



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,¹ with lifetime prevalence rates estimated to be as high as thirty-three percent.² Mental disorders are responsible for twelve to fifteen percent of the total global burden of disease³—a greater percentage than cardiovascular disease and twice as much as all cancers combined.⁴ By 2030, depression is forecasted to be the single highest contributor to the burden of disease in the world.⁵ Moreover, the poor and other marginalized groups are disproportionately affected by mental health problems.⁶ According to the World Health Organization (“WHO”), “Iolver 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.”⁷ Postconflict societies exhibit particularly high rates of mental disorders.⁸ War, violence, and poverty, along with the breakdown in the social and civic fabric that accompanies such conflict, constitute additional mental health risk factors.⁹

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.¹⁰ 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,¹¹ 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.¹² The Report documents the extent to which the government and the international community continue to marginalize mental health despite its significance.¹³ Notably, it is estimated that only 0.02% of the entire Cambodian health budget goes to mental health.¹⁴ 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.¹⁵ Instead, Cambodians with

mental disabilities are largely abandoned without any means of support to their own communities, where they face widespread stigmatization and abuse,¹⁶ including chaining and caging.¹⁷ 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.¹⁸ 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”),¹⁹ including decreasing extreme poverty,²⁰ reducing child mortality,²¹ and improving maternal health,²² among others.²³ 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,²⁴ diabetes,²⁵ HIV/AIDS,²⁶ and tuberculosis.²⁷ 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.²⁸ 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.”²⁹

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”),³⁰ which enshrines “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”³¹ 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

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In addition to the ICESCR, Cambodia is a party to core international human rights instruments, including the International Covenant on Civil and Political Rights,³² the International Convention on the Elimination of All Forms of Racial Discrimination,³³ the Convention on the Elimination of All Forms of Discrimination Against Women,³⁴ the Convention on the Rights of the Child,³⁵ and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.³⁶ Taken together, these international instruments represent Cambodia’s obligation to respect, protect, and fulfill the human rights of all Cambodians,³⁷ including their rights to liberty and security of person,³⁸ non-discrimination,³⁹ equal recognition before the law,⁴⁰ freedom from arbitrary arrest or detention,⁴¹ and to the recognition of basic human dignity.⁴²

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.⁴³ 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.⁴⁴

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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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 Brahmagihara 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 Sopha, and Dr. Kim Savoun, who spoke with

us candidly about the difficult circumstances under which they must carry out their work. We also would 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 instruments⁵¹ 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,⁶¹ without discrimination.⁶² The provision therefore obligates a "clear legal undertaking,"⁶³ which Cambodia can meet through a variety of means, including passing legislation, adopting nationwide policies and plans, and training medical personnel.⁶⁴ 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.⁶⁵

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.⁶⁶ 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.⁶⁷ 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.⁶⁸ Minimum core obligations on states are non-derogable.⁶⁹ The CESCR has determined that retrogressive measures taken by a state that are incompatible with its minimum core obligations violate the ICESCR.⁷⁰

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.⁷¹ This

framework requires that a state party like Cambodia refrain from interfering with the enjoyment of the right to health (“respect”);⁷² 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;⁷³ and adopt “appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health” (“fulfill”).⁷⁴ The obligation to fulfill also entails recognizing, facilitating, providing, and promoting the right to health.⁷⁵

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.⁷⁶ 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.”⁷⁷ These include the social determinants of health, that is, “the conditions, such as poverty and unemployment, which make people ill in the first place.”⁷⁸ Notably, the right to health literature has too seldom focused on the social determinants of health specifically within the mental health context.⁷⁹

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.”⁸⁰ 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.⁸¹ 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.”⁸²

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.⁸³ 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.⁸⁴ Initially, international instruments of more general application characterized the rights of persons with disabilities.⁸⁵ 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.⁸⁶ 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,”⁸⁷ the CRPD provides a powerful normative basis against which to scrutinize health and mental health policies.⁸⁸ Notably, the CRPD embraces a social model of disability,⁸⁹ which places an explicit emphasis on empowerment, rights, participation, and inclusion.⁹⁰

Persons with mental disabilities, in particular,



A mental health patient’s family readying to leave the Khmer-Soviet Friendship Hospital in Phnom Penh.
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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. Above, a child examines a mental health awareness poster at Preah Kossamak Hospital in Phnom Penh. © 2011 Arantxa Cedillo

face a range of intersecting health and human rights issues. Worldwide, putative mental health institutions have been the site of atrocious human rights abuses. These include frequent reports of rape and sexual abuse, forced sterilizations, extended periods of chaining, violence and torture, the administration of treatment without informed consent, and grossly inadequate sanitation and living conditions.⁹¹ As a result, disability rights advocates and international health institutions, like the WHO, have recommended “mental health services, including support services, be based in the community and integrated as far as possible into general health services, including primary health care, in accordance with the vital principle of the least restrictive environment.”⁹² This right to community integration, as it is commonly referred to,⁹³ thus provides that states must take steps towards “ensur[ing] a full package of community-based mental health care and support services conducive to health, dignity, and inclusion.”⁹⁴

Persons with mental disabilities also are vulnerable to a range of abuses within their own communities.⁹⁵ 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.⁹⁶ Abuse and neglect of persons with mental disabilities in prisons also are an “alarming” concern.⁹⁷ Violations of the right to health are indivisible from these broader human rights violations.⁹⁸ 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.⁹⁹

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.¹⁰⁰ 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.¹⁰¹

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.”¹⁰²

There is no available Cambodian jurisprudence on Article 72 of the 1993 Constitution.¹⁰³ However, in keeping with the jurisprudence of other national judiciaries that have examined their own constitutionally-enshrined right to health provisions,¹⁰⁴ Article 72 of the 1993 Constitution should be seen as imposing concrete, positive obligations on the Cambodian government regarding the right to health.¹⁰⁵ Additionally, Cambodian law contains provisions, of both general and specific applicability, that recognize a broad array of rights and protections for persons with disabilities.¹⁰⁶

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.¹⁰⁷ 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.¹⁰⁸ Cambodia, in particular, is home to an elevated number of risk factors for poor mental health.¹⁰⁹ 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.¹¹⁰

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.”¹¹¹ The Khmer Rouge tore families apart, arranged mass marriages, destroyed pagodas, and defrocked Buddhist monks.¹¹² Cambodians suffered through intense forced labor and widespread famine, all the while enduring the continuous threat of violence and death.¹¹³

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.¹¹⁴ Only six to ten lawyers are estimated to have survived the era.¹¹⁵ 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.¹¹⁶ Cambodia’s already-fledgling formal mental health sector was essentially razed in its entirety.¹¹⁷ 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.¹¹⁸ Not a single Cambodian psychiatrist survived the regime.¹¹⁹

During this period, hundreds of thousands of Cambodians escaped the country and found refuge abroad.¹²⁰ 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.¹²¹ Others resettled further abroad, including in France and the United States.¹²² 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.¹²³ Moreover, many Cambodian refugees were

deeply impacted by the tragedies of the Khmer Rouge regime.¹²⁴ Dr. Lim Keuky, who lent his assistance to the delegation, described how only three members of his forty-five-member family survived the regime.¹²⁵

Khmer Rouge forces fled Phnom Penh in 1979, in the face of a Vietnamese military offensive.¹²⁶ 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.¹²⁷ Following the 1991 Paris Peace Accords, national elections were held in Cambodia under United Nations (“UN”) supervision.¹²⁸ 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, 1979.¹²⁹

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”).¹³⁰ 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.¹³¹ By comparison, the worldwide prevalence of PTSD is estimated at less than 0.4%.¹³² Cambodian refugees in Thailand and the United States similarly reveal consistently high, if varied, rates of PTSD.¹³³ While the applicability of PTSD as a crosscultural diagnostic tool has been a source of debate within the scientific literature,¹³⁴ experts have “almost universally . . . found that trauma symptoms among Cambodian refugees are very similar to those observed among other trauma survivors.”¹³⁵

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.”¹³⁶ Another mental health professional added, “[t]he impact of the Khmer Rouge is everywhere. It’s everywhere . . . The impact on parents, their families, the kids.”¹³⁷ The psychological impact of the Khmer Rouge regime also has been a subject

of inquiry during the trials before the ECCC. In his testimony before the ECCC Trial Chamber, Dr. Chhim Sotheara described some of the consequences of Khmer Rouge-era trauma on victims of the regime:

