SPECIAL REPORT
Mental Health and Human Rights in Cambodia

Leitner Center for International Law and Justice
AT FORDHAM LAW SCHOOL, NEW YORK CITY
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SPECIAL REPORT
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INTRODUCTION

Following years of neglect, mental health has emerged as a critical public health and human rights issue.

Worldwide, approximately 450 million people suffer from a mental disorder, with lifetime prevalence rates estimated to be as high as thirty-three percent. Mental disorders are responsible for twelve to fifteen percent of the total global burden of disease—a greater percentage than cardiovascular disease and twice as much as all cancers combined. By 2030, depression is forecasted to be the single highest contributor to the burden of disease in the world. Moreover, the poor and other marginalized groups are disproportionately affected by mental health problems. According to the World Health Organization ("WHO"), "over 80% of people suffering from mental disorders such as epilepsy, schizophrenia, depression, intellectual disability, alcohol use disorders and those committing suicide are living in low- and middle-income countries." Postconflict societies exhibit particularly high rates of mental disorders. War, violence, and poverty, along with the breakdown in the social and civic fabric that accompanies such conflict, constitute additional mental health risk factors.

Today, more than three decades following the devastation of the Khmer Rouge period, few countries are still as associated with the word "trauma" as Cambodia. Yet, to date, little substantive research has been conducted to document the import of mental health in Cambodia. This Report seeks to fill that gap through an innovative application of human rights norms to the Cambodian mental health landscape based on extensive research and fieldwork, including over 150 interviews. It examines the lasting psychological impact of the Khmer Rouge regime, as well as the overlooked, though significant, ongoing social risk factors for poor mental health, including widespread poverty, high rates of violence against women, and the precarious human rights situation. The Report documents the extent to which the government and the international community continue to marginalize mental health despite its significance. Notably, it is estimated that only 0.02% of the entire Cambodian health budget goes to mental health. Deprived of resources, Cambodia’s mental health services remain dwarfed by the scope of the population’s mental health needs, which overwhelmingly go unaddressed and unmet. Instead, Cambodians with mental disabilities are largely abandoned without any means of support to their own communities, where they face widespread stigmatization and abuse, including chaining and caging. Interviewees further reported that family members and government actors warehouse Cambodians with mental disabilities in extrajudicial detention centers that offer no pretense of care and where conditions are notoriously brutal.

In sum, this Report makes evident that mental health in Cambodia is a critical public health issue with deep human rights implications.

Cambodia’s own interests lay in prioritizing issues of mental health domestically. For one, mental health can have a wide-ranging impact on meeting Cambodia’s Millennium Development Goals (“MDGs”), including decreasing extreme poverty, reducing child mortality, and improving maternal health, among others. Further, the failure to adequately address Cambodians’ mental health needs can have significant adverse consequences for the population’s overall health, including increased risks of heart disease, diabetes, HIV/AIDS, and tuberculosis. Improving mental health also can have significant benefits for economic development within Cambodia. Studies have shown that six to seven dollars of lost productivity are avoided for every dollar invested in mental health. Moreover, according to recent research, “mental health interventions have been shown to be affordable in low-income and middle-income countries, and are just as cost effective as, for example, antiretroviral treatment for HIV/AIDS.” Above and beyond these practical considerations, Cambodia’s international legal obligations compel it to redress its current mental health situation. Cambodia is a party to the International Covenant on Economic, Social and Cultural Rights ("ICESCR"), which enshrines "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." As detailed in this Report, Cambodia is falling short of its right to health obligations, even taking into account its limited resources. Further, while the Report uses the right to health as its touchstone, mental health is a crosscutting issue that implicates a broad range of additional human rights obligations to which Cambodia also is bound. In
Today, more than three decades following the devastation of the Khmer Rouge period, few countries are still as associated with the word “trauma” as Cambodia. Yet, to date, little substantive research has been conducted to document the import of mental health in Cambodia. This Report seeks to fill that gap through an innovative application of human rights norms to the Cambodian mental health landscape based on extensive research and fieldwork, including over 150 interviews.

In addition to the ICESCR, Cambodia is a party to core international human rights instruments, including the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Taken together, these international instruments represent Cambodia’s obligation to respect, protect, and fulfill the human rights of all Cambodians, including their rights to liberty and security of person, non-discrimination, equal recognition before the law, freedom from arbitrary arrest or detention, and to the recognition of basic human dignity.

This Report represents the culmination of a yearlong interdisciplinary project undertaken by the Leitner Center for International Law and Justice at Fordham Law School. A delegation from Fordham visited Cambodia in May 2011 to conduct research and interviews. The Fordham delegation was led by 2010-2011 Crowley Fellow in International Human Rights Daniel McLaughlin. The delegation included Fordham Law School Professor James Kainen, Leitner Center Executive Director Elisabeth Wickeri, Fellows Joy Chia and Alena Herklotz, and eight second-year law students: Stephanie Baez, Bridgette Dunlap, Haseeb Fatmi, Alexandra Rizio, Diana Schaffner, Nitzan Sternberg, John Tschirgi, and Michael Zimmerman. Members of the Fordham delegation also returned to Cambodia in January 2012 to carry out follow-up research and interviews.

Prior to conducting fieldwork in Cambodia, the delegation participated in an intense program of study throughout the academic year, including a seminar led by Mr. McLaughlin and Ms. Wickeri focusing on the intersection of mental health and human rights in Cambodia. During its visit to Cambodia, the delegation conducted individual and group interviews with mental health patients and professionals in Battambang, Kampong Speu, Kampong Thom, Phnom Penh Provinces, and Siem Reap. The delegation also interviewed disability rights groups, disabled people’s organizations, community leaders, local and national government officials, prison officials and inmates, representatives of nongovernmental and international organizations, traditional healers, Buddhist monks, human rights advocates, lawyers, prosecutors, and judges.

This Report presents the findings of this research effort. Part I begins by setting out Cambodia’s right to health obligations under international and domestic law and then explores some of the most significant mental health determinants. Part II documents the grave disparity between Cambodians’ mental health needs and available mental health resources. Part II further examines how this mental health treatment gap renders persons with mental disabilities vulnerable to a range of additional human rights abuses. Part III focuses on domestic legal provisions of notable import to the rights of persons with mental disabilities. The Report concludes with recommendations to the Cambodian government, civil society, and the international community.
In May 2011 and January 2012, the Crowley teams traveled to Battambang, Kampong Speu, Kampong Thom, Phnom Penh and Siem Reap Provinces to interview mental health patients and professionals, disability rights groups, disabled people’s organizations, community leaders, local and national government officials, prison officials and inmates, representatives of nongovernmental and international organizations, traditional healers, Buddhist monks, human rights advocates, lawyers, prosecutors, and judges.
It is estimated that only 0.02% of the entire Cambodian health budget goes to mental health. Deprived of resources, Cambodia's mental health services remain dwarfed by the scope of the population's mental health needs, which overwhelmingly go unaddressed and unmet. Above, the inpatient mental health unit of the Khmer-Soviet Friendship Hospital in Phnom Penh. © 2011 Arantxa Cedillo
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The Leitner Center benefited from the contributions and assistance of many individuals and organizations in Cambodia. First, we would like to thank Dr. Chhim Sotheara, executive director of the Transcultural Psychosocial Organization Cambodia (“TPO-Cambodia”), and the organization’s Phnom Penh, Battambang, Siem Reap, and Kampong Thom staff.

TPO-Cambodia facilitated our access to communities and individuals and we are deeply grateful to them. Several other organizations also graciously assisted our work in Cambodia. In particular, we thank the leadership and staff of Social Services of Cambodia, the Center for Child and Adolescent Mental Health, and Louvain Coopération for their help in facilitating interviews. We also are thankful to individuals at the Brahmagiri Cambodia AIDS Project, Maryknoll, the Ragamuffin Project, Hagar Cambodia, Handicap International, the Cambodian Disabled People’s Organization, the Documentation Center of Cambodia, Legal Aid of Cambodia, LICADHO, ADD-Cambodia, International Bridges to Justice, and the Lawyer Training Center, among others, for sharing their insights with us during our visits. Moreover, our gratitude goes to all the dedicated public mental health professionals, including Dr. Ka Sunbaunat, Dr. Chhit Sophal, and Dr. Kim Savoun, who spoke candidly about the difficult circumstances under which they must carry out their work. We also would also like to thank the numerous other government representatives, professors, judges, lawyers, and researchers who took the time to meet with us. For assistance during our seminar on mental health and human rights in Cambodia, we are grateful to Dr. Barry Rosenfeld, Dr. Jean Tropnas, Professor Michael Perlin, Lily Dorment, and Professor Martha Rayner, as well as Joseph Stewart, Dr. Daryn Reicherter, Professor Beth Van Schaack, Catherine Filloux, Dr. Lim Keuky, Arantxa Cedillo, Richard Pearshouse, and Supharidh Hy for their assistance throughout.

Finally, and most importantly, we thank the many women and men who met with us throughout the country to share their experiences, struggles, and insights on issues of mental health. Their courage in the face of great challenges continues to inspire us.

A NOTE ON TERMINOLOGY

As noted by Paul Hunt, the former United Nations Special Rapporteur on the Right to Health: 45

When discussing mental health and mental disability, a complicating factor is the absence of agreement on the most appropriate terminology. Mental illness, mental disorder, mental incapacity, psychiatric disability, mental disability, psychosocial problems, intellectual disability, and several other terms are all used with different connotations and shades of meaning. Intellectual disability, once commonly referred to as mental retardation or handicap, is now sometimes referred to as developmental disability. Moreover, some of the terms reflect very important and sensitive debates, such as the discussion about a ‘medical model’ or ‘social model’ of functioning. 46

Thus, following the approach taken by the Special Rapporteur, this Report utilizes the generic term “mental disability.” In this Report, the umbrella term “mental disability” includes major mental illness and psychiatric disorders, such as schizophrenia and bipolar disorder; less grave mental health illnesses and disorders, often called psychosocial problems, such as mild anxiety disorders; and intellectual disabilities, such as limitations caused by Down syndrome and other chromosomal abnormalities, brain damage before, during, or after birth, and malnutrition during early childhood. “Disability” refers to a range of impairments, activity limitations, and participation restrictions, whether permanent or transitory. 47
I. BACKGROUND

Part I of this Report provides the context for examining mental health in Cambodia through a right to health perspective. Section A details Cambodia’s obligations under international and domestic law. Notably, both international and Cambodian law recognize the right to health and provide for a rights-based approach to mental health. Section B then explores the psychological impact of the Khmer Rouge period, as well as that of three significant social determinants of poor mental health in Cambodia, namely poverty, violence against women, and the country’s precarious human rights situation.

A. Cambodia’s Obligations Under International and Domestic Law

1. INTERNATIONAL LAW

a. Overview of the Right to Health

A central tenet of this Report is that mental health is both a critical public health and human rights issue. As stated by Arthur Kleinman, a leading global public health figure: “The fundamental truth of global mental health is moral: individuals with mental illness exist under the worst of moral conditions.”\(^{48}\) The right to health provides a framework to discuss mental health within the international human rights context, which serves an important normative function. Framing mental health issues within a right to health context brings them within the “rubric of human rights,” where they implicate Cambodia’s legal obligations.\(^{49}\) The discussion concerning mental health is thus no longer solely about needs, which the government may choose to ignore in the exercise of its discretion, but also about rights, which it is legally bound to address.\(^{50}\)

The right to health has long been recognized in international instruments\(^{51}\) and is principally codified in the ICESCR, to which Cambodia is a party.\(^{52}\) Article 12 of the ICESCR proclaims generally the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”\(^{53}\) Authoritative writings, including those of the Committee on Economic, Social and Cultural Rights (“CESCR”)\(^{54}\) and the Special Rapporteur on the Right to Health, have fleshed out a set of analytical tools to measure a state’s compliance with its right to health obligations. In recent years, the international legal community has increasingly recognized the right to mental health as a critical component of the right to health.\(^{55}\)

b. Legal Obligations Under the ICESCR

The right to health is subject to the progressive realization provision laid out in Article 2 of the ICESCR, which obligates a state party “to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant using all appropriate means.”\(^{56}\) At its core, the ICESCR requires Cambodia to work towards the full realization of the right to health, with compliance measured in light of its available resources,\(^{57}\) including those available from the international community.\(^{58}\)

Notwithstanding this progressive realization framework,\(^{59}\) the ICESCR also contains obligations that are both immediate and continuous. Cambodia has an immediate obligation to “take steps”\(^{60}\) towards the realization of the right to health, without discrimination.\(^{61}\) The provision therefore obligates a “clear legal undertaking,”\(^{62}\) which Cambodia can meet through a variety of means, including passing legislation, adopting nationwide policies and plans, and training medical personnel.\(^{63}\) While the international legal system provides a great deal of flexibility for states to choose the strategies and methods that suit their specific context, states must identify means that will produce results.\(^{64}\)

The CESCR has sought to provide further guidance on the specific steps that states must take, especially in light of resource constraints such as those facing low-income countries like Cambodia.\(^{65}\) As one way of approaching the problem of practical limitations, the CESCR has adopted a “minimum core” requirement, which identifies certain minimum levels of rights recognition that each state must achieve even where resources are scarce.\(^{66}\) These include ensuring “the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups”; the “equitable distribution of all health facilities, goods and services”; and the “adoption and implementation of a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population,” among others.\(^{67}\) Minimum core obligations on states are non-derogable.\(^{68}\) The CESCR has determined that retrogressive measures taken by a state that are incompatible with its minimum core obligations violate the ICESCR.\(^{69}\)

Another useful tool developed by the CESCR for assessing a state’s compliance with the right to health is the “respect, protect, and fulfill” framework.\(^{70}\) This
framework requires that a state party like Cambodia refrain from interfering with the enjoyment of the right to health ("respect"); take measures to prevent others from interfering with the right to health ("protect"), including by adopting legislation to ensure that third parties provide equal access to adequate health care and implementing policies that protect vulnerable members of society; and adopt "appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health" ("fulfill"). The obligation to fulfill also entails recognizing, facilitating, providing, and promoting the right to health.

c. The Right to Health as an Inclusive Right

The right to health is an inclusive right that encompasses underlying determinants, as well as access to a functioning system of health services. The CESCR has recognized that the right to health "embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health." These include the social determinants of health, that is, "the conditions, such as poverty and unemployment, which make people ill in the first place." Notably, the right to health literature has too seldom focused on the social determinants of health specifically within the mental health context.

The right to health further entails "facilities, goods, services and conditions that are conducive to the realization of the highest attainable standard of physical and mental health." As articulated by the CESCR, this standard requires that health facilities, goods and services, including the underlying determinants of health, should be: (1) available in sufficient and adequate quantity; (2) accessible; (3) acceptable, which requires respect for medical ethics and the local culture; and (4) of good quality, which consists of medical and scientific appropriateness. Notably, the CESCR has found that states in which many individuals do not have health care are "prima facie failing to discharge [their] obligations under the Covenant."

d. Intersection with Other Human Rights

The right to health cannot be viewed in isolation: it "is closely related and dependent upon the realization of both civil and political rights, as well as economic, social, and cultural rights." The intersection of the right to health and other human rights is of particular significance within the disability rights context. Disability has increasingly been recognized as a human rights issue over the course of the last two decades. Initially, international instruments of more general application characterized the rights of persons with disabilities. The recent adoption of the Convention on the Rights of Persons with Disabilities ("CRPD"), however, created a tool for more specific and targeted assessment of state compliance with the rights of persons with disabilities. Although Cambodia is not currently a state party to the CRPD, which it has signed but not yet ratified, the provisions of the CRPD offer guidance as to the contours of the right to health within the disability rights context. By adopting a rights-based framework, which demands "the human rights and full inclusion and participation of people with disabilities," the CRPD provides a powerful normative basis against which to scrutinize health and mental health policies. Notably, the CRPD embraces a social model of disability, which places an explicit emphasis on empowerment, rights, participation, and inclusion.

Persons with mental disabilities, in particular,
Persons with mental disabilities also are vulnerable to a range of abuses within their own communities. Particularly in low-income countries like Cambodia, persons with mental disabilities receive few, if any, community support services and must confront widespread social stigma and exclusion. Abuse and neglect of persons with mental disabilities in prisons also are an "alarming" concern. Violations of the right to health are indivisible from these broader human rights violations. Cambodia’s international legal obligations within the mental health context thus encompass the right to health, along with a wide spectrum of interrelated human rights.

2. DOMESTIC LAW

The right to health is also recognized within the Cambodian domestic legal framework. Article 31 of the 1993 Cambodian Constitution explicitly incorporates provisions of fundamental international human rights instruments directly into Cambodian law.
The Cambodian Constitutional Council affirmed this constitutional principle in 2007 and ruled that the provisions of the Convention on the Rights of the Child, another fundamental international human rights instrument to which Cambodia is a party, were directly applicable before Cambodian courts. Accordingly, the right to health provision of the ICESCR, along with provisions from other international human rights instruments, should be accorded the force of law in Cambodia.

