law passes »