Some victims who have suffered some kind of depression, they are despaired. They don’t want to live on and they find it difficult to struggle to hold on to life, and they lose the effort to parent the children. And children have to work [doubly hard] to really support, to help the sick parents who were severely traumatized. And because of this kind of traumatic event they experienced, many end up being addicted to alcohol, for example, like drink, and some victims develop some physical conditions, for example, hypertension and chronic disease, because they have experienced such trauma. . . . [S]ome foreigners probably are in doubt why after 30 years or so [many] Cambodian people still suffered from this traumatization. And the answer is that Cambodian people have not had the appropriate opportunity to be treated, due to the fact that the services are inadequate and that many people are very busy [earning] the living to feed their family.¹³⁸

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,¹³⁹ 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.¹⁴⁰ 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.¹⁴¹

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 Sopha, Deputy of the National Program for Mental Health,

“[T]he 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.”¹⁵³

“[g]enerally there is too much emphasis on the Khmer Rouge’s impact.”¹⁴² Another mental health professional agreed, “Yes, [the Khmer Rouge] overshadows mental health.”¹⁴³ 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.¹⁴⁴

a. Poverty

Poverty remains widespread in Cambodia,¹⁴⁵ a “low-income country” by World Bank classifications.¹⁴⁶ Over forty percent of the Cambodian population lives on less than US\$1.25 a day.¹⁴⁷ Despite recent economic growth, there is little government spending on social services, education, housing, or health.¹⁴⁸ Public expenditures represent only 3.5% of Cambodia’s gross domestic product—the lowest level among low-income countries.¹⁴⁹ In many parts of Cambodia today, the government offers little in terms of social or economic assistance.¹⁵⁰

The WHO has documented a “very strong relationship” between indicators of poverty and mental disability in developing countries.¹⁵¹ 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.”¹⁵²

Interviewees described poverty as an underlying cause of poor health generally in Cambodia. As stated by Dr. Varun Kumar: “[T]he 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.”¹⁵³ 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.¹⁵⁴ Mental health patients and professionals alike identified a number of daily stressors linked with poverty.¹⁵⁵

These include low income,¹⁵⁶ lack of work,¹⁵⁷ food insecurity,¹⁵⁸ and lack of access to education.¹⁵⁹ Further, many of these daily stressors disproportionately impact women given traditional gender roles in Cambodia.¹⁶⁰ 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.¹⁶¹

Conversely, interviewees stated that mental disabilities could also lead to poverty.¹⁶² Due to limited public funding,¹⁶³ approximately sixty percent of Cambodia’s total health expenditure is out-of-pocket, which is the second-highest percentage in Southeast Asia.¹⁶⁴ 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.¹⁶⁵ As a result, the high treatment costs of mental disabilities are largely borne by patients,¹⁶⁶ many of whose incomes may already be reduced due to their conditions.¹⁶⁷ In some instances, patients must resort to selling their land to pay for mental health services.¹⁶⁸ The economic costs associated with mental disability also extend to family members.¹⁶⁹ Youn 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-

tive, not invested or anything, so repayment is very difficult and people have to just keep borrowing.¹⁷⁰

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.¹⁷¹ 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, "there is no progress because of depression."¹⁷²

b. Violence Against Women

The Cambodian Human Rights and Development Association estimates that twenty to twenty-five percent of Cambodian women experience domestic violence.¹⁷³ Women in Cambodia have limited effective means to put an end to such abuse or to hold perpe-

trators accountable.¹⁷⁴ Though the Cambodian legislature passed the Law on the Prevention of Domestic Violence and the Protection of Victims in 2005,¹⁷⁵ law enforcement officials tend to lack knowledge of the law or are uninterested in enforcing it.¹⁷⁶ 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.¹⁷⁷

Interviewees identified domestic violence as one of the principal factors driving women to seek out mental health services in Cambodia.¹⁷⁸ 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 to 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,¹⁹⁷ particularly within Southeast Asia.¹⁹⁸ 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 programs²⁰⁰ and laws,²⁰¹ 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, “[t]he 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 ones 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.”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, “[t]he fundamental problem is that people don’t recognize that mental health is an issue.”²¹⁸ Few of the international donors who contribute to Cambodia’s health budget have shown an interest in funding the mental health sector,²¹⁹ despite their international cooperation and assistance obligations under the ICESCR.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,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,”²²² approximately 0.02% of the total health budget. Dr. Sophal adds: “If you look at the WHO report, any country spending less than one percent is bad. Cambodia is even less than that, a new category.”²²³ While there are small additional budget allocations for mental health within Cambodia’s public health system,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.”²²⁵

2. CAMBODIA'S MENTAL HEALTH SYSTEM

The marginalization of mental health severely limits Cambodians’ ability to receive proper mental



“[m]ental 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

“About US\$150 million goes to health every year, and mental health receives about US\$30,000,”²²² approximately 0.02% of the total health budget...“If you look at the WHO report, any country spending less than [one] percent is bad. Cambodia is even less than that, a new category.”²²³

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.²²⁶ Formal mental health services were virtually nonexistent in Cambodia in the decade following the Khmer Rouge.²²⁷ Devoid of trained mental health professionals, Cambodians continued to rely upon Buddhist monks and traditional healers (*Kru Khmer*)²²⁸ for their mental health needs.²²⁹ During the 1990s, international and nongovernmental organizations reintroduced formal mental healthcare practices to Cambodia.²³⁰

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,²³¹ declares the Ministry’s “value-based commitment” to the “right to health for all Cambodians.”²³² It also lists as one of its top three strategic priorities the goal of reducing the burden of noncommunicable diseases, including poor mental health.²³³ The Ministry of Health contains two subdepartments that specifically focus on mental health issues—the National Program for Mental Health²³⁴ and the Bureau of Mental Health.²³⁵ In 2010, the Ministry of Health adopted the *Mental Health and Substance Misuse Strategic Plan 2008–2015*,²³⁶ although it has yet to accord it funds for implementation.²³⁷ Students can pursue specialized training in psychiatry at the University of Health Sciences,²³⁸ as well as in psychology or social work at the Royal University of Phnom Penh.²³⁹

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, refer-

ral hospitals, health centers, and health outposts, in line with WHO guidelines.²⁴⁰ 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 country²⁴¹—the lowest ratio of psychiatric beds per person in Southeast Asia.²⁴² Patients can typically only stay in these inpatient units for up to two weeks²⁴³ and must be accompanied by friends or family who are responsible for tending to them.²⁴⁴ 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.²⁴⁵ Cambodia has eighty-four referral hospitals,²⁴⁶ only about half of which offer some form of mental health services.²⁴⁷ Of the 967 health centers that are smaller than referral hospitals and located in more rural areas,²⁴⁸ less than twenty have staff with some mental health training.²⁴⁹ 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.²⁵⁰ Most rural patients seeking mental health services must travel long distances to receive treatment, which typically entails additional transportation costs.²⁵¹ 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.”²⁵² The lack of accessibility is further

compounded by the low awareness of mental health issues, particularly in rural areas.²⁵³ 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.”²⁵⁴

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



As of 2010, Cambodia had approximately thirty-five trained psychiatrists and forty-five trained psychiatric nurses for a population of close to fifteen million. As a result of their limited numbers and the need for their services, Cambodian mental health professionals like Dr. Eng pictured here, are overwhelmed by patients.
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million.²⁵⁵ While 297 primary care physicians and 270 primary care nurses have also taken basic courses in mental health care,²⁵⁶ it is estimated that only a small percentage of them actually provide “some degree” of mental health care.²⁵⁷ The public mental health system does not allocate any positions for psychologists or social workers,²⁵⁸ which largely reflects its strong biomedical approach to mental health.²⁵⁹ 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.²⁶⁰ 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 “[p]sychiatrists are not well-considered in society” and are called “mad doctor[s]” by their colleagues.²⁶¹ 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.²⁶² 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.²⁶³

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 “[m]aybe [thirty] to [forty] patients per doctor per day.”²⁶⁴ She lamented that the rapid succession of patients left doctors with little time to provide them with adequate care.²⁶⁵ 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.”²⁶⁶

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



Interviewees regretted the Cambodian mental health system's overreliance on medication as the sole method of addressing the needs of patients. Above, a relative speaks with a mental health patient at the Khmer-Soviet Friendship Hospital in Phnom Penh. © 2011 Arantxa Cedillo

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."²⁶⁷ "[T]he resources don't meet the need," confirmed another mental health professional in Battambang Province.²⁶⁸ 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."²⁶⁹

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 ser-

vices 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, "In ninety-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."²⁷⁰

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."²⁷¹ 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, "[w]hen 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, "[t]he 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



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 "[s]ome *Kru Khmer* are okay, others are painful and torture the clients[,] 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 train-

ing, 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



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

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.²⁹⁷ 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."²⁹⁸

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.²⁹⁹ 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.