In addition, the 1993 Constitution contains its own right to health provision. Article 72 of the 1993 Constitution states: “The health of the people shall be guaranteed. The State shall give full consideration to disease prevention and medical treatment. Poor citizens shall receive free medical consultation in public hospitals, infirmaries and maternities. The State shall establish infirmaries and maternities in rural areas.”

There is no available Cambodian jurisprudence on Article 72 of the 1993 Constitution. However, in keeping with the jurisprudence of other national judiciaries that have examined their own constitutionally-enshrined right to health provisions, Article 72 of the 1993 Constitution should be seen as imposing concrete, positive obligations on the Cambodian government regarding the right to health. Additionally, Cambodian law contains provisions, of both general and specific applicability, that recognize a broad array of rights and protections for persons with disabilities.

B. Underlying Determinants of Poor Mental Health

International human rights law places responsibility squarely on states for upholding their legally binding obligations under the right to health. As a result, it is the Cambodian government’s obligation, first and foremost, to ensure that Cambodians’ right to the highest attainable standard of physical and mental health is being fulfilled. This includes addressing the underlying determinants of mental health to the maximum of its available resources. Cambodia, in particular, is home to an elevated number of risk factors for poor mental health. These include the trauma of the Khmer Rouge period, as well as more contemporary social factors, such as widespread poverty, high rates of violence against women, and a precarious human rights situation. The following section explores the role of these underlying determinants in Cambodia.

1. THE KHMER ROUGE PERIOD

a. Historical Context

The starting point for any discussion of mental health in Cambodia is invariably the traumatic impact of the Khmer Rouge period. The Khmer Rouge ruled Cambodia from April 17, 1975, to January 6, 1979, a relatively short period considering the lasting devastation that the regime inflicted upon the country and its people. Scholars estimate that up to two million Cambodians, or approximately one quarter of the entire population, died during the Khmer Rouge regime due to execution, overwork, starvation, and disease.

Those who managed to survive the Khmer Rouge regime did so under brutal conditions. The Khmer Rouge actively sought to destroy the fabric of Cambodian social life in order to transform the “traditional, family-centered” society into a “state-centered, self-supporting communist model.” The Khmer Rouge tore families apart, arranged mass marriages, destroyed pagodas, and defrocked Buddhist monks. Cambodians suffered through intense forced labor and widespread famine, all the while enduring the continuous threat of violence and death.

In addition to the profound human toll brought about by their policies, the Khmer Rouge destroyed much of Cambodia’s civil infrastructure, including the judicial and health systems. The Khmer Rouge killed nearly all of Cambodia’s lawyers, judges, legislators, and law professors. Only six to ten lawyers are estimated to have survived the era. The medical profession was likewise gutted; of the over one thousand doctors practicing in Cambodia prior to 1975, all but fifty died or fled the country during the Khmer Rouge’s rule. Cambodia’s already-fledging formal mental health sector was essentially razed in its entirety. At the outset of the regime, the Khmer Rouge executed many of the 800 patients and staff of the nation’s sole mental health hospital, before converting it into a prison. Not a single Cambodian psychiatrist survived the regime.

During this period, hundreds of thousands of Cambodians escaped the country and found refuge abroad. Many fled to refugee camps along the Thai border, which continued to swell throughout the 1980s and early 1990s as Cambodia suffered through civil war. Others resettled further abroad, including in France and the United States. While life for these refugees was comparatively better than for those who remained trapped in Cambodia, many had to contend with the travails of dislocation and poor living conditions. Moreover, many Cambodian refugees were
deeply impacted by the tragedies of the Khmer Rouge regime. Dr. Lim Keuky, who lent his assistance to the delegation, described how only three members of his forty-five-member family survived the regime.

Khmer Rouge forces fled Phnom Penh in 1979, in the face of a Vietnamese military offensive. Armed conflict continued in Cambodia throughout the 1980s as various factions, including those of the remaining Khmer Rouge, battled the Vietnamese-backed government in Phnom Penh. Following the 1991 Paris Peace Accords, national elections were held in Cambodia under United Nations (“UN”) supervision.

In 2004, the Extraordinary Chambers in the Courts of Cambodia (“ECCC”), a UN-supported hybrid criminal tribunal, was established to try the surviving senior leaders of the Khmer Rouge and those who were the most responsible for the commission of crimes in Cambodia during the period from April 17, 1975, to January 6, 1979.

b. Psychological Impact of the Khmer Rouge Period

More than three decades following the fall of the Khmer Rouge, Cambodians continue to bear the psychological sequela of armed conflict. Most notably, epidemiological studies carried out in Cambodia have documented alarming rates of posttraumatic stress disorder (“PTSD”). Studies have found probable PTSD rates ranging from 14.2% to 33.4% among Khmer Rouge survivors and those who experienced violence associated with armed conflict. By comparison, the worldwide prevalence of PTSD is estimated at less than 0.4%. Cambodian refugees in Thailand and the United States similarly reveal consistently high, if varied, rates of PTSD. While the applicability of PTSD as a crosscultural diagnostic tool has been a source of debate within the scientific literature, experts have “almost universally . . . found that trauma symptoms among Cambodian refugees are very similar to those observed among other trauma survivors.”

In the course of the delegation’s research, mental health professionals confirmed that Cambodians still manifest symptoms of Khmer Rouge-era trauma. Dr. Chea Dany, the Chief of the Health Promotion Unit in Battambang, stated: “In my opinion, the biggest problem is PTSD. Chronic PTSD after mass trauma. It has a very strong impact on society as a whole.” Another mental health professional added, “The impact of the Khmer Rouge is everywhere. It’s everywhere . . . The impact on parents, their families, the kids.”

The psychological impact of the Khmer Rouge extends to the generation of Cambodians born after the fall of the regime. Drawing upon studies of children of World War II Holocaust survivors, mental health professionals believe that trauma in Cambodia was transmitted intergenerationally on account of both the Khmer Rouge period’s impact on the parenting styles of the regime’s survivors and its broader devastation of the Cambodian infrastructure. Indeed, studies have also found elevated rates of PTSD among the general Cambodian population, which may reflect a wider transmission of Khmer Rouge-associated trauma.

2. CONTEMPORARY SOCIAL DETERMINANTS

While the trauma of the Khmer Rouge understandably represents the most notorious facet of the Cambodian mental health landscape, many interviewees cautioned against ascribing too great a share of Cambodia’s current mental health problems to the now-defunct regime. Today, a number of additional factors have a significant, if overlooked, impact on Cambodians’ mental health. For Dr. Chhit Sophal, Deputy of the National Program for Mental Health,
“generally there is too much emphasis on the Khmer Rouge’s impact.” Another mental health professional agreed, “Yes, the Khmer Rouge overshadows mental health.” In meetings with the delegation, many interviewees likewise downplayed the importance of Khmer Rouge events and focused primarily on more contemporary social factors, namely the impacts that poverty, violence against women, and the present-day human rights context have on mental health in Cambodia.

a. Poverty

Poverty remains widespread in Cambodia, a “low-income country” by World Bank classifications. Over forty percent of the Cambodian population lives on less than US$1.25 a day. Despite recent economic growth, there is little government spending on social services, education, housing, or health. Public expenditures represent only 3.5% of Cambodia’s gross domestic product—the lowest level among low-income countries. In many parts of Cambodia today, the government offers little in terms of social or economic assistance.

The WHO has documented a “very strong relationship” between indicators of poverty and mental disability in developing countries. Similarly, interviewees in Cambodia described poverty as both a cause and a consequence of poor mental health. In the words of Lao Lun, a mental health professional in Battambang province, “being poor causes mental health problems, and mental health problems cause poverty. It’s a cycle.”

Interviewees described poverty as an underlying cause of poor health generally in Cambodia. As stated by Dr. Varun Kumar: “The biggest frustration is a lack of national infrastructure—seeing patients whose poverty directly causes their medical problems; it’s frustrating to send people back to the poverty and see the same problems over and over again.” Similarly, Dr. Ka Sunbaunat, the Director of the National Program for Mental Health, focused on poverty as “the main problem” impacting mental health in Cambodia. Mental health patients and professionals alike identified a number of daily stressors linked with poverty. These include low income, lack of work, food insecurity, and lack of access to education. Further, many of these daily stressors disproportionately impact women given traditional gender roles in Cambodia. According to Dr. Mom Sovannara, a psychiatrist at the Siem Reap Referral Hospital, gender roles help to account for the higher rates of depression and anxiety among Cambodian women:

The women are the housewives. . . . Their income is so low so they worry about sending their kids to school. The housewife looks after kids and takes care of house. This is tradition in Cambodia. Men can leave the house and relieve tension, be with friends. It is very hard for women. For men, it is easy.

Conversely, interviewees stated that mental disabilities could also lead to poverty. Due to limited public funding, approximately sixty percent of Cambodia’s total health expenditure is out-of-pocket, which is the second-highest percentage in Southeast Asia. In addition, only twenty-four percent of Cambodia’s population is covered by a financial protection scheme, again placing Cambodia second-to-last in Southeast Asia. As a result, the high treatment costs of mental disabilities are largely borne by patients, many of whose incomes may already be reduced due to their conditions. In some instances, patients must resort to selling their land to pay for mental health services. The economic costs associated with mental disability also extend to family members. Yorn Yorn, a mental health professional in Kampong Thom explained:

Often the caregiver of a person affected by mental health is affected themselves. . . . A family with a schizophrenic family member has to take care of the family member so the caregiver can’t work. So they borrow. Payment for healthcare is expensive. Borrowing for these costs is a problem because the borrowed funds are not produc-
More broadly, experts maintain that poor mental health can have a significant impact on development at a macroeconomic level. This economic burden extends to early mortality, lost productivity, and costs of care on communities. Interviewees reported that Cambodia’s own economic development was being hindered by the population’s poor mental health. Indeed, “especially in the villages,” reported one mental health professional, “[t]here is no progress because of depression.”

b. Violence Against Women

The Cambodian Human Rights and Development Association estimates that twenty to twenty-five percent of Cambodian women experience domestic violence. Women in Cambodia have limited effective means to put an end to such abuse or to hold perpetrators accountable. Though the Cambodian legislature passed the Law on the Prevention of Domestic Violence and the Protection of Victims in 2005, law enforcement officials tend to lack knowledge of the law or are uninterested in enforcing it. A patient at the Kampong Thom Referral Hospital recalled the response of her local officials to her complaints of abuse:

My husband violently beat me with leather on my back. He wounded me. I couldn’t even get up. I complained to the police and the police came, they made a report. They didn’t do anything. They just said not to beat wife. He beat me again and again many times.

Interviewees identified domestic violence as one of the principal factors driving women to seek out mental health services in Cambodia. At one Cambodian hospital, a mental health professional told the delegation:

According to one mental health professional, domestic violence and family conflicts account for up to or over half of all her patients. Above, a woman tearing up paper to cope with the psychological stress caused by her relationship with her arranged husband. © 2011 Arantxa Cedillo
Eighty percent of my mental health patients are women. I see about twenty per day, sometimes up to forty. . . . Domestic violence and family conflicts is the most, up to or over half of the problems. In one family, the mother and the children are all taking mental health medications because of the alcoholic husband.179

According to Dr. Ang Sody, Clinical Supervisor at TPO-Cambodia: “Domestic violence is a problem, it is oppression. Women are expected to be silent, even when they are abused.”180 Further, the frequent use of mental health services to “cope” with the psychological symptoms of abuse is deeply troubling. In these instances, mental health services serve as little more than a palliative that fails to address the underlying abuse, which is left to continue unimpeded.181

c. Human Rights Context

Cambodia’s poor human rights record has been extensively documented in submissions before the United Nations’ treaty-monitoring bodies.182 The current UN Special Rapporteur on Human Rights in Cambodia,183 Professor Surya Subedi, has focused on violations of land rights and freedom of expression as two ongoing areas of particular concern.184 Recent reports from nongovernmental organizations have also decried the use of extrajudicial detention centers,185 the routine use of physical abuse by state security actors,186 and the high level of corruption within the Cambodian government,187 among other issues. While an exposition of the various human rights violations affecting Cambodians is outside the scope of this Report, the delegation’s interviews served to highlight the extent to which the broader human rights context is interconnected with the right to health, particularly in regard to mental health, in Cambodia.188

In light of the current human rights situation in Cambodia, most interviewees were only willing to discuss the matter with the delegation anonymously. A government mental health professional reported that patients suffered psychological harm following abuse by police officials.189 A Human Rights Watch researcher recounted the widespread physical and psychological abuse carried out in extrajudicial detention centers, including against persons with mental disabilities.190 A mental health practitioner who worked with patients forcibly evicted from their land described “a parallel between the symptoms of people who were evicted and the people who faced war trauma.”191 Others with whom the delegation spoke identified pervasive government corruption as a factor leading to poor mental health among Cambodians.192

Interviewees were adamant that the government needed to take greater responsibility for the poor human rights situation in present-day Cambodia, rather than rely on false comparisons with the now-defunct Khmer Rouge regime. According to Youk Chhang, director of the Documentation Center of Cambodia:

The police and military use the Khmer Rouge . . . to justify their actions. The government says ‘why should we worry about corruption? We don’t kill people like the Khmer Rouge.’ . . . The lasting mentality is to exonerate current failures and transgressions by claiming they are not as bad as the Khmer Rouge.193

In sum, the devastation of the Khmer Rouge regime is not solely responsible for the continued presence and impact of many determinants of poor mental health in Cambodia. Cambodia’s right to health obligations extend to addressing these ongoing determinants to the maximum of its available resources. Cambodia’s low public expenditures,194 high rates of violence against women,195 and poor human rights record are prima facie indications that it is currently failing to do so. As detailed in Part II, these right to health shortcomings are further compounded by Cambodia’s mental health treatment gap.

Framing mental health issues within a right to health context brings them within the “rubric of human rights,” where they implicate Cambodia’s legal obligations. The discussion concerning mental health is thus no longer solely about needs, which the government may choose to ignore in the exercise of its discretion, but also about rights, which it is legally bound to address.
II. THE MENTAL HEALTH TREATMENT GAP: A RIGHT TO HEALTH PERSPECTIVE

The WHO proclaims that “mental disorders are perhaps the largest class of diseases for which evidence exists of a substantial discordance between societal burden and health-care expenditures.”196 This mental health “treatment gap” is acute in low-income countries, particularly within Southeast Asia. Only 23.6% of the population in Southeast Asia lives in a country with a mental health policy; the next-lowest region, the Americas, covers nearly double that portion.199 Southeast Asian nations are more likely to have older, obsolete mental health programs and laws and are the least likely to provide community care facilities.202 Half of all countries in Southeast Asia spend less than one percent of their health budgets on mental health.203 Cambodia, in particular, epitomizes the maxim that those who are the most in need of mental health services are also the least likely to receive them.

The following Part examines the Cambodian mental health treatment gap from a right to health perspective. Part A documents the critical imbalance between the need for mental health services and their availability in Cambodia, while Part B investigates how this gap renders Cambodians increasingly vulnerable to a range of interrelated human rights abuses.

A. The Cambodian Mental Health Treatment Gap

1. A CRITICAL YET MARGINALIZED PUBLIC HEALTH ISSUE

Cambodia is home to an elevated number of risk factors for poor mental health.204 As detailed in Part I.B.1.b, the few epidemiological studies that have been carried out in Cambodia have documented alarming rates of trauma-related mental disorders among the population.205 In interviews with the delegation, mental health professionals working in the country described how a wide range of additional concerns—from diagnosable mental disorders, like schizophrenia206 depression,207 and autism,208 to broader psychosocial problems, such as those linked with poverty and violence against women,209—are also overwhelmingly unaddressed. In keeping with global health trends,210 mental health is, if anything, only likely to increase in relative significance as a public health issue in Cambodia. As one health professional estimates, “if the mental health burden is very high, it’s one of the top burdens. If you were to represent all disease burden in Cambodia in a pie chart, all the other wedges would be shrinking, but the mental health wedge would stay the same size.”211

Nonetheless, in a field where what is counted counts, mental health remains all but invisible as a public health issue in Cambodia. Worldwide, a driving factor behind the recognition of mental health as a global public health concern has been the proliferation of epidemiological research documenting the considerable health burden of mental disorders in all world regions.212 Cambodia, however, suffers from a dearth of such data. With one notable exception—the prevalence of PTSD and associated trauma-related disorders—the Cambodian mental health landscape has gone largely undocumented.

The lack of Cambodian mental health data is troubling from a right to health perspective. As noted by the CESCR, parties to the ICESCR have an obligation “to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.”213 Without an awareness of the depth and breadth of its mental health needs, Cambodia is unable to take the “deliberate, concrete and targeted” steps necessary to address these health concerns.214 Furthermore, the “progressive realization” obligation of the right to health requires parties to continuously improve over time.215 In other words, Cambodia should be doing a better job of addressing its mental health needs five years from now than it is today. The lack of mental health indicators or benchmarks, let alone those that are disaggregated,216 makes it nearly impossible for Cambodia to measure its progress, or lack thereof, in doing so.