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. A woman was locked in this bamboo cage for over two years by her relatives who felt they had no other options for her care.
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1. CHAINING AND CAGING BY FAMILY MEMBERS

Family typically offers the first line of mental health care and support in Cambodia.³⁰⁰ Devoid of public assistance, and hampered by a low awareness of mental health issues,³⁰¹ family members quickly become overwhelmed by their caretaking responsibilities, particularly where the mental disabilities are severe.³⁰² As stated by one mental health professional: "On paper there are also community-based services, but the government doesn't provide the resources for communities to take care of mental health issues, and so it becomes community abandonment on the part of the government. People are overwhelmed."³⁰³ As a result, interviewees reported that many family members resort to chaining or caging their relatives

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 "[p]eople 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 "[w]e 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, "[m]ental

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, "[f]or 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 "[i]t 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, "[i]f 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:

III Inlever 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.³³¹

Leam Pheng, the mother of another autistic child added that "[o]nly NGOs give people this kind of education. The government doesn't care."³³²

Notably, advocates for persons with mental disabilities in Cambodia have demonstrated the effectiveness of public education. Seang Charnap runs House of Smiles, a program that seeks to integrate children with mental disabilities into the community.³³³ 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.³³⁴

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:

[T]he 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.³³⁵

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.³³⁶ Nondetention pretrial options, such as bail, are rare and alternative sentencing schemes for convicts, even those with severe mental disabilities, are essentially absent.³³⁷ Further, while the 2009 Cambodian Criminal Code contains provisions barring criminal responsibility for mentally disabled defendants who acted with a suppressed discernment,³³⁸ nongovernmental organizations report that the psychological state of a defendant "rarely affects the outcome of criminal proceedings" in Cambodia.³³⁹ As a result, persons with mental disabilities who become entangled in the criminal justice system are routinely placed in the nation's prisons.³⁴⁰

Prison mental health services are virtually nonexistent.³⁴¹ 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,³⁴² in contravention of the UN Standard Minimum Rules for the Treatment of Prisoners.³⁴³ 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.³⁴⁴ 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, "In neglect and lack of treatment for prisoners with psychological problems [are] common."³⁴⁵

Furthermore, the poor detention conditions within the prisons place increased strain on the mental health of all inmates.³⁴⁶ Inmates must confront physical violence—both guard on inmate,³⁴⁷ and inmate on inmate³⁴⁸—poor living conditions,³⁴⁹ and staff corruption,³⁵⁰ among other hardships.³⁵¹ 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,"³⁵² are a threat to the "psychological integrity and health of detainees."³⁵³ Interviewees, including inmates who spoke to the delegation, confirmed that detainees' mental health could significantly deteriorate under these prison conditions.³⁵⁴

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.³⁵⁵ 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.³⁵⁶ 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.³⁵⁷ 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,³⁵⁸ the distinction between which is often blurred.³⁵⁹ Notably, in March 2012, UN agencies issued a joint statement calling for the general closure of these types of centers.³⁶⁰

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."³⁶¹ Persons with mental disabilities are especially vulnerable to these forms of extrajudicial detention. A Human Rights Watch representative reported that "[f]rustrated family members pay for the police to lock mentally ill family members up,"³⁶² and that "the mentally ill are [also] detained because they are often homeless and because it is easy to put them



Deprived of community-based services and mental health education, interviewees reported feeling overwhelmed by having to care for their relatives with mental disabilities. Above, the beam and chain used by this mentally disabled man's wife to chain him outside their home. © 2011 Arantxa Cedillo

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

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, “[t]he 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.³⁷⁷ 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.³⁷⁸ 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").³⁷⁹ The 2009 Disability Law abrogated older laws that explicitly discriminated against persons with disabilities,³⁸⁰ including mental disabilities,³⁸¹ 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.³⁸² Indeed, the law's passage marks a significant step forward for disabled rights in Cambodia.³⁸³ 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 sup-

port."³⁸⁴ It also contains explicit provisions recognizing the rights of persons with disabilities in a wide-variety of sectors, including health,³⁸⁵ education,³⁸⁶ employment,³⁸⁷ and the political process.³⁸⁸ 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 disabilities³⁸⁹ 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.³⁹⁰ 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.³⁹¹ As of May 2011, interviewees reported that less than half of the implementing *prakas* had been issued by the relevant ministerial bodies.³⁹² 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.³⁹³ This lack of dissemination is emblematic of a broader dearth of public information on disability rights and mental health issues,³⁹⁴ 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

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

given her mental state.⁴¹⁶ 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.”⁴¹⁷ 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.”⁴¹⁸ 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.⁴¹⁹

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.⁴²⁰ 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 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.

Conclusion and Report Recommendations

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."⁴²¹

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.⁴²² 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."⁴²³

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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1. See WORLD HEALTH ORG., *THE WORLD HEALTH REPORT 2001: MENTAL HEALTH; NEW UNDERSTANDING, NEW HOPE* 23 (2001).
 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).
 3. The global burden of disease is an analysis used by the World Health Organization (“WHO”) to provide “a comprehensive and comparable assessment of mortality and loss of health due to diseases, injuries and risk factors for all regions of the world.” *Global Burden of Disease (GBD)*, WORLD HEALTH ORG., http://www.who.int/healthinfo/global_burden_disease/en/ (last visited Apr. 21, 2012).
 4. WORLD HEALTH ORGANIZATION EUROPE, *WHAT ARE THE ARGUMENTS FOR COMMUNITY-BASED MENTAL HEALTH CARE?* 5 (2003).
 5. WORLD HEALTH ORGANIZATION, *THE GLOBAL BURDEN OF DISEASE: 2004 UPDATE*, at 51 (2008).
 6. Special Rapporteur on the Right to Health, *Economic, Social and Cultural Rights: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, Comm’n on Human Rights, Econ. & Soc. Council, ¶ 90, U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003) (by Paul Hunt); see WORLD HEALTH ORGANIZATION, *MENTAL HEALTH AND DEVELOPMENT: TARGETING PEOPLE WITH MENTAL HEALTH CONDITIONS AS A VULNERABLE GROUP* 28–31 (2010) (“Poor mental health can be both a cause and a consequence of the experience of social, civil, political, economic, and environmental inequalities.”).
 7. WORLD HEALTH ORG., *MENTAL HEALTH, POVERTY AND DEVELOPMENT* 1 (2009).
 8. See Daryn Reicherter & Alexandra Aylward, *The Impact of War and Genocide on Psychiatry and Social Psychology*, in *CAMBODIA’S HIDDEN SCARS: TRAUMA PSYCHOLOGY IN THE WAKE OF THE KHMER ROUGE* 14 (Autumn Talbott et al. eds., 2011) (hereinafter *CAMBODIA’S HIDDEN SCARS*).
 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).
 12. See Part I.B.2 (documenting the adverse impacts of poverty, violence against women, and the broader human rights context on mental health in Cambodia).
 13. See Part II.A.1 (documenting the extent to which mental health is a critical yet marginalized issue in Cambodia).
 14. Interview with Chhit Sopha, M.D., Deputy Nat’l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011); see Section II.A.1 (documenting the lack of financial resources accorded to the mental health sector in Cambodia).
 15. See Part II.A.2 (documenting the infrastructure, human resources, and quality of service of the Cambodian mental health system).
 16. See Part II.B (documenting the increased vulnerability to human rights abuses of persons with mental disabilities).
 17. See Part II.B.1 (regarding chaining and caging of persons with mental disabilities by family members).
 18. See Part II.B.3.b (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/bkgd.shtml> (last visited Apr. 21, 2012).
 20. See J. Jaime Miranda & Vikram Patel, *Achieving the Millennium Development Goals: Does Mental Health Play a Role?*, 2 PLoS MED. 0962, 0962 (2005).
 21. *Id.* at 0962–63.
 22. *Id.* at 0963.
 23. *Id.* at 0962 (noting the links between mental health and the issues of access to education and HIV/AIDS).
 24. See Martin Prince et al., *No Health Without Mental Health*, 370 LANCET 859, 861–63 (2007).
 25. See *id.* at 863–64.
 26. See *id.* at 864–66.
 27. See *id.* at 864.
 28. See DAN CHISHOLM ET AL., WORLD HEALTH ORG., *DOLLARS, DALYs AND DECISIONS: ECONOMIC ASPECTS OF THE MENTAL HEALTH SYSTEM* 21 (2006).
 29. Lancet Global Mental Health Group, *Scale Up Services for Mental Disorders: A Call for Action*, 370 LANCET 1241, 1241 (2007).
 30. International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3 (hereinafter ICESCR). Cambodia acceded to the International Covenant on Economic, Social and Cultural Rights (“ICESCR”) on May 26, 1992. *Status of Treaties: International Covenant on Economic, Social and Cultural Rights*, U.N. TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-3&chapter=4&lang=en (last visited Apr. 21, 2012).
 31. ICESCR, *supra* note 30, art. 12.
 32. International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 (hereinafter ICCPR). Cambodia acceded to the International Covenant on Civil and Political Rights (“ICCPR”) on May 26, 1992. *Status of Treaties: International Covenant on Civil and Political Rights*, U.N. TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-4&chapter=4&lang=en (last visited Apr. 21, 2012).
 33. International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S. 195 (hereinafter ICERD). Cambodia ratified the International Convention on the Elimination of All Forms of Racial Discrimination (“ICERD”) on November 28, 1983. *Status of Treaties: International Convention on the Elimination of All Forms of Racial Discrimination*, U.N. TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-2&chapter=4&lang=en (last visited Apr. 21, 2012).
 34. Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13 (hereinafter CEDAW). Cambodia acceded to the Convention on the Elimination of All Forms of Discrimination Against Women (“CEDAW”) on October 15, 1992. *Status of Treaties: Convention on the Elimination of All Forms of Discrimination Against Women*, U.N. TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-8&chapter=4&lang=en (last visited Apr. 21, 2012).
 35. Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3 (hereinafter “CRC”). Cambodia acceded to the Convention on the Rights of the Child (“CRC”) on October 15, 1992. *Status of Treaties: Convention on the Rights of the Child*, U.N. TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-11&chapter=4&lang=en (last visited Apr. 21, 2012).
 36. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 85 (hereinafter