Without demonstrative data, Cambodian policymakers have little impetus to make mental health a priority. In turn, government health workers focus their limited resources on other issues, thereby only accentuating the problem. Even where information might be available, there are currently few incentives to compile mental health data. One government health worker reported: “For the body disease, the center leaders ask me to do the percentage, but for
the mental disease no one cares about them. The top of the center often comes to check the data on body disease, but not mental health.\textsuperscript{217}

Unsurprisingly, the lack of epidemiological data has contributed to the marginalization of mental health in Cambodia. For Graham Shaw, technical officer for the WHO in Cambodia, “the fundamental problem is that people don’t recognize that mental health is an issue.”\textsuperscript{218} Few of the international donors who contribute to Cambodia’s health budget have shown an interest in funding the mental health sector\textsuperscript{219} despite their international cooperation and assistance obligations under the ICESCR.\textsuperscript{220} Furthermore, Cambodia’s government allocates little of the funds at its disposal towards mental health. Figures for Cambodian mental health funding are not publicly disseminated,\textsuperscript{221} but according to Dr. Chhit Sophal, Deputy Director of the National Program for Mental Health: “About US$150 million goes to health every year, and mental health receives about US$30,000,”\textsuperscript{222} approximately 0.02% of the total health budget. Dr. Sophal adds: “If you look at the WHO report, any country spending less than 1% percent is bad. Cambodia is even less than that, a new category.”\textsuperscript{223} While there are small additional budget allocations for mental health within Cambodia’s public health system,\textsuperscript{224} mental health remains vastly underfunded in light of its importance as a public health issue. Nor are there any imminent plans of increasing the level of mental health funding. Graham Shaw remarks that, beyond the de minimis amounts currently allocated, “for the foreseeable future—five years or more—there will be no budget for mental health.”\textsuperscript{225}

2. CAMBODIA’S MENTAL HEALTH SYSTEM

The marginalization of mental health severely limits Cambodians’ ability to receive proper mental health disorders are perhaps the largest class of diseases for which evidence exists of a substantial discordance between societal burden and health-care expenditures.” This mental health “treatment gap” is acute in low-income countries, particularly within Southeast Asia. Given the lack of resources, mental health professionals in Cambodia like You Sophy, pictured here at the referral hospital in Kampong Thom, work under incredibly challenging conditions. © 2011 Arantxa Cedillo
health care and support. This is evidenced most clearly by the lack of mental health infrastructure and human resources, and the poor quality of services available in Cambodia today.

a. Mental Health Infrastructure

Mental health is a relatively new discipline in Cambodia. Formal mental health services were virtually nonexistent in Cambodia in the decade following the Khmer Rouge. Devoid of trained mental health professionals, Cambodians continued to rely upon Buddhist monks and traditional healers (Kru Khmer) for their mental health needs. During the 1990s, international and nongovernmental organizations reintroduced formal mental healthcare practices to Cambodia. Today, the Ministry of Health is the primary government entity in charge of mental health services in Cambodia. The current Health Strategic Plan, which defines the principal policy agenda for the Ministry of Health, declares the Ministry’s “value-based commitment” to the “right to health for all Cambodians.” It also lists as one of its top three strategic priorities the goal of reducing the burden of noncommunicable diseases, including poor mental health. The Ministry of Health contains two subdepartments that specifically focus on mental health issues—the National Program for Mental Health and the Bureau of Mental Health. In 2010, the Ministry of Health adopted the Mental Health and Substance Misuse Strategic Plan 2008–2015, although it has yet to accord it funds for implementation. Students can pursue specialized training in psychiatry at the University of Health Sciences, as well as in psychology or social work at the Royal University of Phnom Penh.

Despite notable progress, Cambodia’s mental health infrastructure remains critically deficient given the scope of the mental health needs it is called upon to address. Cambodia’s mental health facilities are decentralized and incorporated within the public health system’s network of national hospitals, referral hospitals, health centers, and health outposts, in line with WHO guidelines. As a result, there are currently no stand-alone psychiatric institutions in Cambodia. Cambodia only has two short-term inpatient units, both of which are located in Phnom Penh, which amount to fourteen psychiatric beds for the entire country—the lowest ratio of psychiatric beds per person in Southeast Asia. Patients can typically only stay in these inpatient units for up to two weeks and must be accompanied by friends or family who are responsible for tending to them. Aside from these two short-term inpatient units, mental health services are available on an outpatient basis in only a limited number of Cambodia’s health facilities, most of which are concentrated in urban centers. Cambodia’s two national hospitals are both in Phnom Penh and offer outpatient mental health services. Cambodia has eighty-four referral hospitals, only about half of which offer some form of mental health services. Of the 967 health centers that are smaller than referral hospitals and located in more rural areas, less than twenty have staff with some mental health training. While no information is available regarding the mental health services provided at the more remote health outposts there are no grounds to believe that any such services exist.

Mental health facilities are concentrated in major urban centers, namely in Phnom Penh and Siem Reap, despite the fact that an estimated eighty-five percent of Cambodians live in rural communities. Most rural patients seeking mental health services must travel long distances to receive treatment, which typically entails additional transportation costs. This lack of accessibility is of particular concern given that Cambodia’s rural demographic faces elevated risk factors, including “lower socioeconomic status, challenges of the agricultural industry, low educational and vocational opportunities, limited access to quality health care, and myriad other factors that bring greater risk of poor mental health.” The lack of accessibility is further...
compounded by the low awareness of mental health issues, particularly in rural areas. As a result, only a fraction of Cambodians who might need mental health services seek out health facilities. According to a joint nongovernmental report, despite the high estimated prevalence of mental disabilities in Cambodia, “in 2008, there were 15,320 new psychiatric cases in eight provinces, which altogether provide a very low mental health service utilization rate of 0.001 per capita.”

b. Mental Health Human Resources

As of 2010, Cambodia had approximately thirty-five trained psychiatrists and forty-five trained psychiatric nurses for a population of close to fifteen million. While 297 primary care physicians and 270 primary care nurses have also taken basic courses in mental health care, it is estimated that only a small percentage of them actually provide “some degree” of mental health care. The public mental health system does not allocate any positions for psychologists or social workers, which largely reflects its strong biomedical approach to mental health. While a number of trained psychologists and social workers operate in the private and nongovernmental sectors, the delegation was unaware of any reliable estimates of their numbers.

The severe shortage of mental health professionals is attributable to several factors. First, formal mental health services have only recently been established in Cambodia. Second, the stigma surrounding mental health discourages health professionals from entering the field. Dr. Ka Sunbaunat, the Head of the National Program for Mental Health in Cambodia, commented that “psychiatrists are not well-considered in society” and are called “mad doctors” by their colleagues. Third, the lack of financial resources dedicated to the mental health sector provides health professionals with few incentives to study or practice in the field. Public mental health staff indicated that many of them must supplement their minimal government salaries by running private health clinics during their afternoon hours, a common practice in Cambodia.

As a result of their limited numbers, Cambodia’s mental health professionals are overwhelmed by patients, even though these individuals represent only a fraction of those who might need mental health treatment or care. During morning visits by the delegation, the mental health wing of the Khmer-Soviet Friendship Hospital, the country’s largest mental health facility, was routinely filled with hundreds of waiting patients. Dr. Chak Thida estimated that the hospital’s mental health service typically sees 200 to 300 patients each morning, which averaged to “maybe thirty to forty patients per doctor per day.” She lamented that the rapid succession of patients left doctors with little time to provide them with adequate care. Similarly, Dr. Chhim Sotheara, the Director of TPO-Cambodia, has commented: “At the government mental health clinics, one psychiatrist sees over 30 patients a day—you would be exhausted. I can see only three or four a day in order to provide good care.”

Mental health staff at smaller referral hospitals and health centers located outside Phnom Penh also reported being unable to adequately address the needs of their patients. They indicated that few of their fellow
colleagues at these health facilities were interested in mental health, which often left them to handle the large volume of new and recurring mental health patients with little assistance. One mental health professional outside Phnom Penh commented: “The current staff is not enough . . . I see 400 patients a month.” Another mental health professional in Battambang Province confirmed, “The resources don’t meet the need,” and another added, “the government doesn’t want to spend money on mental health services. For other services like body disease, they spend a lot. For mental health it is little.”

c. Quality of Mental Health Services

In addition to the availability and accessibility issues described above in Subsections II.A.2.a–b, the poor quality of services constitutes another barrier for Cambodians seeking mental health care. The delegation met with a number of dedicated mental health professionals who acknowledged the shortcomings of the services they could provide given their resource limitations. Interviewees regretted the Cambodian mental health system’s overreliance on medication as the sole method of addressing the needs of patients. Dr. Chhit Sophal, Deputy of the National Program for Mental Health, conceded, “Ininity-nine percent of mental health services currently from Cambodian doctors are in the form of medication. . . . We need a holistic approach to mental health but do not have the capacity.”

Interviewees considered this strictly biomedical approach ill-suited to the needs of most Cambodians. One mental health professional observed: “‘Care’ is a big word here; there is so little of it in the government hospitals. They have drugs, exams, but no care for the patients.” Another mental health professional’s criticism was more pointed: “It’s a disaster, honestly. . . . Nobody asks about the quality of services, what kind of services you actually provide and other services in any way reflecting the needs of people.
It’s a purely biomedical approach.\(^{272}\) The overwhelming reliance on medication is especially problematic where patients are seeking mental health services to cope with the psychological impacts of domestic or other human rights abuses. As stated by one mental health professional, “When you give medications but the underlying problems remain it isn’t enough.”\(^{273}\)

Interviewees also reported that patients were seldom informed of their diagnosis or the medications they were being prescribed, in contravention of right to health norms.\(^{274}\) According to one psychiatrist, “The biggest problem is that the psychiatrists at the public health facility don’t explain anything to their clients. They give them medicine without any explanation or information.”\(^{275}\) Indeed, many patients who volunteered to speak with the delegation had little idea of their condition or the medications they were taking. “I don’t know what kind of medicine it is. I go to a doctor and he gives me medicine,” stated one woman.\(^{276}\)

Another woman similarly commented about her medication, “I only know the color. Sometimes white, sometimes yellow.”\(^{277}\)

Moreover, the medications prescribed are often older generations of pharmaceuticals, which typically have greater side effects and lower efficacy.\(^{278}\) “New medications are hard to find. It is too expensive. Mostly, I can only give the old medicine, not the new generation medicines,” indicated a psychiatrist at the Siem Reap Referral Hospital.\(^{279}\) Medication shortages are also frequent. Dr. Chak Thida noted that the Khmer-Soviet Friendship Hospital’s three-month supply of medications allocated by the Ministry of Health is sometimes exhausted within a month.\(^{280}\) Some health center staff stated that the Ministry of Health had simply stopped providing them with mental health medication altogether.\(^{281}\) The medication shortage likely reflects both the lack of financial resources allocated to the mental health sector and

\[\text{In light of the mental health system’s shortcomings, the majority of Cambodians who need mental health services do not consult a trained mental health professional. Instead, many often turn to Buddhist monks or traditional healers for their mental health needs. © 2011 Arantxa Cedillo}\]
the sector’s over-reliance on prescription, rather than psychosocial interventions. Regardless of its causes, the unavailability of medication can prove especially detrimental to mental health patients, some of whom may require continuous treatment.282

d. Alternative Mental Health Services

In light of the foregoing shortcomings, the majority of Cambodians who need mental health services do not consult a trained mental health professional.283 Mental health facilities are often too far or of too poor quality to be of assistance, assuming anyone in the community even knows about them. Instead, most Cambodians go without treatment or turn to alternative actors, many of whom have little to no mental health training.

Many Cambodians may assign physical or spiritual explanations to conditions that mental health professionals would otherwise regard as clinically diagnosable disorders.284 As a result, Cambodians often turn to Buddhist monks or traditional healers, like Kru Khmer, for their mental health needs, particularly if they live in rural areas.285 Buddhist monks and traditional healers provide a variety of remedies to address the conditions of those who consult them, including herbal remedies, “cupping,” or “coining,” as well as meditation, chanting, and praying.286 The quality of these remedies remains a source of debate. Mental health professionals agree that traditional and religious actors need to be integrated within the broader mental health framework to ensure a “culturally appropriate blend of Western and Eastern methodology in treatment.”287 A combination of traditional and religious remedies also can prove beneficial, particularly where a mental disability is less grave.288 Where the mental disability is more severe, however, traditional remedies risk aggravating the condition by delaying or entirely deferring a clinical diagnosis and treatment.289 Furthermore, the traditional remedies employed can themselves be harmful. A mental health professional reported that “some Kru Khmer are okay; others are painful and torture the client[,] some even shoot guns near the client.”290

Alternatively, Cambodians also may resort to the more expensive, and largely unregulated, private health sector.291 The higher costs of the private health sector may impose increased financial strain on patients and their family. A patient at the Prey Pros Health Center stated that, prior to consulting with the Center’s mental health professional, she had gone to “three or four private clinics” and had “sold a lot of property” to cover the costs of her treatment.292 Given the general low level of mental health training, there is also an increased risk of misdiagnoses and inappropriate or even harmful treatment.293 One study, for example, found that out of 200 simulated consultations with qualified private physicians in Phnom Penh, approximately half of all consultations were potentially hazardous.294

Finally, Cambodians also may seek out one of a number of nongovernmental organizations that have tried to “fill the gaps” in the mental health sector by providing services, either directly or in partnership with public facilities.295 Among the more successful of these nongovernmental organizations are TPO-Cambodia, Social Services of Cambodia, the Center for Child and Adolescent Mental Health, Psicólogos Sin Fronteras, the Ragamuffin Project, and Louvain Coopération. Unfortunately, there is little coordination among these organizations, which offer a patchwork of services to disparate target populations.296 Further, given their limited funds, they can only reach a small

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A traditional healer, a Kru Khmer, in Kampong Thom province. © 2011 Arantxa Cedillo

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number of the Cambodians who could benefit from their services. The international health organizations with more substantial resources and potentially greater reach have focused their attention elsewhere. For example, the WHO’s Cambodia office, which many view as ideally placed to play a central role coordinating mental health services, has, by its own admission, done “very little” on the issue. Graham Shaw, the WHO’s point person for mental health in Cambodia, concedes: “Most of my job revolves around substance abuse, on top of that, prisons, and then mental health. Five percent of my day is devoted to mental health. That’s not enough.”

Thus, despite its significance, the Cambodian government and the international donor community have continued to marginalize mental health as an issue. Mental health facilities and services are largely unavailable, inaccessible, and of too poor quality to meet the mental health needs of most Cambodians. As a result, much of the population goes without any form of treatment and care, or consults alternative actors with little or no mental health training. In sum, Cambodia’s mental health treatment gap flies in the face of Cambodians’ right to the enjoyment of the highest attainable standard of physical and mental health.

B. Increased Vulnerability to Human Rights Violations

The impact of Cambodia’s mental health treatment gap goes beyond the right to health and implicates a broad range of interrelated human rights for persons with mental disabilities. Cambodia has modeled its mental health system on a decentralized, community-based model that rightly rejects outdated notions that revolve around institutionalization. In practice, however, such a community-based model requires a network of mental health treatment and support services, which Cambodia currently lacks. As a result, Cambodians with mental disabilities are largely left to their own devices or cared for by family or community members with few mental health resources. Predictably, where community integration becomes community abandonment, Cambodians with mental disabilities are particularly vulnerable to human rights abuses. The following Section expands the right to health lens to focus on three such interrelated human rights abuses identified by the delegation, namely chaining and caging by family members, community stigmatization and abuse, and detention in government prisons and extrajudicial facilities.
with mental disabilities. 304 Although exact figures are impossible to come by, mental health professionals estimated that between ten and forty percent of persons with severe mental disabilities are chained or locked in cages by their family members. 305 This situation can become routine and long-lasting. One caretaker described how a mother resorted to tying down her son’s “whole body everyday” because of his mental disability. 306 Another mother interviewed by the delegation recalled how she locked her daughter in a bamboo cage for several years before mental health professionals learned of the daughter’s situation and provided her with treatment for her psychosis. 307

Family members may resort to chaining or caging on the advice of a traditional healer. 308 Others may do so to protect a relative with a mental disability from abuse, including sexual abuse, 309 carried out by members of the community, or because they perceive the relative as dangerous to themselves or others. 310 Family members also may seek to keep a relative’s mental disability hidden from public view given the stigma associated with their condition. 311 One psychiatric nurse explained that “people reason that the illness will be temporary, so they try to spare themselves the embarrassment.” 312 Yet others may consider chaining or caging the only option available to them for economic reasons. Seang Chamnap, who works with children with mental disabilities, recounted how the single mother of an eight-year-old girl with cerebral palsy “was forced to chain and cage [her daughter] so she could go to work to earn money to support herself and her daughter.” 313

In response, Dr. Kim Savoun, the Chief of the Bureau of Mental Health, acknowledged that the public mental health system currently offers family members few alternatives, saying “we do not allow the patients to be chained but in some situations we have to accept it because we do not have other options or possibilities for treatment.” 314

2. COMMUNITY STIGMATIZATION AND ABUSE

There is considerable social stigma surrounding issues of mental health in Cambodia, particularly as concerns more severe mental disabilities. 315 Interviewees reported that individuals with mental disabilities were often excluded from everyday social interactions, such as ceremonies. 316 In some instances, persons with mental disabilities are simply isolated from society and left to wander on their own. 317 According to one mental health practitioner, “mental health in Cambodia is like leprosy 2000 years ago. Everyone is scared of it.” 318

The stigma is so pervasive that entire families can be affected. A psychiatric nurse at a referral hospital noted: “When a family has a daughter with mental illness they are ashamed. There is a traditional belief that mental conditions can be transmitted to the children.” 319 Another mental health professional stated that the stigma could also pass from parent to child, “for example, if a mother has schizophrenia the others won’t ask the daughter to marry.” 320 Dr. Ang Sody, Clinical Supervisor at TPO-Cambodia, concluded that “it is the culture. There is stigma in the family and in the community. There is stigma against the individuals and stigma against the families.” 321

Stigmatization also hinders access to needed mental health services. 322 Mental health professionals reported that prospective clients are often unwilling to visit them for fear of being seen entering a mental health clinic. 323 As noted above, stigma also may play a role in a family member’s decision to chain or lock up a relative with a mental disability, rather than seek out mental health services. Health professionals themselves also can propagate the stigma. Sek Maroum, the father of a child with Down syndrome, recalled first bringing his son to the hospital: “At first, I did not know that he had Down Syndrome. I brought him to the hospital when he was three months old. The hospital said my child was a waste . . . .” 324

All too often, stigma can serve as a precursor to abuse. “Generally, in the community, people like my son are looked down on, called crazy, beaten,” indicated the father of one mentally disabled child. 325 Another parent noted, “if parents are not educated, they can’t help their child. If they are poor, not from the city, they treat the child like animals.” 326 There are also reports that children with mental disabilities face “suggestions of euthanasia.” 327 One mother, answering questions about her mentally disabled son, reported that people in her community tell her she would be better off if her son died. 328

In light of the foregoing, interviewees highlighted the responsibility of the government to publicly disseminate mental health information, 329 in keeping with right to health norms. 330 Unfortunately, to date, the government has done little, if anything, to distribute mental health information. Mr. Kadum, the father of an autistic son, recalled how neither he, nor anyone in his community, had ever received mental health information:
I never had anything from the government on mental health education. We have nothing at all. We need to let other parents know about these problems, like autism. I didn’t know about it until my son was four years old! I feel very angry about that. It was important and we didn’t know.

Leam Pheng, the mother of another autistic child added that “Only NGOs give people this kind of education. The government doesn’t care.”

Notably, advocates for persons with mental disabilities in Cambodia have demonstrated the effectiveness of public education. Seang Chamnap runs House of Smiles, a program that seeks to integrate children with mental disabilities into the community. She recalled how she was able to overcome resistance to the establishment of integrated classrooms within the public school system:

People don’t know about these people, avoid and ignore them, parents are ashamed and believe they did something bad in a past life to deserve a child with these illnesses. . . . We had to do a lot of education with school principals in the beginning. Principals said it would be very frightening for the other children, and also worried our clients would give the diseases to others. It took about a year to secure their permission, and we also had to get a letter from the Ministry of Education, which also took a lot of time and effort. But now we have integrated classrooms in three schools in Phnom Penh and the students play with each other.

The delegation met with a number of other disabled people’s and disability rights organizations, including the Cambodian Disabled People’s Organization, ADD-Cambodia, the Center for Child and Adolescent Mental Health, Cambodia Trust, and Handicap International, which also operate important disability rights and public education programs in Cambodia.

3. DETENTION IN STATE FACILITIES

In the absence of functioning community mental health services, State detention facilities have functioned as de facto holding centers for Cambodians with mental disabilities. As noted by the CESCR:

The lack of mental health services often results in patients being incarcerated in prisons, compulsory drug treatment centres or social rehabilitation centres that offer poor mental or social services, and where there have been instances of abuse and where individuals who should be receiving mental health care have been held criminally responsible, convicted and imprisoned.

The following Section explores the detention of persons with mental disabilities in these state facilities.

a. Detention in Prisons

Cambodia relies almost exclusively on incarceration as the default for both people awaiting trial and as punishment for convicted criminals. Nondetention pretrial options, such as bail, are rare and alternative sentencing schemes for convicts, even those with severe mental disabilities, are essentially absent. Further, while the 2009 Cambodian Criminal Code contains provisions barring criminal responsibility for mentally disabled defendants who acted with a suppressed discernment, nongovernmental organizations report that the psychological state of a defendant “rarely affects the outcome of criminal proceedings” in Cambodia. As a result, persons with mental disabilities who become entangled in the criminal justice system are routinely placed in the nation’s prisons.

Prison mental health services are virtually nonexistent. Indeed, many prisons do not have qualified doctors on staff, relying instead on “health workers” who receive very basic health training with no mental health component, in contravention of the UN Standard Minimum Rules for the Treatment of Prisoners. Instead, prisoners must rely largely on threadbare mental health services provided by a small number of international and nongovernmental organizations that occasionally visit detention facilities. As noted by the Cambodian League for the Promotion and Defense of Human Rights (“LICADHO”), a leading Cambodian human rights nongovernmental organization that monitors Cambodia’s prisons, “Neglect and lack of treatment for prisoners with psychological problems are all common.”

Furthermore, the poor detention conditions within the prisons place increased strain on the mental health of all inmates. Inmates must confront physical violence—both guard on inmate and inmate on inmate—poor living conditions, and staff corruption among other hardships. The Committee Against Torture has stated
that Cambodia’s prisons, which are on pace to become “the most overcrowded prison system in the world by 2018,” are a threat to the “psychological integrity and health of detainees.” Interviewees, including inmates who spoke to the delegation, confirmed that detainees’ mental health could significantly deteriorate under these prison conditions.

b. Detention in Extrajudicial Centers

Cambodian detention facilities also include drug treatment and social affairs centers, which operate outside of the criminal justice system. The drug treatment centers purport to address problems of drug dependence, while the social affairs centers are ostensibly designed as voluntary government facilities that provide social rehabilitation services. In reality, reports have documented that the centers are instead used to illegally detain drug users and other “undesirables,” such as sex workers, the homeless, and persons with mental disabilities. Individuals detained at drug treatment or social affairs centers are not charged with any crime nor are they given the right to confer with counsel or otherwise have their detention reviewed. The exact number and location of these centers remains unknown, though estimates are that there are now between eleven and fourteen drug treatment centers and a handful of social affairs centers in Cambodia, the distinction between which is often blurred. Notably, in March 2012, UN agencies issued a joint statement calling for the general closure of these types of centers.

Individuals are typically brought for detention to these centers in one of two ways: either the detainee’s family pays the police to apprehend the detainee or the police round up the detainee in one of their periodic “street sweeps.” Persons with mental disabilities are especially vulnerable to these forms of extrajudicial detention. A Human Rights Watch representative reported that “frustrated family members pay for the police to lock mentally ill family members up,” and that “the mentally ill are also detained because they are often homeless and because it is easy to put them...”
In the absence of functioning community mental health services, State detention facilities have functioned as de facto holding centers for Cambodians with mental disabilities. [...] “[F]rustrated family members pay for the police to lock mentally ill family members up.”362 “[T]he mentally ill are [also] detained because they are often homeless and because it is easy to put them in [these centers]. It requires less paperwork than putting them in prison.”363

Family members and police forces are not alone in using these centers as makeshift holding facilities for persons with mental disabilities. Interviewees indicated that, in some instances, public mental health facilities transferred patients directly to these centers,364 despite any official protocol governing such transfers. Moreover, prosecutors and judges acknowledged that they resorted to sending mentally disabled defendants to these centers, notably where they did not wish to release an otherwise criminally irresponsible defendant back into the community.365 Judges and prosecutors conceded that there are no legal mechanisms allowing them to order these detentions.366 Rather, detention in these centers was considered the only available option given the lack of mental health facilities and services available in Cambodia. As stated by judges at the Siem Reap Provincial Court: “We have no specialized hospital to care [for] these people. We have to find some place to send them for public safety.”367

Persons with mental disabilities are thus funneled by numerous actors into drug treatment and social affairs centers, which do not have the means, or even the pretense, of caring for them.368 Conditions in these drug treatment and social affairs centers are notoriously brutal. According to one apt description, “the drug treatment centers are reminiscent of the accounts of mental patients from 18th or 19th century Europe—with shackles, chains, and beatings masquerading as treatment, gross overcrowding, the ever-present stench of human waste, and the always dangerous mix of locking away children and youth with adults.”369 Similarly, the conditions at social affairs centers have been described as “abysmal” and worse than those in Cambodia’s prisons.370 One interviewee, who visited the social affairs center in Prey Speu, recalled seeing a woman “very disturbed, almost naked” who had been “chained next to a tree.”371 Inside the walls of these centers, persons with mental disabilities are subject to “appalling physical violence,” according to reports by former detainees.372 Detainees can be held under these conditions for months, or even years, without recourse to the law, in violation of all fundamental human rights norms.

This Report’s right to health framework reveals myriad ways in which mental health is a significant international human rights issue in Cambodia. Cambodia’s international legal obligations under the right to health are implicated by its failure to sufficiently address the underlying social determinants of mental health,373 reduce the mental health treatment gap,374 and protect Cambodians with mental disabilities from a range of interrelated human rights violations.375 Cambodia’s multifaceted failures in this context have concrete consequences for a wide range of individuals, including health professionals, human rights and disability rights advocates, judicial and prison officials, family members and caretakers, and, most notably, persons with mental disabilities. Advocacy efforts, at both the international and domestic levels, must recognize the crosscutting nature of the issue and work to engage these disparate actors in a broad coalition working to promote mental health and the rights of persons with mental disabilities. Further, the international and domestic legal frameworks can be used to help reframe mental health as more than just a public health issue. As recognized by Graham Shaw, the WHO’s point person for mental health in Cambodia: “If you base mental health in the constitution, and have national covenants that exist to protect it, it puts more of a baton to the Minister of Finance. It’s not just a health issue, but a legal issue that may make the Minister of Health and others act more. It would make the leveraging of respect easier.”376 Part III provides a brief overview of two key sets of domestic legal provisions of relevance to mental health, namely those contained in the 2009 Disability Law and in the Cambodian Criminal Codes. The Report’s recommendations follow thereafter.
III. BRIEF OVERVIEW OF DOMESTIC LAWS OF IMPORT TO MENTAL HEALTH

A number of Cambodian legal provisions concern issues of mental health. As an initial matter, Cambodia’s shortcomings under international law regarding the right to health, and other interrelated human rights norms, are of legal import domestically. As detailed earlier, the Cambodian Constitutional Council has affirmed that fundamental international human rights norms are given the force of law through their domestic incorporation under Article 31 of the 1993 Constitution. Moreover, the 1993 Constitution itself contains a right to health provision that arguably imposes obligations on the Cambodian government to redress the current mental health situation. Additionally, both the 2009 Disability Law and the Cambodian Criminal Codes contain provisions of significance to mental health and the rights of persons with mental disabilities.

A. 2009 Disability Law

In 2009, Cambodia adopted the Law on the Protection and the Promotion of the Rights of Persons with Disabilities (“2009 Disability Law”). The 2009 Disability Law abrogated older laws that explicitly discriminated against persons with disabilities, including mental disabilities, and was described as a “landmark accomplishment” that promised to improve the standard of living for people with disabilities and encourage the inclusion of the disabled in Cambodian society. Indeed, the law’s passage marks a significant step forward for disabled rights in Cambodia. It requires the establishment of a budget line in the nation’s annual budget to assist persons who have “severe disabilities, are very poor and have no support.” It also contains explicit provisions recognizing the rights of persons with disabilities in a wide-variety of sectors, including health, education, employment, and the political process. Used in conjunction with applicable international human rights norms and constitutional provisions regarding the right to health, the 2009 Disability Law provides a holistic, rights-based legal instrument that can potentially be employed to promote the rights of persons with mental disabilities domestically.

The 2009 Disability Law is not without its shortcomings, however. Certain provisions of the 2009 Disability Law emphasize the impairment of persons with disabilities rather than the barriers that hinder their full and effective participation in society on an equal basis with others, which is the focus of more progressive international instruments like the CRPD. Implementation of the 2009 Disability Law also remains problematic. Many of the 2009 Disability Law’s enforcement mechanisms or implementation processes are not outlined in the law itself. Instead, these provisions state that the details will be worked out by prakas or ministerial orders. As of May 2011, interviewees reported that less than half of the implementing prakas had been issued by the relevant ministerial bodies. There is also a lack of awareness of the 2009 Disability Law’s existence, even within the judicial sector. In an interview with the delegation, the chief judge in Battambang province stated that, more than two years following its passage, he had yet to be informed by the government that the 2009 Disability Law even existed. This lack of dissemination is emblematic of a broader dearth of public information on disability rights and mental health issues, which

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runs counter to the obligation to promote the right to health and associated human rights.395

The 2009 Disability Law nevertheless offers a unique opportunity to build a coalition of disparate actors focused on various issues related to mental health. Indeed, the holistic nature of the 2009 Disability Law ensures that it is of significance to groups that otherwise have little interaction with one another. Human rights, disability rights, and public health groups might focus, respectively, on provisions in the 2009 Disability Law that bar discrimination,396 promote the participation of persons with mental disabilities in issues that affect their interests,397 or call for the expansion of community-based rehabilitation services, for example.398 Such a broad-based concerted push to uphold the rights of persons with mental disabilities would mark an important milestone towards ending the marginalization of mental health in Cambodia.

B. Criminal Law Provisions

Cambodian criminal law is governed by the provisions of the 2007 Cambodian Criminal Procedural Code399 and the 2009 Cambodian Criminal Code.400 These Codes contain specific provisions that intersect with issues of mental health, namely as concerns criminal responsibility and forensic evaluations.

Article 31 of the 2009 Cambodian Criminal Code addresses the criminal responsibility of an individual suffering from a mental disorder that suppresses or reduces his or her mental discernment. It states in relevant part:

When a person commits an offence right at the time when he/she is [sic] suffered from [a] mental disorder which suppresses his/her discernment, he/she is not criminally responsible.

When a person commits an offence right at the time where he/she is suffered [sic] from [a] mental disorder which reduces his/her discernment, he/she still remains criminally responsible. However, the court must take into account that circumstance when it determines the penalty.401

As noted above, however, nongovernmental organizations have reported that the psychological state of a defendant is often overlooked in Cambodian criminal proceedings.402 A number of factors impede a greater respect for Article 31 of the 2009 Cambodian Criminal Code. First, lawyers and judges may be unaware that Article 31 exists,403 or may simply choose to disregard it.404 Second, even where lawyers and judges are aware of and willing to apply the provision, there is a dearth of trained forensic experts who are able to provide the required psychological report to the parties or the court—Cambodia has approximately forty trained psychiatrists for a population of close to fifteen million.405 Third, while Article 163 of the 2007 Cambodian Criminal Procedure Code provides for the creation of a national list of experts,406 which would facilitate the task of finding one of the few trained Cambodian mental health professionals, an official from the Ministry of Justice indicated that the implementing prakas needed to establish the list had yet to be adopted.407 Fourth, Article 171 of the 2007 Cambodian Criminal Procedure Code places the costs of a forensic evaluation on the requesting party or judicial entity.408 As a result, interviewees indicated that some mentally disabled defendants were simply unable to afford these needed psychiatric evaluations.409 In light of the foregoing difficulties, judicial officials sometimes resort to carrying out psychological evaluations on their own, despite their lack of mental health training—a practical solution they acknowledged was inappropriate, if necessary.410

The issue of forensic evaluations is further complicated by the potential for political interference. In interviews with the delegation, Cambodian mental health professionals who provided these evaluations in the past stated that they had been subject to political pressure to reach a desired outcome.411 Interviewees indicated that there was a need to standardize the process of forensic evaluations, which is now largely conducted on an ad hoc basis, to better insulate it from extraneous political pressures.412 In a recent positive development, the Royal University of Phnom Penh instituted a forensic psychology-training program, which addresses the drafting of psychological assessments for criminal law purposes.413

The Cambodian Criminal Codes do not contain any specific criminal provisions regarding competency to stand trial.414 The issue of competency to stand trial was, however, the subject of a recent decision by the ECCC Supreme Court Chamber regarding Ieng Thirith, one of four elderly defendants in Case 002.415 The ECCC Supreme Court Chamber focused its decision on the remedial powers of the ECCC Trial Chamber under Cambodian and international law as they regard the defendant, who was found unable to effectively participate in her own defense.
given her mental state. In its decision, the ECCC Supreme Court Chamber found that “considering the interest of justice in trying the accused, upon a finding of unfitness, remedial action must be undertaken in light of a possibility, even slight, of a meaningful improvement.” The ECCC Supreme Court ruled that the ECCC Trial Chamber has the power to order the continued detention of the defendant, including “in a hospital or other appropriate facility” and to request, in consultation with appropriate medical experts, treatment “which may help improve her mental health such that she could become fit to stand trial.” The ECCC Supreme Court Chamber further ordered that the defendant was to undergo an expert examination no later than six months following the start of such treatment, after which time the ECCC Trial Chamber was to reassess her fitness to stand trial.