- "CAT". Cambodia acceded to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("CAT") on October 15, 1992. *Status of Treaties: Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtidsg_no=IV-9&chapter=4&lang=en (last visited Apr. 21, 2012).
37. See United Nations, Econ. & Soc. Council, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights), ¶ 33, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment No. 14] ("The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect, protect and fulfill*").
 38. See, e.g., ICCPR, *supra* note 32, art. 9.
 39. See, e.g., United Nations, Econ. & Soc. Council, General Comment 33: Persons with Disabilities, ¶ 5, U.N. Doc. E/1995/22 (Dec. 9, 1994); see ICCPR, *supra* note 32, art. 26.
 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.
 45. The Commission on Human Rights established the position of the Special Rapporteur on the Right to Health in April 2002. The Special Rapporteur is responsible for the global investigation of and reporting on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. See *Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. OFF. HIGH COMM'R HUM. RTS., <http://www.ohchr.org/EN/Issues/Health/Pages/SRRRightHealthIndex.aspx> (last visited Apr. 21, 2012).
 46. Special Rapporteur on the Right to Health, *Report on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, Comm'n on Human Rights, Econ. & Soc. Council, ¶ 18, U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005) (by Paul Hunt) [hereinafter Special Rapporteur 2005 Report]. Notably, the medical model "views disability as a feature of the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals . . . [to] 'correct' the problem with the individual." In contrast, the social model "sees disability as a socially-created problem and not at all an attribute of an individual," and views a disability as demanding "a political response, since the problem is created by an unaccommodating physical environment brought about by attitudes and other features of the social environment." World Health Org., *Towards a Common Language for Functioning, Disability and Health: ICF*, at 8–9, WHO/EIP/GPE/CAS/01.3 (2002); see Rosemary Kayess & Phillip French, *Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities*, 8 HUM. RTS. L. REV. 1, 5–7 (2008) (contrasting the medical and social models of disability).
 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).
 48. Arthur Kleinman, *The Art of Medicine: Global Mental Health: A Failure of Humanity*, 374 LANCET 603, 603 (2009).
 49. Mariana Chilton, *Developing a Measure of Dignity for Stress-Related Health Outcomes*, 9 HEALTH & HUM. RTS. 208, 225 (2006) (arguing for using a "dignity approach" to strengthen a health and human rights framework).
 50. See JUDITH ASHER, THE RIGHT TO HEALTH: A RESOURCE MANUAL FOR NGOs 3 (2004).
 51. The right to health was first included in the 1946 WHO Constitution, and soon thereafter also was included in the enumerated rights recognized in the Universal Declaration of Human Rights ("UDHR"). See Constitution of the World Health Organization pmbl., July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185; Universal Declaration of Human Rights, art. 25, G.A. Res. 217 (III) A, U.N. Doc A/RES/217(III) (Dec. 10, 1948) [hereinafter UDHR]. Some authors also have traced the principles on which the right to health, among other socioeconomic rights, is based to the revolutionary eras in North America and Europe. See, e.g., Stephen P. Marks, *Health from a Human Rights Perspective 3–7* (Harvard Univ. François-Xavier Bagnoud Ctr. for Health & Human Rights, Working Paper No. 14, 2003), available at http://www.harvardfbcenter.org/resources/working-papers/FXBC_WP14-Marks.pdf.
 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*, U.N. OFF. HIGH COMM'R 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. CRAVEN, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS: A PERSPECTIVE ON ITS DEVELOPMENT 91–92 (1995) (citing THEODOR MERON, HUMAN RIGHTS LAW-MAKING IN THE UNITED NATIONS 10 (1986)).
 55. See Special Rapporteur 2005 Report, *supra* note 46; see also WORLD HEALTH ORG. & U.N. OFF. HIGH COMM'R HUM. RTS., THE RIGHT TO HEALTH, FACT SHEET No. 31, at 9–10 (2006).
 56. ICESCR, *supra* note 30, art. 2.
 57. *Id.*
 58. See United Nations, Econ. & Soc. Council, General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant), ¶¶ 13–14, U.N. Doc. E/1991/23 (Dec. 14, 1990) [hereinafter General Comment No. 3].
 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 critiqued for not imposing stringent enough demands on state parties to the ICESCR. See, e.g., Louis B. Sohn, *The New International Law: Protection of the Rights of Individuals Rather than States*, 32 AM. U. L. REV. 1, 40 (1982). Sohn explains:
[The language of the ICESCR has] 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.” *Id.*
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 CESCR “takes the view” that discrimination is prohibited on the grounds of physical and mental health).
 63. Philip Alston & Gerard Quinn, *The Nature and Scope of States Parties’ Obligations Under the International Covenant on Economic, Social and Cultural Rights*, 9 HUMAN RIGHTS Q. 156, 166 (1987).
 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(f).
 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 *fulfil (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 *fulfil (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 *fulfil (promote)* the right to health requires States to undertake actions that create, maintain and restore the health of the population.”).
 76. See *id.* ¶¶ 11–12; see also Special Rapporteur on the Right to Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, Comm’n on Human Rights, Econ. & Soc. Council, ¶ 10, U.N. Doc. E/CN.4/2006/48 (Mar. 3, 2006) (by Paul Hunt) (hereinafter Special Rapporteur 2006 Report).
 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: an effective, 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 “Immodern scientific evidence indicates that mental and behavioural disorders are the result of *genetics 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 “[p]ersons 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).
 82. General Comment No. 3, *supra* note 58, ¶ 10.
 83. General Comment No. 14, *supra* note 37, ¶ 3.
 84. See Michael L. Perlin & Éva Szeli, *Mental Health Law and Human Rights: Evolution and Contemporary Challenges*, in MENTAL HEALTH AND HUMAN RIGHTS: VISION, PRAXIS, AND COURAGE (Michael Dudley et al. eds.) (forthcoming Apr. 2012), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1132428 (describing development of disability rights as a human rights issue); see also Alicia Ely Yamin & Eric Rosenthal, *Out of the Shadows: Using Human Rights Approaches to Secure Dignity and Well-Being for People with Mental Disabilities*, 2 PLoS MED. 0296, 0296–97 (2005).
 85. See, e.g., CAT, *supra* note 36; CRC, *supra* note 35; ICERD, *supra* note 33; see also, e.g., International Convention on the Protection of the Rights of All Migrant Workers and Their Families, Dec. 18, 1990, 2220 U.N.T.S. 93. Cambodia has signed but not ratified the International Convention on the Protection of the Rights of All Migrant Workers and Their Families. See *Status of Treaties: International Convention on the Protection of the Rights of All Migrant Workers and Their Families*, U.N. TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtidsg_no=IV-13&chapter=4&lang=en (last visited Apr. 21, 2012). In addition, in the early 1990s, the United Nations issued two nonbinding measures critical to the promotion of a rights-based approach to disability: the 1991 Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (“MI Principles”) and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (“Standard Rules”). See generally *The Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, G.A. Res. 46/119, U.N. Doc. A/RES/46/119 (Dec. 17, 1991) (hereinafter MI Principles); *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, G.A. Res. 48/96, U.N. Doc. A/RES/48/96 (Dec. 20, 1993). The MI Principles established minimum standards for practice in the mental health field. See MI Principles, *supra*. While the MI Principles have since been overshadowed by the Convention on the Rights of Persons with Disabilities (“CRPD”), they are important for the guidance they provided in the drafting of some mental health legislation. Nevertheless, the MI Principles have been criticized by disability rights advocates who claim that they set lower standards on some issues than other human rights laws and policies. See JANET E. LORD ET AL., HUMAN RIGHTS, YES! ACTION AND ADVOCACY ON THE RIGHTS OF PERSONS WITH DISABILITIES 14 (Nancy Flowers ed., 2007) (hereinafter HUMAN RIGHTS, YES!). The MI Principles also are considered to reflect a medical model of disability. See Kayess & French, *supra* note 46, at 15. As a result, disability rights advocates argue that the provisions of the MI Principles are now trumped by those of the CRPD, which are more rooted in a social model of disability. See U.N. OFF. HIGH COMM’R, HUMAN RIGHTS, FORGOTTEN EUROPEANS, FORGOTTEN RIGHTS: THE HUMAN RIGHTS OF PERSONS PLACED IN INSTITUTIONS 8 (2012).
 86. See Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3 (hereinafter CRPD).
 87. HUMAN RIGHTS, YES!, *supra* note 85, at 19; see CRPD, *supra* note 86, pmbl. (c) (“*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 . . .”).
 88. See Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MD. L. REV. 20, 21 (2004).
 89. See Kayess & French, *supra* note 46, at 7. For more information on the “social model,” see MICHAEL OLIVER & BOB SAPEY, SOCIAL WORK WITH DISABLED PEOPLE 29–39 (3d ed., 2006) (Oliver is credited with coining the phrase “social model”) and Raymond Lang, *The Development and Critique of the Social Model of Disability* (Leonard Cheshire Disability & Inclusive Dev. Ctr., Working Paper Series No. 3, 2007), available at http://www.ucl.ac.uk/lc-ccr/centrepublishations/workingpapers/WP03_Development_Critique.pdf.
 90. See, e.g., CRPD, *supra* note 81, art. 3 (including the following major principles: respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, independence of persons, non-discrimination, full and effective participation and inclusion in society, respect for difference and acceptance of persons with disabilities as part of human diversity and humanity, equality of opportunity, accessibility, equality between men and women, and respect for the evolving capaci-

- ties of children with disabilities and the right to preserve their identities).
91. Special Rapporteur 2005 Report, *supra* note 46, ¶ 9. Notably, nongovernmental organizations, such as Human Rights Watch and Disability Rights International, have played a leading role in documenting these abuses. See generally HUMAN RIGHTS WATCH, "ONCE YOU ENTER, YOU NEVER LEAVE": DEINSTITUTIONALIZATION OF PERSONS WITH INTELLECTUAL OR MENTAL DISABILITIES IN CROATIA (2010), available at http://www.hrw.org/sites/default/files/reports/croatia0910webwcover_0_0.pdf (documenting the plight of the more than 9000 persons with intellectual or mental disabilities living in institutions in Croatia and the lack of community-based programs for housing and support); MENTAL DISABILITY RIGHTS INT'L, BEHIND CLOSED DOORS: HUMAN RIGHTS ABUSES IN THE PSYCHIATRIC FACILITIES, ORPHANAGES, AND REHABILITATION CENTERS OF TURKEY (2005), available at <http://www.mdri.org/PDFs/reports/turkey%20final%209-26-05.pdf> (explaining abuses against and inadequate treatment for institutionalized people with physical and mental disabilities in Turkey); MENTAL DISABILITY RIGHTS INT'L, HIDDEN SUFFERING: ROMANIA'S SEGREGATION AND ABUSE OF INFANTS AND CHILDREN WITH DISABILITIES (2006), available at http://www.disabilityrightsintl.org/wordpress/wp-content/uploads/romania-May-9-final_with-photos.pdf (reporting on human rights abuses against children with disabilities in institutions in Romania); MENTAL DISABILITY RIGHTS INT'L & CTR. FOR LEGAL & SOC. STUDIES, RUINED LIVES: SEGREGATION FROM SOCIETY IN ARGENTINA'S PSYCHIATRIC ASYLUMS 6-36 (2007), available at http://www.disabilityrightsintl.org/wordpress/wp-content/uploads/MDRI.ARG_ENG_NEW-Argentina.pdf (describing inhumane conditions for individuals with mental disabilities in psychiatric institutions in Argentina).
 92. Special Rapporteur 2005 Report, *supra* note 46, ¶ 14.
 93. See, e.g., *id.* ¶¶ 83-86.
 94. *Id.* ¶ 43; *accord id.* ¶ 86 ("[T]he 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, prmb. (c) ("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 Khmer 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.").
 100. See Kingdom of Cambodia Constitutional Council Decision N° 092/003/2007 C.C.D (July 10, 2007). An unofficial translation from the Office of the High Commissioner for Human Rights ("OHCHR") is available at <http://cambodia.ohchr.org/WebDOCs/DocPublications/CCBHR%20Constitution/CCBHR-EN.pdf>.
 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, protec- tion 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 and 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.
 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 Khet Samity 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 Khet Samity 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 III.
 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 Penh, 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) ("[T]he Khmer Rouge rendered Cambodia a black hole that outsiders could not enter and some 2 million Cambodians would not survive.").
 111. W.A.C.M. Van de Put & Maurice Eisenbruch, *The Cambodian Experience*, in TRAUMA, WAR AND VIOLENCE: PUBLIC MENTAL HEALTH IN SOCIO-CULTURAL CONTEXT 93, 95 (Joop de Jong ed., 2002).
 112. See *id.* at 95-96.
 113. See *id.* at 96.
 114. See Dolores A. Donovan, *Cambodia: Building a Legal System from Scratch*, 27 INT'L L. 445, 445 (1993).
 115. See *id.*
 116. See Stewart et al., *supra* note 1, at 20
 117. See Alexis Stockwell et al., *Mental Health Policy Development: Case Study of Cambodia*, 13 AUSTRALASIAN PSYCHIATRY 190, 190 (2005); see also Daya J. Somasundaram et al., *Starting Mental Health Services in Cambodia*, 48 SOC. SCI. & MED. 1029, 1029 (1999).
 118. See Stockwell et al., *supra* note 117, at 190; see also Somasundaram, *supra* note 117.
 119. See Stewart et al., *supra* note 10, at 20.
 120. See Steven R. Ratner, *The Cambodia Settlement Agreements*, 87 AM. J. INT'L L. 1, 3 (1993).
 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 amassed 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 Goldring, Founder, Brahmavihara 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.”).
126. Prosecutor v. Kaing Guek Eav *alias* “Duch,” Case No. 001/18-07-2007/ECCC/TC, Judgment, ¶ 59 (Extraordinary Chambers in the Courts of Cambodia July 26, 2010).
127. See DAVID CHANDLER, A HISTORY OF CAMBODIA 233–35 (3d ed. 2000).
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/RKM/1004/006 (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/ECCC/SC, 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:
 [D]elayed 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.
 World Health Org., *ICD-10 Guide for Mental Retardation*, WHO/MNH/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:
 [T]he 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 other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the 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.
 AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 309.81 (Rev. 4th ed. 2000).
131. 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 Trials*, 302 JAMA 527, 527 (2009); see also Joop de Jong et al., *Common Mental Disorders in Postconflict Settings*, 361 LANCET 2128, 2129 (2003).
132. See WORLD HEALTH ORG., *supra* note 1, at 43.
133. A 1993 study found a fifteen percent rate of PTSD and fifty-five percent rate of depression among Cambodian refugees living in camps in Thailand. Richard F. Mollica et al., *The Effect of Trauma and Confinement on Functional Health and Mental Health Status of Cambodians Living in Thailand-Cambodia Border Camps*, 270 JAMA 581, 581 (1993). A 2005 study of Cambodian refugees living in the United States twenty years after resettlement found that everyone in the sample had experienced trauma. There was a sixty-two percent rate of PTSD and a fifty-one percent rate of major depression. Grant N. Marshall et al., *Mental Health of Cambodian Refugees 2 Decades After Resettlement in the United States*, 294 JAMA 571, 571 (2005).
134. See James K. Boehnlein & J. David Kinzie, *The Effect of the Khmer Rouge on the Mental Health of Cambodia and Cambodians*, in CAMBODIA’S HIDDEN SCARS, *supra* note 8, at 33, 34.
135. *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 Conroy, Maryknoll, in Phnom Penh, Cambodia (May 16, 2011).
136. 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.”).
137. Interview with Mental Health Professional 1, in Phnom Penh, Cambodia (May 24, 2011); see Interview with Ka Sunbaunat, M.D., Dir., Nat’l 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 (Jan. 14, 2012) (“The Khmer Rouge is also a significant cause of poor mental health. The Khmer Rouge has left significant trauma for families.”).
138. Prosecutor v. Kaing Guek Eav *alias* “Duch,” Case No. 001/18-07-2007/ECCC/TC, Transcript of Trial Proceedings, 10, 12–13 (Extraordinary Chambers in the Courts of Cambodia Aug. 25, 2009).
139. 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 HIDDEN SCARS, *supra* note 8, at 78, 78–79.
140. 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 (Dr. Chhim Sotheara describing the “severe traumatizing effect” of the Khmer Rouge era on the younger generation of Cambodians).
141. 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).
142. Interview with Chhit Sophal, M.D., Deputy, Nat’l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011).
143. Interview with Mental Health Professional 2, in Phnom Penh, Cambodia (May 17, 2011).
144. See, e.g., Interview with Tan Ouk, 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).
145. See WORLD BANK, REP. NO. 35213-KH, CAMBODIA: HALVING POVERTY BY 2015?; POVERTY ASSESSMENT 2006, at v (2006) (noting that despite recent progress, poverty remains “widespread and multidimensional” in Cambodia).
146. *Country and Lending Groups Data*, WORLD BANK, <http://data.worldbank.org/about/country-classifications/country-and-lending-groups> (last