The ECCC Trial Chamber’s upcoming decision reassessing Ieng Thirith’s fitness to stand trial will likely highlight significant gaps in the Criminal Codes, as well as deficiencies in Cambodia’s mental health infrastructure. In its decision, the ECCC Trial Chamber may be called upon to determine the legal mechanisms that would govern Ieng Thirith’s continued detention or release should she remain unfit to stand trial. According to interviewees and the delegation’s review of applicable Cambodian law, there are currently no domestic legal mechanisms that would permit the compulsory detention or treatment in a mental health facility of an individual deemed to be permanently unfit to stand trial (or criminally irresponsible by virtue of Article 31 of the 2009 Cambodian Criminal Code). In these instances, Cambodian law appears to mandate their unconditional release, notwithstanding the extra-judicial detention practices described earlier in Section II.B.3.b. Further, as a practical matter, Cambodia currently lacks any facilities able to provide care for an individual in Ieng Thirith’s condition for an extended period of time. Permitting Ieng Thirith to voluntarily remain within the ECCC’s custody to receive care would confront a host of legal and logistical problems, including that the ECCC is a non-permanent institution with a limited mandate. By bringing these challenges to the fore, the ECCC’s upcoming Ieng Thirith decision will shine a rare spotlight on issues of mental health in Cambodia. Advocates should capitalize on the opportunity presented by these legal proceedings to push for a broader recognition of the significance of mental health as a critical public health and human rights issue in Cambodia.

The issue of forensic evaluations is further complicated by the potential for political interference. In interviews with the delegation, Cambodian mental health professionals who provided these evaluations in the past stated that they had been subject to political pressure to reach a desired outcome.

The international community must acknowledge the deep human rights implications of mental health, which have broad repercussions across Cambodian society. Support for mental health should extend beyond public health organizations to include those whose mission includes the promotion and respect of human rights. Indeed, as documented by this Report, few issues implicate as wide a range of human rights concerns in Cambodia as does mental health.
Mental health is too significant a public health and human rights issue in Cambodia to remain so marginalized. While Cambodia’s own interests counsel that it accord mental health a priority commensurate with its importance, its international and domestic legal obligations mandate that it act to do so now.

Cambodia is to be congratulated for the steps it has taken to date. The Ministry of Health has, at least on paper, declared mental health to be a priority, created subdepartments specifically for mental health, incorporated the delivery of mental health services within the general public health system, and adopted a mental health policy. Cambodia also possesses a small, and growing, group of dedicated mental health professionals, as well as a range of specialized university training programs in the sector. Further, Cambodia has recognized, both internationally and domestically, a broad spectrum of rights for persons with mental disabilities, which complement their right to health. Particularly in light of the devastation that marked Cambodia’s tragic past, these represent notable accomplishments.

Yet, more than three decades following the traumatic Khmer Rouge period, the mental health needs of most Cambodians continue to go unmet. As documented in this Report, Cambodia and the international donor community are failing to sufficiently address the underlying determinants of health, close the mental health treatment gap, and protect persons with mental disabilities from a range of interrelated human rights abuses. This Report, and the following recommendations, are aimed at remedying these violations and at the full realization of Cambodians’ rights under international and domestic law.

A. Recommendations to the Government of Cambodia

The government of Cambodia should take steps towards improving access to the highest attainable standard of mental health with respect to policy, legislation, and resourcing at a range of government levels. These steps include:

Prioritization of mental health across government sectors. The government should grant a far greater priority to mental health, in accordance with its significance as a public health and human rights issue. Notably, the crosscutting nature of mental health issues mandates that this prioritization take place across all government sectors. In the words of Dr. Ka Sunbaunat, the Director of the National Program for Mental Health: “This is not the responsibility of the Ministry of Health alone but of all the government Ministries and of the community as well.”

Increase in resources for mental health services. Clearly, the financial resources allocated to the mental health sector must be increased beyond their current de minimis amounts. Government allocations to the sector should be made public and transparent, and be brought into line with WHO recommendations for low-income countries. These increased financial resources for the mental health sector should be sustainable, preferably in the form of legislation requiring that a set percentage of the overall health budget be allocated towards mental health. This would allow for an expansion of services and a greater integration of mental health in primary health care. Greater coordination is also needed among governmental entities responsible for mental health, whose internal factional disputes are currently paralyzing progress in the sector.

Establishment of community-based mental health care and support, especially for rural areas. In keeping with the Ministry of Health’s stated policies, community-based mental health care and support services need to actually exist. There is a dearth of such services for persons with mental disabilities or their caretakers, particularly in rural communities where a majority of Cambodians live. These community services are needed if Cambodia is to address the mental health needs of its population and curb egregious practices like the chaining and caging of persons with mental disabilities. Support services also are crucial to allowing Cambodians with mental disabilities to fully participate in their own communities.
Integration of mental health services and holistic approaches towards care. Public mental health services should move away from a purely biomedical model, which relies overwhelmingly on the use of pharmaceuticals, towards a more holistic model of mental health care and support. Psychologists and social workers should be integrated within public mental health services, which should more fully acknowledge the psychosocial nature of many determinants of mental health in Cambodia. Notably, mental health services should not continue to function merely as a palliative for broader concerns, including widespread poverty, high rates of violence against women, and a precarious human rights situation, that otherwise continue unaddressed.

Education campaigns and destigmatization. The government should play an active role in awareness-raising and advocacy efforts to educate the public on mental health issues and combat stigmatization. Training and sensitization to mental health issues also is needed within the government itself, including among health professionals, judges, prosecutors, and prison officials. The government should also make full use of applicable legal provisions, including the 2009 Disability Law, to stem discrimination against persons with mental disabilities.

Closure of drug treatment and social affairs centers. The government should close its drug treatment and social affairs centers, which operate as dumping grounds for society’s undesirables, including persons with mental disabilities. The human rights violations associated with these centers in Cambodia are simply too endemic to rectify. Instead, in keeping with UN recommendations, the government should move to replace them with voluntary, rights-based, evidence-informed programs in the community. The government should also take this opportunity to consult with domestic and international organizations, including disability rights and disabled people’s organizations, about the need for voluntary long-term inpatient mental health services in Cambodia.

Ratification and implementation of international instruments. The government should ratify the CRPD, which it has already signed. Further, the government should fully respect, protect, and fulfill the provisions of the other international human rights instruments to which it is already bound, including the right to health provision of the ICESCR. This includes increasing service availability in line with the recommendations above, as well as collecting data—and disaggregating it—to ensure that policies and programs are adopted in line with actual need. Prioritizing issues of mental health through a rights-based framework will benefit Cambodia’s own development, while also helping it to meet its international and domestic legal obligations.

B. Recommendations to Cambodian Civil Society and the International Community

Whereas the primary responsibility for ensuring that the right to health is ensured in Cambodia falls to the government, local civil society and the international community have an important roles to play. These groups should consider:

Coordinated approaches. Greater cooperation among Cambodian civil society members is crucial if a sustained push to promote mental health and the rights of persons with mental disabilities is to be effective.

Creating networks. A framework must be found to bring together the disparate local actors working on various issues related to mental health. The creation of a broad-based mental health coalition would be a significant step towards ending the marginalization of mental health in Cambodia. The 2009 Disability Law and the upcoming ECCC decision on Ieng Thirith’s fitness to stand trial represent two potential vehicles through which to galvanize these efforts.

Focus on mental health as an international priority. The international community must focus a larger share of its efforts on issues of mental health in Cambodia. The WHO, in particular, needs to play a more central role in the mental health sector. The resources allocated by the WHO to mental health should be commensurate with its stated belief that there truly is “no health without mental health.”

Adoption of mental health as a donor priority. International assistance also should be provided to carry out epidemiological and psychosocial research to document the significance of mental health as a public health issue in Cambodia.

Recognition of mental health as a human rights issue. The international community must acknowledge the deep human rights implications of mental health, which have broad repercussions across Cambodian society. Support for mental health should extend beyond public health organizations to include those whose mission includes the promotion and respect of human rights. Indeed, as documented by this Report, few issues implicate as wide a range of human rights concerns in Cambodia as does mental health.
Endnotes

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2. See Laura Andrade et al., Cross-National Comparisons of the Prevalences and Correlates of Mental Disorders, 78 BULL. WORLD HEALTH ORG. 413, 416 (2000).


7. WORLD HEALTH ORG., MENTAL HEALTH, POVERTY AND DEVELOPMENT 1 (2009).


9. See id. at 15–19.

10. For two recent notable exceptions see generally CAMBODIA’S HIDDEN SCARS; supra note 8 (considering the mental health implications of the Khmer Rouge era among the general populace); Joseph Stewart et al., Mental Health in Cambodia: A Qualitative Evaluation (Nov. 2010) (unpublished manuscript) (on file with the author) (providing a qualitative evaluation of mental health in Cambodia). For an overview of the epidemiological data on mental health in Cambodia that focuses almost exclusively on trauma-related disorders, see infra Part I.B.1.b.

11. See Part I.B.1 (regarding the lasting psychological impact of the Khmer Rouge period).


13. See Part I.A.1 (documenting the extent to which mental health is a critical yet marginalized issue in Cambodia).

14. Interview with Chit Sophal, M.D., Deputy, Natl Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011); see Section I.A.1 (documenting the lack of financial resources accorded to the mental health sector in Cambodia).

15. See Part I.A.2 (documenting the infrastructure, human resources, and quality of service of the Cambodian mental health system).

16. See Part I.B (documenting the increased vulnerability to human rights abuses of persons with mental disabilities).

17. See Part I.B.1 (regarding chaining and caging of persons with mental disabilities by family members).

18. See Part I.B.3 (regarding the detention of persons with mental disabilities in extrajudicial centers).

19. The Millennium Development Goals ("MDGs"), formulated by the United Nations in 2000, are an aggressive set of economic and social targets that signatory states, including Cambodia, must meet by 2015. There are eight MDGs: halve extreme poverty, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS and other diseases, ensure environmental sustainability, and develop a global partnership for development. Each MDG contains between one and sixteen subgoals, each of which is measured with discrete data sets. See generally Millennium Development Goals: Background, UNITED NATIONS, http://www.un.org/millenniumgoals/bgdleigh/ (last visited Apr. 21, 2012).


21. Id. at 962–63.

22. Id. at 963.

23. Id. at 962 (noting the links between mental health and the issues of access to education and HIV/AIDS).


25. See id. at 863–64.

26. See id. at 864–66.

27. See id. at 864.


29. LANCET Global Mental Health Group, Scale Up Services for Mental Disorders: A Call for Action, 370 LANCET 1241, 1241 (2007).


31. ICESCR, supra note 30, art. 12.


36. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 85 (hereinafter


38. See, e.g., ICCPR, supra note 32, art. 9.


40. See, e.g., ICCPR, supra note 32, art. 14.

41. See, e.g., id. art. 9.

42. See, e.g., id. pmbl.

43. All interviews were conducted in English by the Fordham delegation, assisted by translators fluent in both Khmer and English, where needed. Interviews with individuals consulting mental health services were conducted in partnership with local nongovernmental organizations that have established ties with these individuals. The delegation ensured that all interviewees were informed of the interview's purpose, its voluntary nature, and the ways that the information provided would be used. All consented verbally to be interviewed and were told they could decline to answer any question and end the interview at any time.

44. Because of the sensitive nature of the issues examined, the full names of many of the interviewees who contributed to this Report have been withheld.


47. Special Rapporteur 2005 Report, supra note 46, ¶ 20 (emphasizing that "mental disability" encompasses a wide range of profoundly different conditions and notably two sets of conditions, psychiatric disabilities and intellectual disabilities, which are distinct in their causes and effects).


52. See ICESCR, supra note 30, art. 12.

53. Id

54. The Committee on Economic, Social and Cultural Rights ("CESCR") is a body of independent experts that monitors the implementation of the ICESCR by its state parties. The CESCR reviews reports submitted by state parties regarding implementation, receives individual communications related to economic, social, and cultural rights violations, and publishes authoritative interpretations of the ICESCR in the form of general comments. See Committee on Economic, Social and Cultural Rights, UN Off. High Comm'rs Hum. Rts., http://www2.ohchr.org/english/bodies/cescr/ (last visited Apr. 21, 2012) (hereinafter OHCHR). The CESCR's general comments are not binding sources of law but do have considerable legal weight and influence the practice of states in applying the ICESCR. See Matthew C.R. Craun, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS: A PERSPECTIVE ON ITS DEVELOPMENT 91–92 (1995) (citing Theodore Meron, Human Rights Law-Making in the United Nations 10 (1986)).


56. ICESCR, supra note 30, art. 2.

57. Id


59. The ICESCR’s progressive realization framework differs substantially from the implementation provision of the ICCPR. Compare ICCPR, supra note 32, art. 2(1) ("Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant . . . ."), with ICESCR, supra note 30, art. 2 ("Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."). Notably, the progressive realization framework was originally criticized for not imposing stringent enough demands on state parties to the ICESCR. See, e.g., Louise B. Sohn, THE NEW INTERNATIONAL LAW: PROTECTION OF THE RIGHTS OF INDIVIDUALS RATHER THAN STATES, 32 ASU. U. L. Rev. 1, 40 (1982). Sohn explains: (The language of the ICESCR had been criticized for not going far enough and for being full of loopholes. Critics pointed out that to undertake ‘to take steps’ for the realization of rights was not equivalent to guaranteeing these rights; that a state criticized for doing nothing could always plead lack of resources; and that to allow states to achieve ‘progressively’ the realization of the economic, social, and cultural rights would permit indefinite delays. Because the obligations under the Covenant thus could easily be evaded, the value of the document was arguably greatly diminished.

Id In response ‘proponents argued that it would have been futile to impose obligations that could not be fulfilled; either no state would ratify
the Covenant, or those ratifying it would soon discover that they were unable to comply and therefore would withdraw from the Covenant.”

60. See General Comment No. 3, supra note 58, ¶ 2.

61. See id. (explaining that state parties have an obligation to take steps to fully realize the rights enumerated in the ICESCR, which includes the right to health).

62. See General Comment No. 14, supra note 37, ¶ 30; see also Special Rapporteur 2005 Report, supra note 46, ¶ 31 (explaining that although it is not explicitly stated in the ICESCR, the CESC “takes[es] the view” that discrimination is prohibited on the grounds of physical and mental health).


64. See Special Rapporteur 2005 Report, supra note 46, ¶ 50.

65. See id. ¶ 5.

66. See, e.g., General Comment No. 3, supra note 58, ¶¶ 9–12.

67. See, e.g., id. ¶ 10.

68. See General Comment No. 14, supra note 37, ¶ 43(10).

69. See id. ¶ 47 (“It should be stressed . . . that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.”).

70. See General Comment No. 3, supra note 58, ¶ 9–10.

71. See General Comment No. 14, supra note 37, ¶ 33.

72. See id. ¶ 34; see also id. ¶ 26 (emphasizing that the health sector needs to focus on nondiscrimination with respect to persons with disabilities).

73. See id. ¶¶ 33, 35.

74. See id. ¶¶ 33, 36–37.

75. See id. ¶ 37 (“The obligation to fulfill (facilitate) requires States inter alia to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to fulfill (provide) a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to fulfill (provide) the right to health requires States to undertake actions that create, maintain and restore the health of the population.”).


77. General Comment No. 14, supra note 37, ¶ 4; see Special Rapporteur 2006 Report, supra note 76, ¶ 10 (“Fundamentally, this is what the right to health is all about: a comprehensive, integrated, responsive health system, encompassing health care and the underlying determinants of health, accessible to all.”).

78. Special Rapporteur 2006 Report, supra note 76, ¶ 9; see General Comment No. 14, supra note 37, ¶¶ 11–12; see also WORLD HEALTH ORGANIZATION, supra note 1, at 10 (noting that “improved scientific evidence indicates that mental and behavioural disorders are the result of genetic, plus environment or, in other words, the interaction of biology with psychological and social factors”).

79. But see Special Rapporteur 2005 Report, supra note 46, ¶ 45 (discussing the underlying determinants of health and noting that “families with mental disabilities are disproportionately affected by poverty, which is usually characterized by deprivations of these entitlements.”)

80. Id. ¶ 32.

81. See General Comment No. 14, supra note 37, ¶ 12. Accessibility in particular includes: (i) nondiscrimination, which requires equal accessibility to health care, especially for vulnerable groups; (ii) physical accessibility, that requires that “health facilities, goods and services must be within safe physical reach for all sections of the population, especially . . . persons with disabilities”; (iii) economic accessibility, that requires that health care be “affordable for all”, and (iv) information accessibility, which “includes the right to seek, receive and impart information and ideas concerning health issues.” Id. ¶ 12(b).
ties of children with disabilities and the right to preserve their identities.


93. See, e.g., id. ¶¶ 83–86.

94. Id. ¶ 43. accord id. ¶ 86 (“IThe segregation and isolation of persons with mental disabilities from society is inconsistent with the right to health, as well as the derivative right to community integration, unless justified by objective and reasonable considerations, grounded in law and subject to independent scrutiny and determination.”).