- visited Apr. 21, 2012).
147. U.N. DEV. PROGRAMME, HUMAN DEVELOPMENT REPORT 2009: OVERCOMING BARRIERS; HUMAN MOBILITY AND DEVELOPMENT 177 (2009).
 148. See CTR. FOR ECON. & SOC. RIGHTS, INDIVIDUAL SUBMISSION TO THE OFFICE OF THE HIGH COMM'R FOR HUMAN RIGHTS ON THE OCCASION OF THE SIXTH SESSION OF THE UNIVERSAL PERIODIC REVIEW DECEMBER 2009: CAMBODIA ¶¶ 16–19 (2009).
 149. See Human Rights Council, Summary Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(C) of the Annex to Human Rights Council Resolution 5/1: Cambodia, ¶ 44, U.N. Doc. A/HRC/WG.6/6/KHM/3 (Sept. 9, 2009) (hereinafter OHCHR Summary).
 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 LS, 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 Jishnu Das et al., *Mental Health and Poverty in Developing Countries: Revisiting 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) (demonstrating 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).
 153. Interview with Varun Kumar, Med. Advisor, Angkor Hosp. for Children, in Siem Reap Province, Cambodia (May 16, 2011).
 154. Interview with Ka Sunbaunat, M.D., Dir., Nat'l Program for Mental Health, in Phnom Penh, Cambodia (Jan. 11, 2012) ("The main problem is poverty, developing the country is the first priority to addressing cause of mental health.").
 155. See, e.g., Interview with Sek 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 Chhit Sophal, M.D., Deputy, Nat'l 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 stresses 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).
 163. See WORLD HEALTH ORG., *DEPT OF MENTAL HEALTH & SUBSTANCE ABUSE, MENTAL HEALTH ATLAS 2005*, at 115 (2005).
 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 (US\$0.50) to receive public health services and an additional 5000 Riels (slightly more than US\$1) for a psychological consultation. See JAN OVESEN & ING-BRITT TRANKELL, *CAMBODIANS AND THEIR DOCTORS: A MEDICAL ANTHROPOLOGY OF COLONIAL AND POST-COLONIAL CAMBODIA* 233, 257 (2010); see also WORLD HEALTH ORG., *supra* note 163, 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 OVESEN & TRANKELL, *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 OVESEN & TRANKELL, *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 Manager, Psychiatrist, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).
 170. Interview with Youn Yorn, 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).
 172. Interview with Kevin Conroy, Maryknoll, in Phnom Penh, Cambodia (May 16, 2011).
 173. See OHCHR Summary, *supra* note 149 (citing the Joint Submission of Cambodian Human Rights and Development Association ("ADHOC") and the Asian Forum for Human Rights and Development); see also Rep. of the Joint Field Visit to Cambodia by Members of the Executive Boards of UNDP, UNFPA, UNICEF and WFP, Mar. 2–13, 2009, ¶ 24, DP-FPA/2009/CRP.1 (May 22, 2009), available at http://www.un.org/kh/index.php?option=com_jdownloads&Itemid=65&task=view.download&cid=34 (hereinafter Joint Field Visit).
 174. See CAMBODIAN HUM. RTS. & DEV. ASS'N ET AL., *JOINT CAMBODIAN NGO REPORT ON TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT IN THE KINGDOM OF CAMBODIA* ¶¶ 115–18 (2010).
 175. An unofficial English translation of the Law on the Prevention of Domestic Violence and the Protection of Victims can be found at http://www.wcwonline.org/pdf/lawcompilation/Cambodia_dv_victims2005.pdf.
 176. See CAMBODIAN COMM. OF WOMEN, *VIOLENCE AGAINST WOMEN: HOW CAMBODIAN LAWS DISCRIMINATE 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 Gülçür, *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 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 nonreturn 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).
 184. See generally Special Rapporteur on the Situation of Human Rights in Cambodia, *Report of the Special Rapporteur on the Situation of Human Rights in Cambodia*, Human Rights Council, U.N. Doc. A/HRC/18/46 (Aug. 2, 2011) (by Surya P. Subedi) (discussing land rights and freedom of expression in Cambodia).
 185. See *Universal Periodic Review Submission: Cambodia*, HUM. RTS. WATCH (Dec. 1, 2009), <http://www.hrw.org/en/news/2009/12/01/universal-periodic-review-submission-cambodia> (recommending that Cambodia "[c]lose drug treatment centers that are extra-judicially detaining alleged drug users").
 186. See United Nations, Human Rights Council, Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(B) of the Annex to Human Rights Council Resolution 5/1, Cambodia, ¶ 36, U.N. Doc. A/HRC/WG.6/6/KHM/2 (Sept. 18, 2009) ("The Committee Against Torture expressed concern over impunity for human rights violations committed by law enforcement and armed forced members and, particularly, the State's failure to investigate torture and punish the perpetrators . . .").
 187. See *id.* ¶ 34 ("CESCR, the Special Representative and [the 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. Gostin, *Mental Health as a Human Right*, in 3 SWISS 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).
 193. Interview with Youk Chhang, Dir. Documentation Ctr. Cambodia, in Phnom Penh, Cambodia (May 25, 2011); see also Margo Picken, *The Beleaguered Cambodians*, N.Y. REV. OF BOOKS, Jan. 13, 2011, <http://www.nybooks.com/articles/archives/2011/jan/13/beleaguered-cambodians/> (stating that Cambodia's leadership "uses Pol Pot's record as the yardstick to measure progress, thereby making failure impossible").
 194. See OHCHR Summary, *supra* note 149, ¶ 44.
 195. See *id.* ¶ 19; see also Joint Field Visit, *supra* note 173, at ¶ 24.
 196. Ronald C. Kessler & T. Bedirhan Üstün, *Introduction*, in THE WHO WORLD MENTAL HEALTH SURVEYS: GLOBAL PERSPECTIVES ON THE EPIDEMIOLOGY OF MENTAL DISORDERS 3, 3 (Ronald C. Kessler & T. Bedirhan Üstün eds., 2008).
 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 . . . [or in other words] the percentage of individuals who require care but do not receive treatment." Robert Kohn et al., *The Treatment Gap in Mental Health Care*, 82 BULL. WORLD HEALTH ORG. 858, 859 (2004).
 198. See DEF'T 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.
 204. See Interview with Chhit Sophal, M.D., Deputy, Nat'l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011); see Hannah Beech, *Hidden Away*, TIME WORLD, Nov. 10, 2003, <http://www.time.com/time/world/article/0,8599,2047610,00.html> (stating that seventy-five percent of adults who lived through Khmer Rouge suffer extreme stress or PTSD and forty percent of youth suffer from stress due to tattered social network); Aubrey Belford, *Mental Health Crisis Strains Cambodia*, VOA NEWS, Apr. 16, 2010, <http://www.voanews.com/khmer-english/news/Mental-Health-Crisis-Strains-Cambodia-91069979.html> (documenting the critical mental health situation in Cambodia).
 205. See *supra* Part I.B.1.b.
 206. See Interview with HS, in Kampong Thom Province, Cambodia (May 20, 2011); Interview with Mom Sovannara, 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 Chamnap, Manager, House of Smiles Program, Hagar Cambodia, in Phnom Penh, Cambodia (May 25, 2011).
 209. Interview with Youm Yorn, Clinical Supervisor, TPO-Cambodia, in Kampong Thom Province, Cambodia (May 18, 2011).
 210. See WORLD HEALTH ORG., *supra* note 5, at 51.
 211. Interview with Varun Kumar, Med. Advisor, Angkor Hosp. for Children, in Siem Reap Province, Cambodia (May 16, 2011).
 212. See Vikram Patel & Martin Prince, *Global Mental Health: A New Global Health Field Comes of Age*, 303 JAMA 1966, 1976 (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. *Id.*
213. General Comment No. 14, *supra* note 37, ¶ 43(f).
214. *See id.* ¶ 30.
215. Special Rapporteur 2005 Report, *supra* note 46, ¶ 33.
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 “[s]tate 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 86, at art. 31(1). Notably, the CRPD calls for the information collected to be disaggregated. *See id.* art. 31(2).
217. Interview with Mental Health Professional 7, in Battambang Province, Cambodia (May 18, 2011).
218. Interview with Graham Shaw, Technical Officer, WHO, in Phnom Penh, Cambodia (May 27, 2011).
219. *See* Interview with Chea Dany, M.D., Chief, Health Promotion Unit, in Battambang Province, Cambodia (May 19, 2011).
220. The CESCR 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 CESCR 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* DEP’T HEALTH & SUBSTANCE ABUSE, *supra* note 163, at 115 (noting that while “[t]here are budget allocations for mental health . . . [d]etails 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/CAMBODIA-What-ails-Cambodia-s-mental-health-system>. Even assuming that US\$300,000 of the mental health budget goes to mental health, this would represent just 0.2% of a US\$150,000,000 health budget.
225. Interview with Graham Shaw, Technical Officer, WHO, in Phnom Penh, Cambodia (May 27, 2011).
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, kuru khmer, 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* DEP’T MENTAL HEALTH & SUBSTANCE ABUSE, *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.*
231. MINISTRY OF HEALTH, KINGDOM OF CAMBODIA, HEALTH STRATEGIC PLAN 2008–2015, at 3 (2008), available at <http://apps.who.int/medicinedocs/en/mv/abstract/Js18360en/>.
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 (“NPMH”) 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 RITSUMEIKAN 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 NPMH). The NPMH “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.
237. *See* Interview with Graham Shaw, Technical Officer, WHO, in Phnom Penh, Cambodia (May 27, 2011); Interview with Chhit Sophal, M.D., Deputy, Nat’l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011).
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 bachelor 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, in 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).
240. *See* Interview with Kim Savoun, M.D., Chief, Bureau of Mental Health, Ministry of Health, in Phnom Penh, Cambodia (May 26, 2011); Stewart et al., *supra* note 114, at 35, 37–39.
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, tbl1.
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.
248. *See* DAVID COLLINS ET AL., USAID, COST AND FUNDING PROJECTIONS FOR THE MINIMUM PACKAGE OF ACTIVITIES FOR HEALTH CENTERS: MINISTRY OF HEALTH; ROYAL GOVERNMENT OF CAMBODIA 7 (2009).
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(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

- Hosp., in Siem Reap Province, Cambodia (May 18, 2011); Stewart et al., *supra* note 10, at 8–9, 20–21.
252. Stewart et al., *supra* note 10, at 35.
253. *Id.* at 24–26.
254. Joint Field Visit, *supra* note 173, at 18.
255. See Stewart et al., *supra* note 114, at 22; see also Maramis et al., *supra* note 242; JOINT NGO REPORT, *supra* note 169, at 19. The number of 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 in the African Region to 9.80 in the European Region. *Id.*
256. 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 Munny Sothara, M.D., Project Coordinator, Justice & Relief for Khmer Rouge Victims Project, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011).
261. Mom Kunthear & Christopher Shay, *Few Resources for the Mentally Ill*, PHNOM PENH POST, July 23, 2009, http://www.phnompenhpost.com/index.php?option=com_jcs&view=jcs&layout=form&Itemid=555.
262. Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 20, 2011).
263. See OVESEN & TRANKELL, *supra* note 166, at 251.
264. Interview with Chak Thida, M.D., Russian Hosp., in Phnom Penh, Cambodia (May 24, 2011).
265. *Id.*
266. *Cambodia's Long Look Backwards; Doctors Struggle to Heal a Troubled Country*, AGENCE FRANCE-PRESSE, Sept. 3, 2007, <http://afp.google.com/article/ALeqM5idAIOjK3ixMBq5JqFvuqDOZaRtc>.
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).
277. Interview with Patients, Prey Pros Health Ctr., in Kampong Thom Province, Cambodia (May 20, 2011).
278. See generally Bernard Pécoul et al., *Access to Essential Drugs in Poor Countries: A Lost Battle?*, 281 JAMA 361, 361–65 (1999).
279. Interview with Mom 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 SAVUON, KINGDOM OF CAMBODIA, SUMMARY COUNTRY REPORT ON COMMUNITY MENTAL HEALTH, CONCEPT OF MENTAL HEALTH 4 (2010), available at <http://mhtech.dnh.moph.go.th/blog/wp-content/uploads/2010/03/country-report-cambodia.pdf>. The Khmer word *chhcuot* refers to a person who is "crazy" because of "black magic, spirits[is], or ghost[is]." *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 bad 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); SAVUON, *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 & TRANKELL, *supra* note 166, at 234. It is believed that "as 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.* Coining, 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-*khyol'* (wind) properties, but a bottle top may also be substituted if a coin cannot be found. *Id.*
287. Stewart et al., *supra* note 10, at 19–20.
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 & TRANKELL, *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 & TRANKELL, *supra* note 166, at 265–66, 272.
294. OVESEN & TRANKELL, *supra* note 166, at 253–54.
295. See Interview with Kim Savoun, M.D., Chief, Bureau of Mental Health, Ministry of Health, in Phnom Penh, Cambodia (May 26, 2011).
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.
297. Interview with Graham Shaw, Technical Officer, WHO, in Phnom Penh, Cambodia (May 27, 2011).
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 Sek Sisokhom, 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 Chamnap, 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).
302. See Interview with Ang Sody, M.D., Clinical Supervisor, TPO-Cambodia, in Phnom Penh, Cambodia (May 23, 2011). See generally Interview with Leam Pheng & Kadum Y., parents of children with mental disabilities, Ctr. for Child & Adolescent Mental Health ("CCAMH"), in Takhmau-Kandal Province, Cambodia (May 24, 2011).
303. Interview with Mental Health Professional 11, in Phnom Penh, Cambodia (Jan. 14, 2012).
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 Sek Sisokhom, 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").
306. Interview with Patient, Staung Referral Hosp., in Kampong Thom Province, Cambodia (May 20, 2011).
307. Interview with Sokheng, in Phnom Penh, Cambodia (May 17, 2011).
308. See *id.*; see also Aubrey Belford, *Mental Health Crisis Strains Cambodia*, VOA NEWS, Apr. 16, 2010, <http://www.voanews.com/khmer-english/news/Mental-Health-Crisis-Strains-Cambodia-91069979.html>.
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 Chamnap, Manager, House of Smiles Program, Hagar Cambodia, in Phnom Penh, Cambodia (May 25, 2011).
314. Interview with Kim Savoun, M.D., Chief, Bureau of Mental Health, Ministry of Health, in Phnom Penh, Cambodia (May 26, 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 Sody, 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 Sek Maroum, parent of child with Down syndrome, CCAMH, in Takhmau-Kandal Province, Cambodia (May 24, 2011).
325. Interview with Kadum Y., parent of child with mental disabilities, CCAMH, in Takhmau-Kandal Province, Cambodia (May 24, 2011).
326. Interview with Leam Pheng, parent of child with mental disabilities, CCAMH, in Takhmau-Kandal Province, Cambodia (May 24, 2011).
327. JENNIFER CARTER, UNICEF CAMBODIA, PREPARING FOR THE JOURNEY: A COOPERATIVE APPROACH TO SERVICE PROVISION FOR CHILDREN WITH INTELLECTUAL DISABILITIES IN CAMBODIA 27 (2009), available at http://www.unicef.org/cambodia/Intellectual_Disabilities_Children_Report.pdf.
328. *Id.* at 58 ("[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 Takhmau-Kandal Province, Cambodia (May 24, 2011).
332. Interview with Leam Pheng, parent of child with mental disabilities, CCAMH, in Takhmau-Kandal Province, Cambodia (May 24, 2011).
333. See Interview with Seang Chamnap, Manager, House of Smiles Program, Hagar Cambodia, in Phnom Penh, Cambodia (May 25, 2011).
334. *Id.*
335. United Nations, Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights (CESCR), Consideration of Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: Concluding Observations of the Committee on Economic, Social and Cultural Rights; Cambodia, ¶ 33 U.N. Doc. E/C.12/KHM/CO/1 (June 12, 2009).
336. Joint Field Visit, *supra* note 173, at 23; see also LICADHO, BEYOND CAPACITY: CAMBODIA'S EXPLODING PRISON POPULATION & CORRECTIONAL CENTER 4, 10 (2010), available at <http://www.licadho-cambodia.org/reports.php?perm=142>.
337. LICADHO, CAMBODIAN LEAGUE FOR THE PROMOTION & DEFENSE OF HUMAN RIGHTS (LICADHO) SUBMISSION TO THE UNITED NATIONS UNIVERSAL PERIODIC REVIEW, CAMBODIA 2 (2009), available at <http://www.licadho-cambodia.org/reports/files/133LICADHOUprSubmissionCambodia.pdf>.
338. CAMBODIAN CRIMINAL CODE art. 31 (Cambodia 2009); see *infra* Part III (discussing Article 31 of the Cambodian Criminal Code).
339. Joint Field Report, *supra* note 169, at 29.
340. LICADHO, *supra* note 337.
341. See Interview with Kang Saren, Prison Chief, Battambang Provincial Prison, in Battambang Province, Cambodia (May 20, 2011).
342. Interview with Chhem Sabuth, Warden, Siem Reap Prison, in Siem Reap Province, Cambodia (May 20, 2011); see LICADHO, HUMAN RIGHTS AND CAMBODIA'S PRISONS: HEALTH IN PRISONS 2002 & 2003, at 13 (2004) available at <http://www.licadho-cambodia.org/reports.php?perm=64&pagenb=7&filter=-1>.
343. Standard Minimum Rules for the Treatment of Prisoners art. 22(1), E.S.C. Res. 663C (XXIV), U.N. Doc. E/3048 (July 1, 1957), amended by E.S.C. Res. 2076 (LXII), U.N. Doc. E/5988 (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.
346. See WORLD HEALTH ORG., MENTAL HEALTH PROMOTION IN PRISONS: REPORT ON A WHO MEETING 4 (1998).
347. See Joint Field Visit, *supra* note 173, at 24.
348. See *id.* at 25.
349. See *id.* at 25–26.
350. See LICADHO, HUMAN RIGHTS AND CAMBODIA'S PRISONS: PRISON CONDITIONS 2004, at 22–23 (2005), available at <http://www.licadho-cambodia.org/>