95. See id. ¶¶ 10, 13.

96. See id. ¶ 52.

97. See id. ¶ 11.

98. See CRPD, supra note 86, pmbl. id. (“Reaffirming the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms and the need for persons with disabilities to be guaranteed their full enjoyment without discrimination . . . .”).

99. CONST. OF THE KINGDOM OF CAMBODIA, Sept. 21, 1993, art. 31 (“The Kingdom of Cambodia shall recognize and respect human rights as stipulated in the United Nations Charter, the Universal Declaration of Human rights, the covenants and conventions related to human rights, women’s and children’s rights. Every citizen shall be equal before the law, enjoying the same rights, freedom and fulfilling the same obligations regardless of race, color, sex, language, religious belief, political tendency, birth origin, social status, wealth or other status. The exercise of personal rights and freedom by any individual shall not adversely affect the rights and freedom of others. The exercise of such rights and freedom shall be in accordance with the law.”).


101. These would include the provisions of the international instruments to which Cambodia is a party, including the CRC, CEDAW, CAT, and the ICCPR. Further, at least on its face, Article 31 of the 1993 Cambodian Constitution does not require that Cambodia be a party to the instruments. CONST. OF THE KINGDOM OF CAMBODIA, Sept. 21, 1993, art. 31. Thus the provisions of the CRPD, which Cambodia has signed but not ratified, also might be considered to be incorporated into Cambodian law. See id.

102. CONST. OF THE KINGDOM OF CAMBODIA, Sept. 21, 1993, art. 72. Notably, no distinction is drawn between ‘physical’ or ‘mental’ health in Article 72. ‘Health’ also is also mentioned in Articles 48 and 64 of the 1993 Constitution. CONST. OF THE KINGDOM OF CAMBODIA, Sept. 21, 1993, art. 48 (“The State shall protect the rights of children as stipulated in the Convention on Children, in particular, the right to life, education, protection during wartime, and from economic or sexual exploitation. The State shall protect children from acts that are injurious to their educational opportunities, health and welfare.”). CONST. OF THE KINGDOM OF CAMBODIA, Sept. 21, 1993, art. 64 (“The State shall ban and severely punish those who import, manufacture land sell illicit drugs, counterfeit and expired goods which affect the health and life of the consumers.”).

103. The delegation was unaware of any comprehensive compilations of Cambodian jurisprudence generally, let alone jurisprudence that focused on Article 72 of the 1993 Constitution. See id.

104. Following Chile’s lead in 1925, many countries have since adopted explicit constitutional guarantees for the right to health. Today, almost seventy percent of countries have an explicit right to health provision in their constitution. See Iain Byrne, Enforcing the Right to Health: Innovative Lessons from Domestic Courts, in REALIZING THE RIGHT TO HEALTH 525, 526 (Andrew Clapham & Mary Robinson eds., 2009). Where no such explicit provision exists, some national judiciaries have found an implicit right to health in their constitutions, namely through an expansive interpretation of the right to life. A leading example of this approach is India’s Paschim Banag Rhet Samaty v. State of West Bengal, which interpreted the right to life to include a right to emergency medical care that could not be avoided by claiming a lack of financial resources. See Paschim Banag Rhet Samaty v. State of West Bengal, (1996) 4 S.C.C. 37 (India).

105. See, e.g., Byrne, supra note 104, at 531–32 (discussing case law holding that the right to health imposed negative obligations as well as “positive obligations to take measures designed to ensure that those rights are effectively protected”). Regional jurisprudence also has imposed obligations on states with regard to the right to health. In Victor Rosario Congo v. Ecuador, the Inter-American Commission of Human Rights “found a violation of the right to humane treatment when a mentally disabled person was denied health services in a state-run facility.” See Rosario Congo v Ecuador, Case 11.427, Inter-Am. Comm'n H.R., Report No. 63-99, OEA/Ser.L/V/II/95, doc. 7 rev. ¶ 66 (1999).

106. See infra Part Ill.

107. See, e.g., ICESCR, supra note 30, art. 12.

108. See supra Part I.A.1.

109. See Interview with Chhit Sophal, M.D., Deputy, Nat’l Program for Mental Health, in Phnom Pehn, Cambodia (May 27, 2011) (“Looking at the WHO, rates of mental disabilities in Cambodia are higher than the average rates. In Cambodia, many risk factors: war, poverty, education, jobs, substance abuse, lack of educational opportunities, and political corruption all contribute to this.”).

110. See SAMANTHA POWER, A PROBLEM FROM HELL: AMERICA AND THE AGE OF GENOCIDE 90 (2002) (“The Khmer Rouge rendered Cambodia a black hole that outsiders could not enter and some 2 million Cambodians would not survive.”).


112. See id. at 95–96.

113. See id. at 96.


115. See id.

116. See Stewart et al., supra note 1, at 20.

117. See Alexis Stockweill et al., Mental Health Policy Development: Case Study of Cambodia, 13 AUSTRALIAN PSYCHIATRY 190, 190 (2005); see also Daya J. Somasundaram et al., Starting Mental Health Services in Cambodia, 46 SOC. SCI. & Med. 1029, 1029 (1999).

118. See Byrne & Stewart, supra note 117, at 190; see also Somasundaram, supra note 117.

119. See Stewart et al., supra note 10, at 20.


121. See SUCHENG CHAN, SURVIVORS: CAMBODIAN REFUGEES IN THE UNITED STATES 37 (2004) (“During the twelve years that the Second Cambodian Civil War raged, several hundred thousand Cambodians amasssed in a no-man’s land along the Thai-Cambodian border.”).
122. See id. at 39.
123. See generally id. (discussing the experience of Cambodian refugees in the United States).
124. See id. at 227–36 detailing the psychological impact of the Khmer Rouge period among refugees and the prevalence of posttraumatic stress disorder (“PTSD”) symptoms among Cambodians.
125. See Interview with Lim Keuky, M.D., President, Cambodian Diabetes Ass’n, in Siem Reap Province, Cambodia (May 16, 2011) (describing his experience as “not exceptional”); see also Interview with Beth Goldberg, Founder, Brahmaputra Cambodia AIDS Project, in Phnom Penh, Cambodia (May 16, 2011) (“Any Cambodian above forty years or older has seen death more than we can ever know or understand.”)
128. Id. at 239–41.
129. See Law on the Establishment of the Extraordinary Chambers in the Courts of Cambodia for the Prosecution of Crimes Committed During the Period of Democratic Kampuchea art. 1 (2004) (Cambodia), amended by NS/RK3U/304/006 (Oct. 27, 2004) (“The purpose of this law is to bring to trial senior leaders of Democratic Kampuchea and those who were most responsible for the crimes and serious violations of Cambodian penal law, international humanitarian law and custom, and international conventions recognized by Cambodia, that were committed during the period from 17 April 1975 to 6 January 1979.”). To date, the Extraordinary Chambers in the Courts of Cambodia (“ECCC”) has convicted one defendant, Kaing Guek Eav, alias “Duch,” the chairman of the notorious S-21 Security Centre, where upwards of 12,273 detainees were interrogated, tortured, and executed. See Kaing Guek Eav alias “Duch,” Judgment, ¶¶ 602–03; see also Prosecutor v. Kaing Guek Eav alias “Duch,” Case No. 001/18-07-2007/ECC/TC, Appeal Judgment (Extraordinary Chambers in the Courts of Cambodia Feb. 3, 2012).
130. According to the International Classification of Diseases, which is used by the WHO, PTSD is a: (1) delayed and/or protracted response to a stressful event or situation (either short or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g. natural or manmade disaster, combat, serious accident, witnessing the violent death of others, or being the victim of trauma in intrusive memories (“flashbacks”) or dreams), occurring against the persisting background of a sense of “numbness” and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma.
131. World Health Org., ICD-10 Guide for Mental Retardation, WHO/ MINI/96.3, ¶ F43.1 (1996) (The Diagnostic and Statistical Manual of Mental Disorders, Revised Fourth Edition (DSM-IV), which is widely used in the United States, defines PTSD as: “The development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or threat to one’s physical integrity; or witnessing an event that involves death, injury, or threat of physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate, resulting in intense fear, helplessness, or horror.”)
133. See Jeffrey Sonis et al., Probable Posttraumatic Stress Disorder and Disability in Cambodia: Associations with Perceived Justice, Desire for Revenge, and Attitudes Toward the Khmer Rouge Trial, 302 JAMA 527, 527 (2009); see also Joop de Jong et al., Common Mental Disorders in Postconflict Settings, 361 LANCET 1218, 1219 (2003).
134. See World Health Org., supra note 1, at 43.
136. See James K. Boehmlein & J. David Rinzie, The Effect of the Khmer Rouge on the Mental Health of Cambodia and Cambodians, in CAMBODIA’S HELDEN SCABS, supra note 8, at 33, 34.
137. Id.; see Interview with Judith Strasser, Senior Advisor, Transcultural Psychosocial Org., Cambodia (“TPO-Cambodia”), in Phnom Penh, Cambodia (May 23, 2011) (stating that her organization has found that the “Western diagnosis of PTSD fits in Cambodia”). PTSD is also referred to by some in Cambodia as “broken courage.” See Interview with Kevin Conway, Maryknoll, in Phnom Penh, Cambodia (May 16, 2011).
138. Interview with Chea Dany, M.D., Chief, Health Promotion Unit, in Battambang Province, Cambodia (May 19, 2011); see Interview with Carrie Herbert, Dir. of Arts Therapy Servs., The Ragamuffin Project, in Phnom Penh, Cambodia (May 17, 2011) (“There are multiple layers of trauma. For those with unresolved trauma in the past, it has affected their ability to be resilient. They are very affected by sounds and noise, they are not eating or sleeping, and they flash back to Pol Pot and other hardships in their lives, like poverty.”).
139. Interview with Mental Health Professional 1, in Phnom Penh, Cambodia (May 24, 2011); see also Interview with Ka Sunbaunmat, M.D., Dir., Narl Program for Mental Health, in Phnom Penh, Cambodia (May 25, 2011) (describing the Cambodian personality as “completely broken as a result of the Khmer Rouge period”); see also Interview with Sek Sisokhom, Deputy Head of Research & Experimental Psychology, Royal Univ. of Phnom Penh, in Phnom Penh, Cambodia (Jun. 14, 2012) (“The Khmer Rouge is also a significant cause of poor mental health. The Khmer Rouge has left significant trauma for families.”).
141. See Reicherter & Aylward, supra note 8, at 18–19; see also Nigel P. Field, Intergenerational Transmission of Trauma Stemming from the Khmer Rouge Regime: An Attachment Perspective, in CAMBODIA’S HELDEN SCABS, supra note 8, at 78, 79–79.
142. See Interview with Muny Sothara, M.D., Project Coordinator, Justice & Relief for Khmer Rouge Victims Project, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011); Interview with Chea Dany, M.D., Chief, Health Promotion Unit, in Battambang Province, Cambodia (May 19, 2011); see also Kaing Guek Eav alias “Duch,” Transcript of Trial Proceedings at 16–17 (“Chhim Sotheara describing the ‘severe traumatizing effect’ of the Khmer Rouge era on the younger generation of Cambodians.”).
143. See Sonis et al., supra note 131, at 527; see also Joop de Jong et al., supra note 131, at 2129. Other, more informal studies, also point toward elevated PTSD rates in Cambodia. See Interview with Judith Strasser, Senior Advisor, Transcultural Psychosocial Organisation Cambodia, in Phnom Penh, Cambodia (May 23, 2011) (indicating that based on consultations at TPO-Cambodia’s outpatient mental health clinic, staff place the PTSD prevalence rate at around ten to eighteen percent in Cambodia).
144. Interview with Chhit Sophal, M.D., Deputy, Narl Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011).
145. Interview with Mental Health Professional 2, in Phnom Penh, Cambodia (May 17, 2011).
146. See e.g. Interview with Tan Ouak, Deputy Village Chief, in Battambang Province, Cambodia (May 18, 2011); Interview with HT, in Battambang Province, Cambodia (May 17, 2011); Interview with Lao Lun, Provincial Coordinator, TPO-Cambodia, in Battambang Province, Cambodia (May 16, 2011).
visited Apr. 21, 2012).


150. See, e.g., Interview with TO, in Battambang Province, Cambodia (May 18, 2011); Interview with VS, in Battambang Province, Cambodia (May 18, 2011); Interview with HT, in Battambang Province, Cambodia (May 17, 2011); Interview with KS, in Battambang Province, Cambodia (May 17, 2011); Interview with TK, in Battambang Province, Cambodia (May 17, 2011).

151. WORLD HEALTH ORG., supra note 7, at 1; see also Jishu Das et al., MENTAL HEALTH AND POVERTY IN DEVELOPING COUNTRIES: REVISING THE RELATIONSHIP, 65 SOC. SCI. & MED. 467, 468 (2007) (confirming that sociocultural vulnerability is correlated to mental disorders); Crick Lund et al., POVERTY AND COMMON MENTAL DISORDERS IN LOW AND MIDDLE INCOME COUNTRIES: A SYSTEMATIC REVIEW, 71 SOC. SCI. & MED. 517, 517 (2010) (documenting empirical evidence of mental disorder/poverty correlation via an epidemiological survey).

152. Interview with Lao Lun, Provincial Coordinator, TPO-Cambodia, in Battambang Province, Cambodia (May 16, 2011).


154. Interview with Ka Sunbaunat, M.D., Dir., Nari Program for Mental Health, in Phnom Penh, Cambodia (Jan. 11, 2012) (“[T]he main problem is poverty, developing the country is the first priority to addressing cause of mental health.”).

155. See, e.g., Interview with Sok Sisokhom, Deputy Head of Research and Experimental Psychology, Royal Univ. of Phnom Penh, in Phnom Penh, Cambodia (Jan. 14, 2012) (identifying poverty as one of the main causes of poor mental health in Cambodia); Interview with Chhut Sophal, M.D., Deputy, Nari Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011).

156. See Interview with KC, in Battambang Province, Cambodia (May 18, 2011); Interview with Lao Lun, Provincial Coordinator, TPO-Cambodia, in Battambang Province, Cambodia (May 16, 2011).

157. See Interview with Tan Ouk, Deputy Village Chief, in Battambang Province, Cambodia (May 18, 2011).

158. See Interview with Vat Ang, Deputy Village Chief, in Siem Reap Province, Cambodia (May 17, 2011); see also PHILIPPA THOMAS, DISABILITY KNOWLEDGE & RESEARCH, POVERTY REDUCTION AND DEVELOPMENT IN CAMBODIA: ENABLING DISABLED PEOPLE TO PLAY A ROLE 7 (2005) (noting that the Cambodian poor, unable to afford sufficient caloric intake or a balanced diet, are at increased risk of developmental delays and intellectual disabilities).

159. See Interview with Vat Ang, Deputy Village Chief, in Siem Reap Province, Cambodia (May 17, 2011); Interview with PV, in Battambang Province, Cambodia (May 17, 2011).

160. See WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2001: MENTAL HEALTH: NEW UNDERSTANDING, NEW HOPE 42 (2001) (noting that the traditional role of women in societies exposes women to greater stressors as well as making them less able to change their stressful environment).

161. Interview with Mom Sovannara, M.D., Psychiatrist, Siem Reap Referral Hosp., in Siem Reap Province, Cambodia (May 18, 2011); see Interview with Ang Sody, M.D., Clinical Supervisor, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).

162. See Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 20, 2011) (noting that the income of individuals with depression or anxiety can be reduced by seventy percent or more because of their condition).


164. See Viroj Tangcharoensathien et al., HEALTH FINANCING REFORMS IN SOUTHEAST ASIA: CHALLENGES IN ACHIEVING UNIVERSAL COVERAGE, 377 LANCET 863, 865 (2011).

165. See id at 870. Viroj Tangcharoensathien defines a “financial protection scheme” as a state’s willingness and capacity to subsidize the poor, enforce formal sector enrolment into social health insurance, and protect the rest of the population through prepayment, whether through tax or contributions. See id. at 863. Cambodia has established a health equity fund to assist the poor. Under this plan, individuals are entitled to a comprehensive package, including transport cost and food allowance, but the scope and quality of care provided at government health facilities are restricted. See id. at 866–87.

166. Patients must pay a consultation fee of around 2000 Riels ($0.50) to receive public health services and an additional 5000 Riels (slightly more than US$1 for a psychological consultation. See JAN OVESS & ING-BRITT TRANSELL, CAMBODIANS AND THEIR DOCTORS: A MEDICAL ANTHROPOLOGY OF COLONIAL AND POST-COLONIAL CAMBODIA 233, 257 (2010); see also WORLD HEALTH ORG., supra note 161, at 115. While the WHO reports that “prescribed medicines are provided free of charge,” in practice, the option to defer or relinquish medicinal fees is usually only offered to poorer patients. WORLD HEALTH ORG., supra note 163, at 115; see also OVESS & TRANSELL, supra, at 258. Even then, there are bureaucratic difficulties. The government does not provide official guidelines describing who is “poor” enough to qualify for fee deferral or exemption, so the decision is made on an ad hoc basis with little consistency. See OVESS & TRANSELL, supra, at 258. Those that do qualify generally must pay an administrative fee before obtaining the exemption. This fee alone can be cost prohibitive. Additionally, some doctors who work in both the public and private sectors will offer patients private services on public premises, and then charge the higher private rate. See id.

167. See Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 20, 2011).

168. See Interview with Seang Leap, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).

169. See Interview with Sok Phaneth, Clinical Supervisor, Psychiatrist, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).

170. Interview with Youm Yum, Clinical Supervisor, TPO-Cambodia, in Kampong Thom Province, Cambodia (May 18, 2011); see WORLD HEALTH ORG., supra note 160, at 24 (noting the impact of mental disabilities on families and caregivers).

171. For a discussion on the economic impact of mental health in low-income countries, see generally David McDaid et al., BARRIERS IN THE MIND: PROMOTING AN ECONOMIC CASE FOR MENTAL HEALTH IN LOW- AND MIDDLE-INCOME COUNTRIES 7 WORLD PSYCHIATRY 79 (2008) (discussing the relatively few studies of mental health and economic impact in low-income countries, but citing to studies in Kenya and India as evidence that low-income countries are deeply impacted economically by mental health issues).


176. See CAMBODIAN COMM. OF WOMEN, VIOLENCE AGAINST WOMEN: HOW CAMBODIAN LAW DISCRIMINATES AGAINST WOMEN 7 (2007).

177. Interview with Mental Health Patient, in Kampong Thom Province, Cambodia (May 19, 2011).

178. See Interview with Mental Health Professional 5, in Kampong Thom Province, Cambodia (May 19, 2011); see also Interview with LS, in
Battambang Province, Cambodia (May 17, 2011) (identifying domestic violence as the biggest problem in the village). Worldwide, the deleterious effects of violence against women and other gender-based abuses on mental health are well documented. Women who experience domestic and other forms of violence suffer from significantly higher rates of anxiety, major depression, suicidal tendencies, nightmares, hyper-vigilance, dissociation, somatization, low self-esteem, alcoholism, and symptoms associated with PTSD. See Leyla Gülbacı, Evaluating the Role of Gender

Inequalities and Rights Violations in Women’s Mental Health, 5 HEALTH & HUM. RTS. 46, 54 (2000). Research on the relationship between domestic violence and mental health has been conducted primarily in industrialized nations. However, studies indicate that violence has similar negative effects in developing countries. See id. at 55.

179. See Interview with Mental Health Professional 5, in Kampong Thom Province, Cambodia (May 19, 2011).

180. Interview with Ang Sody, M.D., Clinical Supervisor, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).

181. See Interview with Muriel Dewitte, Clinical Psychologist, in Kampong Thom Province, Cambodia (May 19, 2011) (“Women come here for consultation and medication. But actually it is because they are suffering from their husbands’ drinking and violence. So who should be treated? Are we treating the wrong person?”).

182. See generally OHCHR Summary, supra note 149 (collecting stakeholder reports on Cambodia’s human rights situation in preparation for Cambodia’s Universal Periodic Review).

183. The Human Rights Council established the position of the Special Rapporteur on the Situation of Human Rights in Cambodia in 1991 to ensure the protection of human rights and the nonrenewal of the policies and practices of Cambodia’s past. The Special Rapporteur assesses the human rights situation, reports publicly about it, and works with the government, civil society, and others to foster international cooperation in this field. The Special Rapporteur undertakes regularly visits or missions to Cambodia and reports annually to the Human Rights Council. OHCHR provides the Special Rapporteur with logistical and technical assistance. See generally The Special Rapporteur, OHCHR CAMBODIA, http://cambodia.ohchr.org/EN/PagesFiles/SpecialRapporteur/SpecialRapporteurIndex.htm (last visited Apr. 21, 2012).


187. See id. ¶ 34 (“CESCR, the Special Representative and Ithe Committee against Torture were alarmed by reports of widespread corruption, including in the judiciary”).

188. For a discussion on the link between mental health and human rights generally, see Lance Gable & Lawrence O. Gottin, Mental Health as a Human Right, in 3 SWSN HUMAN RIGHTS BOOK: REALIZING THE RIGHT TO HEALTH 249, 257 (Andrew Clapham & Mary Robinson eds., 2009) (“Another conceptual way to consider the interconnected relationship between the right to mental health and other human rights is to view protection of other human rights as themselves underlying determinants of mental health. Strong and consistent protections for liberty, equality, and dignity are not only beneficial for their own sake: These conditions are likely to reduce stress, anxiety, discrimination, and depression.”).

189. Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 20, 2011).

190. Interview with Researcher, Human Rights Watch, in Phnom Penh, Cambodia (May 24, 2011); see infra Part II.B.3.b (regarding the use of extrajudicial detention centers).

191. Interview with Mental Health Professional 6, in Phnom Penh, Cambodia (May 17, 2011).

192. See Interview with Human Rights Advocate, in Battambang, Cambodia (May 19, 2011); Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 19, 2011).


194. See OHCHR Summary, supra note 149, ¶ 44.

195. See id. ¶ 19; see also Joint Field Visit, supra note 173, at ¶ 24.


197. See Shekhar Saxena et al., Resources for Mental Health. Scarcity, Inequality, and inefficiency, 370 LANCET 878, 886 (2007) (stating that the challenge posed by the mental health treatment gap is greatest in developing regions of the world. A ‘mental health treatment gap’ represents “the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder . . . . for other word[is] the percentage of individuals who require care but do not receive treatment.” Robert Rohn et al., The Treatment Gap in Mental Health Care, 62 Bull. WORLD HEALTH ORG. 858, 859 (2004).

198. See DEPT OF MENTAL HEALTH & SUBSTANCE ABUSE, supra note 163, at 25.

199. Id. at 15.

200. Id. at 16.

201. Id. at 19.

202. Id. at 17.

203. Id. at 25.


205. See supra Part II.B.1.b.

206. See Interview with HS, in Kampong Thom Province, Cambodia (May 20, 2011); Interview with Mom Suvanna, M.D., Psychiatrist, Siem Reap Referral Hosp., in Siem Reap Province, Cambodia (May 18, 2011).

207. Interview with Chak Thida, M.D., Russian Hosp., in Phnom Penh, Cambodia (May 24, 2011).

208. Interview with Seang Channas, Manager, House of Smiles Program, Hagar Cambodia, in Phnom Penh, Cambodia (May 25, 2011).

209. Interview with Youn Yorn, Clinical Supervisor, TPO-Cambodia, in Kampong Thom Province, Cambodia (May 18, 2011).

210. See WORLD HEALTH ORG., supra note 5, at 51.


212. See Vikram Patel & Martin Prince, Global Mental Health: A New Global Health Field Comes of Age, 303 LANCET 878, 886 (2010) (stating that proliferation of epidemiological research constitutes one of the three critical foundations that account for the emergence of the new field of global mental health). The WHO is currently conducting the World Mental Health Surveys, a set of comprehensive and standardized studies, which will be the first to ever bring together prevalence data from around the world. See RONALD C. KESSLER, THE WHO WORLD MENTAL HEALTH SURVEYS: GLOBAL PERSPECTIVES ON THE EPIDEMIOLOGY OF MENTAL DISORDERS 3–4 (2008). In 2008, the WHO released data from seventeen
countries of the twenty-seven selected for sampling. See id. at 36.

213. General Comment No. 14, supra note 37, ¶ 43(b).

214. Id. ¶ 30.


216. The Special Rapporteur on the Right to Health has stressed the importance of indicators disaggregated by sex, race, and ethnicity, among others, within a human rights framework. See Special Rapporteur 2006 Report, supra note 76, ¶ 26. Article 31(1) of the CRPD, entitled “Statistics and data collection,” also states in relevant parts that “states-parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention.” CRPD, supra note 80, at art. 31(1). Notably, the CRPD calls for the information collected to be disaggregated. See id. at 31(2).

217. Interview with Mental Health Professional 7, in Battambang Province, Cambodia (May 18, 2011).


219. See Interview with Chea Dang, M.D., Chief, Health Promotion Unit, in Battambang Province, Cambodia (May 19, 2011).

220. The CERS has stated that the phrase “to the maximum of its available resources” includes resources “available from the international community through international cooperation and assistance.” General Comment No. 3, supra note 58, ¶ 13. Consequently, the CERS has found that “international cooperation for development and thus for the realization of economic, social and cultural rights is an obligation of all States.” Id. ¶ 14.

221. See DEPT’L HEALTH & SUBSTANCE ABBUSE, supra note 163, at 115 (noting that while “there are budget allocations for mental health . . . (details about expenditure on mental health are not available”).

222. Interview with Chhit Sophal, M.D., Deputy, Nat’l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011).

223. Id.

224. Dr. Kim Savoun, Chief of the Bureau of Mental Health, also reported that his Bureau receives around US$20,000 per year. See Interview with Kim Savoun, M.D., Chief, Bureau of Mental Health, Ministry of Health, in Phnom Penh, Cambodia (May 26, 2011). Recent reports indicate that the 2012 mental health budget may have been increased to US$300,000, although the majority of this budget goes to methadone treatment for injecting drug users. See Analysis: What Ails Cambodia’s Mental Health System?, IRIN (Mar. 12, 2012) http://www.irinnews.org/Report/95054/.


226. Interview with Muny Sothara, M.D., Project Coordinator, Justice & Relief for Khmer Rouge Victims Project, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).

227. See Daya J. Somasundaram et al., supra note 117, at 1029–30; see also Interview with Chhit Sophal, M.D., Deputy, Nat’l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011) (stating that “there were no mental health services offered inside of Cambodia. There was no mental health training in medical schools”).

228. See Stewart et al., supra note 10, at 19 (noting that “Cambodians often seek the assistance of monks, traditional healers, Khmer Rua, or Khmer mediums”).

229. See Stockwell et al., supra note 112, at 190.

230. In 1994, the first ten psychiatrists to be trained in Cambodia received instruction from the Cambodian Mental Health Training Program (“CMHTP”), which was implemented by the International Organization for Migration (“IOM”), in conjunction with the Norwegian Council for Mental Health and the Cambodian Ministry of Health. See DEPT’L MENTAL HEALTH & SUBSTANCE ABBUSE, supra note 163, at 116. The CMHTP continued to train additional groups of Cambodian psychiatrists and, in 1996, Harvard University implemented a mental health training program for doctors and medical assistants. See Somasundaram et al., supra note 117, at 1030. Nongovernmental organizations also began to provide limited mental health services directly to Cambodians throughout the 1990s. See id.


232. Id. at 6.

233. Id. at 8.

234. With the help of the IOM and the University of Oslo, the National Program for Mental Health (“NPMPH”) was established in 1994 to coordinate the Cambodian Mental Health Training Program. See Stewart et al., supra note 10, at 22–23, 38, see also Lor Vann Thary, A Review of the Transcultural Psychosocial Organization (TPO), The Community-Mental Health Program in Rural Cambodia, 25 RITSMERHANS J. ASIAN STUD. 107, 108 (explaining that the Mental Health Coordination Subcommittee that was formed to facilitate the Mental Health Training Program later became the NPMPH. The NPMPH “provides advice to government on mental health policies and legislation, coordinates training of health providers in mental health, and will provide guidance on research activities once sufficient capacity is built.” Stewart et al., supra note 10, at 23.

235. See Interview with Chhit Sophal, M.D., Deputy, Nat’l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011); Interview with Kim Savoun, M.D., Chief, Bureau of Mental Health, Ministry of Health, in Phnom Penh, Cambodia (May 26, 2011).

236. MINISTRY OF HEALTH, supra note 231.


238. See Stewart et al., supra note 10, at 31.

239. See id. at 22 (noting that the Department of Psychology of the Royal University of Phnom Penh has offered a bachelors degree program for psychology since 1994 and now also offers a Master of Arts in Clinical Psychology and Counseling. In addition, a Masters of Arts degree in Social Work has recently begun at the Royal University of Phnom Penh); see also Interview with Sek Sisokhom, Deputy Head of Research and Experimental Psychology, Royal Univ. of Phnom Penh, Phnom Penh, Cambodia (Jan. 14, 2012) (indicating that the psychology program at Royal University of Phnom Penh has trained a total of 946 students, including undergraduates and graduates).


241. See Stewart et al., supra note 10, at 21; see also E-mail from Muny Sothara, M.D., Head of Psychiatric Outpatient Unit, Preah Kossamak Hosp., to Daniel McLaughlin, 2010–11 Crowley Fellow in Int’l Human Rights, Leitner Ctr. for Int’l Law & Justice, Fordham Law School (Dec. 8, 2011, 6:23 PM) (on file with the author).

242. See Albert Maramis et al., Mental Health in Southeast Asia, 377 LANCET 700, 701 (2011).

243. See Interview with Chak Thida, M.D., Russian Hosp., in Phnom Penh, Cambodia (May 24, 2011); see also E-mail from Muny Sothara, supra note 241.

244. Id.

245. See Joint Field Visit, supra note 173, tbl.1.

246. Stewart et al., supra note 10, at 21; see also JOINT NGO REPORT, supra note 169, at 18.

247. Joint Field Visit, supra note 173, at 18; Stewart et al., supra note 10, at 21.


249. Stewart et al., supra note 114, at 21.

250. Id. Notably, Article 25(c) of the CRPD requires that state parties “Provide . . . health services as close as possible to people’s own communities, including in rural areas.” CRPD, supra note 86, at art. 25(c); see also id. arts. 9, 26(b)(1)(B) (requiring state parties to take appropriate measures to ensure accessibility for persons with disabilities in urban and rural areas and regarding the availability of habilitation and rehabilitation services in rural areas).

251. Interview with Mom Sovannara, M.D., Psychiatrist, Siem Reap Referral
Relief for Khmer Rouge Victims Project, TPO-Cambodia, in Phnom Penh, Cambodia (May 20, 2011); median number of psychiatrists per 100,000 population varies from 0.04 to 0.2 psychiatrists in Cambodia equates to approximately 0.2 psychiatrists per 100,000 population, which is in keeping with the average in Southeast Asia WORLD HEALTH ORG., supra note 163, at 33 (2005): Worldwide, the median number of psychiatrists per 100,000 population varies from 0.04 to 0.2 in the African Region to 9.80 in the European Region. Id.

Stewart et al., supra note 10, at 22.

257. See id.

258. See id. at 33–34.

259. See supra note 46 and accompanying text (discussing the medical versus social models of disability).

260. Interview with Muny Sothara, M.D., Project Coordinator, Justice & Relief for former Rouge Victims Project, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).


262. Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 20, 2011).

263. See OVESEN & TRASKELL, supra note 166, at 251.

264. Interview with Chak Thida, M.D., Russian Hosp., in Phnom Penh, Cambodia (May 24, 2011).

265. Id.


267. Interview with Mental Health Professional 18, in Cambodia (May 19, 2011).

268. Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 20, 2011).

269. Interview with Mental Health Professional 7, in Battambang Province, Cambodia (May 18, 2011).

270. Interview with Chhit Sophal, M.D., Deputy, Nat'l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011).

271. Interview with Mental Health Professional 3, in Phnom Penh, Cambodia (May 16, 2011).

272. Interview with Mental Health Professional 8, in Phnom Penh, Cambodia (May 23, 2011).

273. Interview with Yourn Yorn, Clinical Supervisor, TPO-Cambodia, in Kampong Thom Province, Cambodia (May 18, 2011).

274. See Special Rapporteur 2005 Report, supra note 46, ¶ 46(b) (“Information on health (and other) matters, including diagnosis and treatment, must be accessible to persons with mental disabilities, and the parents of children with mental disabilities.”).

275. Interview with Mental Health Professional 1, in Phnom Penh, Cambodia (May 24, 2011).

276. Interview with SL, Mental Health Patient, Battambang Province, Cambodia (May 17, 2011).


279. Interview with Mam Sovannara, M.D., Psychiatrist, Siem Reap Referral Hosp., in Siem Reap Province, Cambodia (May 18, 2011).

280. See Interview with Chak Thida, M.D., Russian Hosp., in Phnom Penh, Cambodia (May 24, 2011); see also Kunthear & Shay, supra note 261.

281. See Interview with Mental Health Professional 7, in Battambang Province, Cambodia (May 18, 2011).

282. See Kunthear & Shay, supra note 261.

283. Joint Field Visit, supra note 173, at 18.

284. According to traditional medicine, mental disorders are often attributed to an overload of “wind,” or internal “flow of health.” Stewart et al., supra note 10, at 18. Believed to be the equivalent of a panic attack, a wind overload occurs when “one becomes hyper-aware of one’s ‘wind’ . . . to the point where they become anxious and hyper-aroused.” Id. In addition, having a “weak heart” is akin to PTSD, and “involves the belief that excessive bodily wind causes a breakdown in functioning of the heart, caused by psychic distress and bodily fatigue.” Id. at 18–19. Another common traditional diagnosis is sleep paralysis, which occurs when “a person who is lying in bed sees a shadow in the shape of a human, and is temporarily paralyzed by fear.” Id. at 19. While Western medicine would likely classify this as a panic attack, traditional healers attribute it to “low energy” or “low luck.” Id. In addition to attributing mental disorders to an overload of wind, Cambodians frequently believe that people with mental disabilities are possessed by bad spirits. See Kim SAVOX, KINGDOM OF CAMBODIA, SUMMARY COUNTRY REPORT ON COMMUNITY MENTAL HEALTH CONCEPT OF MENTAL HEALTH 4 (2010), available at http://mhotech.moph.go.th/blog/wp-content/uploads/2010/03/country-report-cambodia.pdf. The Khmer word chhucat refers to a person who is “crazy” because of “black magic, spirits, or ghosts.” Id. Another belief is that a mother can give a mental disorder to her unborn child if she sleeps through a lunar or solar eclipse. Id. This is because of the belief that a “theological demon” causes eclipses by swallowing the sun or moon and takes revenge on those who are not awake for the experience. Id. While bed wind is generally the diagnosis for mild or trauma-based disorders such as anxiety or PTSD, bad spirits are likely cited as the cause of more serious mental disorders, such as schizophrenia. Id.

285. See Interview with Mental Health Professional 1, in Phnom Penh, Cambodia (May 24, 2011); Savox, supra note 184, at 6, 25; Stewart et al., supra note 10, at 19.

286. See Stewart et al., supra note 10, at 19, 26. Cupping involves the placement of small, heated glass cups on a patient’s upper arms and chest, or forehead. See OVESEN & TRASKELL, supra note 166, at 234. It is believed that “lats the air inside the cup cools and a vacuum is built, the wind may pass through the cupped area of the skin,” thus relieving the patient of his wind overload. Id. Cupping, which requires “vigorously rubbing the neck, chest, back, shoulder, and upper arms with the edge of a silver coin,” also is predicated on the belief that wind will be released as the skin is placed under pressure. Id. Silver coins are preferred for the treatment because they possess “anti-kyoh” (wind) properties, but a bottle top may also be substituted if a coin cannot be found. Id.


288. See id. at 7, 26.

289. See id. at 27.

290. Interview with Heng Srey, Soc. Servs. of Cambodia, in Kampong Thom Province, Cambodia (May 18, 2011).

291. See OVESEN & TRASKELL, supra note 166, at 263.

292. Interview with NS, in Kampong Thom Province, Cambodia (May 20, 2011).

293. Stewart et al., supra note 10, at 26; see also OVESEN & TRASKELL, supra note 166, at 265–66, 272.

294. OVESEN & TRASKELL, supra note 166, at 252–54.


296. See Interview with Kevin Conroy, Maryknoll, in Phnom Penh, Cambodia (May 16, 2011); see also Stewart et al., supra note 10, at 20–21.


298. Id.

299. See Stewart et al., supra note 10, at 39 (noting that Cambodia’s decentralized mental health system is considered a strength by mental health professionals); see also Special Rapporteur 2005 Report, supra note 46, ¶ 85 (“Deriving from the right to health and other human rights, the right to community integration has general application to all persons with mental disabilities. Community integration better supports their dignity, autonomy, equality and participation in society.”).
300. See Stewart et al., supra note 114, at 27.
301. See Interview with Sok Soksong, Deputy Head of Research and Experimental Psychology, Royal Univ. of Phnom Penh, in Phnom Penh, Cambodia (Jan. 14, 2012); Interview with Chhit Sophal, M.D., Deputy, Nat’l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011); Interview with Seang Channap, Manager, House of Smiles Program, Hagar Cambodia, in Phnom Penh, Cambodia (May 25, 2011); Interview with Mom Sovannara, M.D., Psychiatrist, Siem Reap Referral Hosp., in Siem Reap Province, Cambodia (May 18, 2011).
304. See Interview with Sok Phaneth, Clinical Manager, Psychiatrist, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011); Interview with Mental Health Professional 9, in Kampong Speu Province, Cambodia (May 19, 2011); Interview with Saveay Mark, TPO-Cambodia, in Van to Dong Village, Cambodia (May 17, 2011).
305. See Interview with Son Songhak, in Phnom Penh, Cambodia (May 25, 2011); Interview with Sok Phaneth, Clinical Manager, Psychiatrist, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011); Interview with Mental Health Professional 9, in Kampong Thom Province, Cambodia (May 19, 2011); see also Interview with Sok Soksong, Deputy Head of Research and Experimental Psychology, Royal Univ. of Phnom Penh, in Phnom Penh, Cambodia (Jan. 14, 2012) (describing chaining and caging of family members with mental disabilities as ‘very common’).
309. See Interview with Son Songhak, in Phnom Penh, Cambodia (May 25, 2011).
310. See Interview with Psychiatric Nurse, in Cambodia (May 19, 2011).
311. See Interview with Mental Health Professional 10, in Kampong Thom Province, Cambodia (May 20, 2011).
312. Id.
313. Interview with Seang Channap, Manager, House of Smiles Program, Hagar Cambodia, in Phnom Penh, Cambodia (May 25, 2011).
315. See Stewart et al., supra note 10, at 25.
316. See Interview with Lao Lun, Provincial Coordinator, TPO-Cambodia, in Battambang Province, Cambodia (May 16, 2011).
317. See Interview with Mom Sovannara, M.D., Psychiatrist, Siem Reap Referral Hosp., in Siem Reap Province, Cambodia (May 18, 2011); see also Interview with Saveay Mark, TPO-Cambodia, in Van to Dong Village, Cambodia (May 17, 2011).
318. Interview with Mental Health Professional 3, in Phnom Penh, Cambodia (May 17, 2011).
319. Interview with Mental Health Professional 9, in Cambodia (May 19, 2011).
320. Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 20, 2011).
321. Interview with Ang Sophy, M.D., Clinical Supervisor, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).
322. See Saxena et al., supra note 197, at 884 (noting that “stigma and discrimination are important factors in the reluctance of many people worldwide to seek help, or even to accept that their difficulties relate to mental illness”).
323. See Interview with Sok Phaneth, Clinical Manager, Psychiatrist, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).
324. Interview with Sok Maroum, parent of child with Down syndrome, CCAMH, in Takeo Kandal Province, Cambodia (May 24, 2011).
325. Interview with Kadum Y., parent of child with mental disabilities, CCAMH, in Takeo Kandal Province, Cambodia (May 24, 2011).
326. Interview with Leam Pheng, parent of child with mental disabilities, CCAMH, in Takeo Kandal Province, Cambodia (May 24, 2011).
328. Id. at 18 (“Neighbors call him crazy. When people get angry with him, they torture him and beat him. There are a few people who are nice to him, but most don’t like him. I want encouragement from the community, but people say, ‘if the child dies soon that is good.’ “)
329. See Interview with Mental Health Professional, in Battambang Province, Cambodia (May 20, 2011) (“Mental health information is not broadcast to the community. . . . We need the government to do public education campaigns.”).
330. See supra Part I.A.1.b (discussing legal obligations under the ICESCR regarding the obligation to fulfill the right to health); see also General Comment No. 14, supra note 33, at ¶ 12 (regarding the accessibility of information).
331. Interview with Kadum Y., parent of child with mental disabilities, CCAMH, in Takeo Kandal Province, Cambodia (May 24, 2011).
332. Interview with Leam Pheng, parent of child with mental disabilities, CCAMH, in Takeo Kandal Province, Cambodia (May 24, 2011).
333. See Interview with Seang Channap, Manager, House of Smiles Program, Hagar Cambodia, in Phnom Penh, Cambodia (May 25, 2011).
334. Id.
338. CAMBODIAN CRIMINAL CODE art. 31 (Cambodia 2009), see infra Part III (discussing Article 31 of the Cambodian Criminal Code).
340. LICADHO, supra note 337.
343. Standard Minimum Rules for the Treatment of Prisoners art. 22(a), E.S.C. Res. 663(C) (XXIV), U.N. Doc. E/3048 (July 1, 1957), amended by E.S.C. Res. 2076 (XXV), U.N. Doc. E/598 (May 13, 1977) (calling for every institution to have ‘at least one qualified medical officer who should have some knowledge of psychiatry’).
344. See Stewart et al., supra note 10, at 3.
345. LICADHO, supra note 342, at 13.
347. See Joint Field Visit, supra note 173, at 24.
348. See id. at 25.
349. See id. at 25–26.
By the police. See also id. at 27. See id. at 20; HUMAN RIGHTS WATCH, “SHIN ON THE CABLE”: THE ILLEGAL ARREST, ARBITRARY DETENTION AND TORTURE OF PEOPLE WHO USE DRUGS IN CAMBODIA, tbl. 7 (2010).

tentcenters/ (calling for closure of these types of centers worldwide); see also HUMAN RIGHTS WATCH, supra note 359, at 6–11 (calling for the closure of drug detention and social rehabilitation centers in Cambodia).


362. Id.

363. See Joint Field Visit, supra note 173, at 28.

364. See id. at 20; HUMAN RIGHTS WATCH, “SHIN ON THE CABLE”: THE ILLEGAL ARREST, ARBITRARY DETENTION AND TORTURE OF PEOPLE WHO USE DRUGS IN CAMBODIA, tbl. 7 (2010).


366. See id. at 15; see also WORLD HEALTH ORG., ASSESSMENT OF COMPELLARY TREATMENT OF PEOPLE WHO USE DRUGS IN CAMBODIA, CHINA, MALAYSIA AND VIET NAM: AN APPLICATION OF SELECTED HUMAN RIGHTS PRINCIPLES 9 (2009) (citing a 2008 study that showed that of 405 detainees, only one was a voluntary admission); Interview with Mental Health Professional 11, in Phnom Penh, Cambodia (Jan. 14, 2012) (“Sometimes families will pay for members of the families to be placed in social affairs or drug rehab centers.”). See id. at 20.

367. See Human Rights Watch, supra note 359, at 6 (noting that the drug detention centers “function as a convenient means of removing people with apparent mental illnesses from the general community and public view”).

368. See Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 19, 2011); Interview with Battambang Prosecutor, in Battambang Province, Cambodia (May 19, 2011); Interview with Battambang Prosecutor, in Battambang Province, Cambodia (May 19, 2011); Interview with Siem Reap Provincial Judges, in Siem Reap Province, Cambodia (May 18, 2011); see also Interview with Battambang Prosecutor, in Battambang Province, Cambodia (May 19, 2011); Interview with Siem Reap Provincial Judges, in Siem Reap Province, Cambodia (May 18, 2011); see also Interview with Battambang Prosecutor, in Battambang Province, Cambodia (May 19, 2011).
See CRPD, supra note 86, art. 1 (stating that “[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”).

See LAW ON THE PROTECTION AND PROMOTION OF THE RIGHTS OF PERSONS WITH DISABILITIES art. 35 (on employment quotas), art. 7 (on the organization of the Disability Action Council), art. 12 (on the development of a budget line for aid to certain populations), art. 15 (on the establishment of rehabilitation centers), art. 17 (on disability prevention), art. 19 (on healthcare and treatment for the very poor with severe disabilities), art. 24 (on the right to acquire a driving license), art. 28 (on the development of policies and national strategies for the education of students with disabilities), art. 30 (on discounted school fees for students with disabilities), art. 37 (on fines for employers who do not comply with employment quotas).


Interview with Neou Yarath, President, Battambang Provincial Court, in Battambang, Cambodia (May 19, 2011) (“The court hasn't yet been informed of the 2009 Disability Law. ... yes, sometimes the government is late to inform me of new laws.”).

See Interview with Human Rights Advocate, in Battambang, Cambodia (May 19, 2011).

See General Comment 14, supra note 33, at ¶ 37.

See, e.g., LAW ON THE PROTECTION AND THE PROMOTION OF THE RIGHTS OF PERSONS WITH DISABILITIES art. 27 (providing that children with disabilities have the right to public or private schooling without discrimination), id. art. 33 (requiring that qualified people with disabilities be hired without discrimination), id. art. 44 (stating that all disabled persons have the right to vote or to stand for elected office), id. art. 45 (prohibiting discrimination against electoral candidates with disabilities).

See, e.g., id. art. 18 (indicating that ministries shall facilitate the participation of persons with disabilities in the social, economic, and cultural development plans that may affect their interests).

See, e.g., id art. 16.


CRIMINAL CODE, ch. 2, art. 31 stating “[w]hen a person commits an offence against the state in time where he/she suffered from latent mental disorder (sic due to a result of using alcohol, addicted drugs or substances prohibited by laws) cannot be exempted from criminal responsibility”).

Article 31 also states: “When a person commits an offence against the state in time where he/she suffered from latent mental disorder (sic due to a result of using alcohol, addicted drugs or substances prohibited by laws) cannot be exempted from criminal responsibility.” Id.

Joint Field Visit, supra note 173, at 29.


Joint Field Visit, supra note 173, at 29.

See Stewart et al., supra note 10, at 22.

CRIMINAL CODE art. 163 (2007) (Cambodia).

See Interview with Ministry of Justice Official, in Phnom Penh, Cambodia (Jan. 12, 2012) (“Judges can appoint outside experts. They can decide practices on a case-by-case basis, but since there is no national list of experts, it is hard to be certain of the experts’ qualifications.”); see also Interview with Neou Yarath, President, Battambang Provincial Court, in Battambang, Cambodia (May 19, 2011). While in Phnom Penh, members of the delegation attended the sentencing of an accused that was employing an “insanity defense.” A non-Cambodian psychologist had diagnosed him with a number of disorders and in her official evaluation declared that he had lacked the capacity to reason at the time of his alleged crime, and was therefore not criminally responsible. The presiding judge did not allow the evaluation into evidence because the psychologist was not on the official list of evaluators, despite the list’s reported nonexistence. The judge reiterated this point at the sentencing, saying he was legally forbidden to consider the evaluation, yet then proceeded to give the defendant a sentence lower than the statutory minimum. No explanation was otherwise provided by the court.

CRIMINAL PROCEDURE CODE art. 171 (stating in relevant part that “(c)laims of forensic examination shall be the burden of the applicant”).

See Interview with OSI Consultant, in Phnom Penh, Cambodia (May 25, 2011); Interview with Mental Health Professional 1, in Phnom Penh, Cambodia (May 24, 2011); Interview with Anonymous Client, Soc. Servs. of Cambodia, in Kampong Speu, Cambodia (May 20, 2011).

Interview with Neou Yarath, President, Battambang Provincial Court, in Battambang, Cambodia (May 19, 2011). While some interviewees reported that a committee existed within the Ministry of Health to provide forensic psychological evaluations, the activity of any such a committee appears to be very limited. See Interview with Mental Health Professional 16 (Jan. 13, 2012); see also Interview with Ang Eng Thong, Atty., Dir. of Lawyer Training Ctr., in Phnom Penh, Cambodia (Jan. 13, 2012).

See Interview with Mental Health Professional 15, in Phnom Penh, Cambodia (Jan. 9, 2012); Interview with Mental Health Professional 14, in Phnom Penh, Cambodia (May 27, 2011); Interview with Mental Health Professional 13, in Phnom Penh, Cambodia (May 25, 2011).

Interview with Mental Health Professional 14, in Phnom Penh, Cambodia (May 27, 2011).

See Interview with Ministry of Justice Official, in Phnom Penh, Cambodia (Jan. 15, 2012) (confirming that the Cambodian Criminal Codes contain no explicit provisions addressing competency to stand trial). The primary distinction between issues of criminal responsibility and competency to stand trial is temporal: the former largely focuses on the mental state of a defendant at the time of the commission of the alleged crime, while the latter largely focuses on the mental state of a defendant at the time of the proceedings against them. See WORLD HEALTH ORGANIZATION, RESOURCE BOOK ON MENTAL HEALTH, HUMAN RIGHTS AND LEGISLATION 76 (2005).


See id. (concluding that Ieng Thirith suffered from a demestic illness probably caused by Alzheimer’s disease).

Id. ¶ 29.

Id. ch. 7. The ECCC Supreme Court Chamber added that where the defendant consents, the ECCC Trial Chamber also has the power to conditionally release the defendant from detention under judicial supervision, and to impose conditions including, but not limited to, the undergoing of a medical examination and/or treatment under medical supervision in a hospital. Id. ¶¶ 46–48 (finding that continued detention, rather than judicial supervision, was warranted given that the Ieng Thirith’s consent for judicial supervision could not be established).

Id. ¶ 49.

See Interview with Mental Health Professional 14, in Cambodia (Jan. 13, 2012); Interview with Mental Health Professional 16, in Cambodia (Jan. 13, 2012); Interview with Ang Eng Thong, Dir. of the Lawyer Training Ctr., Atty., in Phnom Penh, Cambodia (Jan. 13, 2012). Interview with Youk Chhang, Dir. of the Documentation Ctr. of Cambodia, in Cambodia (Jan. 11, 2012); Interview with Mental Health Professional 17, in Phnom Penh, Cambodia (Jan. 11, 2012); Interview with Mental Health Professional 8, in Cambodia (Jan. 9, 2012); see also generally Part IIA.2 (describing the lack of mental health infrastructure and human resources in Cambodia).

Interview with Dr. Ka Sunbaunat, Dir., Nat’l Program for Mental Health, Cambodia (May 25, 2011); Interview with Mental Health Professional 15, in Phnom Penh, Cambodia (Jan. 9, 2012).

See Joint UN Statement Calls for Closure of Compulsive Drug Detention and Rehabilitation Centers, supra note 360.

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