- reports/files/80LICADHOReportPrisonConditions2004.pdf.
351. See LICADHO, *supra* note 342, at 13.
 352. LICADHO, *supra* note 336, at 8.
 353. United Nations, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Comm. Against Torture, Consideration of Reports Submitted by States Parties Under Article 19 of the Convention: Concluding Observations of the Committee Against Torture, Cambodia, ¶ 19, U.N. Doc. CAT/C/KHM/CO/2 (Jan. 20, 2011).
 354. See Interview with Saim Sivutha, Prison Nurse, Battambang Provincial Prison, in Battambang, Cambodia (May 20, 2011); see also Interview with Inmates at Correctional Centre 2, in Prey Sar, Cambodia (May 24, 2011); Interview with Researcher, Human Rights Watch, in Phnom Penh, Cambodia (May 24, 2011).
 355. See Interview with Researcher, Human Rights Watch, in Phnom Penh, Cambodia (May 24, 2011).
 356. *Id.*
 357. See Joint Field Visit, *supra* note 173, at 28.
 358. See *id.*
 359. See *id.* at 20; HUMAN RIGHTS WATCH, “SKIN ON THE CABLE”: THE ILLEGAL ARREST, ARBITRARY DETENTION AND TORTURE OF PEOPLE WHO USE DRUGS IN CAMBODIA 17 tbl. (2010).
 360. See Joint UN Statement Calls for Closure of Compulsory Drug Detention and Rehabilitation Centers, UNAIDS (Mar. 8, 2012), <http://www.unaids.org/en/resources/presscentre/featurestories/2012/march/20120308adentioncenters/> (calling for closure of these types of centers worldwide); see also HUMAN RIGHTS WATCH, *supra* note 359, at 8–11 (calling for the closure of drug detention and social rehabilitation centers in Cambodia).
 361. Interview with Researcher, Human Rights Watch, in Phnom Penh, Cambodia (May 24, 2011). The National Authority for Combating Drugs (“NACD”), which has issued statistics regarding the drug treatment centers, reports that sixty-one percent of drug treatment center detainees were arrested after their families requested and paid for police intervention, while thirty-seven percent of those in detention were arrested directly by the police. See HUMAN RIGHTS WATCH, *supra* note 359, at 15. In fact, according to the NACD, just one to two percent of admissions in 2010 resulted from people voluntarily admitting themselves. See *id.* at 15, n.13; see also WORLD HEALTH ORG., ASSESSMENT OF COMPULSORY 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.”).
 362. Interview with Researcher, Human Rights Watch, in Phnom Penh, Cambodia (May 24, 2011).
 363. *Id.*; 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”).
 364. See Interview with Mental Health Professional 4, in Battambang Province, Cambodia (May 20, 2011).
 365. See 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 Mental Health Professional 16, in Cambodia (Jan. 13, 2012) (stating that courts can send defendants with mental disabilities to drug treatment and social detention centers).
 366. See 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 Chhit Sophal, M.D., Deputy, Nat’l Program for Mental Health, in Phnom Penh, Cambodia (May 27, 2011); Interview with Kang Saren, Prison Chief, Battambang Provincial Prison, in Battambang Province, Cambodia (May 20, 2011).
 367. Interview with Siem Reap Provincial Judges, in Siem Reap Province, Cambodia (May 18, 2011).
 368. See HUMAN RIGHTS WATCH, *supra* note 359, at 80 (noting that, according to a former drug treatment center detainee: “There are crazy people detained there. They are not drug users. They don’t know what is wrong and right, they speak during the night, they eat on the ground Their families put them there. Some were arrested while they were wandering in the markets.”); see also Interview with Mental Health Professional 11, in Phnom Penh, Cambodia (Jan. 14, 2012).
 369. NICK THOMSON, DETENTION AS TREATMENT: DETENTION OF METHAMPHETAMINE USERS IN CAMBODIA, LAOS, AND THAILAND 5 (2010).
 370. LICADHO, UPR SUBMISSION, *supra* note 337, at 3; see Joint Field Visit, *supra* note 173, at 27.
 371. Interview with Mental Health Professional 12, in Phnom Penh, Cambodia (May 23, 2011).
 372. HUMAN RIGHTS WATCH, *supra* note 359, at 24, 79, 80.
 373. See *supra* Part I.B.
 374. See *supra* Part II.A.
 375. See *supra* Part II.B.
 376. Interview with Graham Shaw, Technical Officer, WHO, in Phnom Penh, Cambodia (May 27, 2011).
 377. While Cambodia has a patchwork of nonlegal policies that may be of relevance to persons with mental disabilities, an examination of these disparate ministerial documents is outside the scope of this Report. See, e.g., MINISTRY OF EDUC. YOUTH & SPORT, KINGDOM OF CAMBODIA, POLICY ON EDUCATION FOR CHILDREN WITH DISABILITIES (2008), available at <http://www.moeys.gov.kh/en/policies-and-strategies/73-policies/120-policy-on-education-for-children-with-disabilities.html>; MINISTRY OF HEALTH, KINGDOM OF CAMBODIA, OPERATIONAL GUIDELINES FOR IMPLEMENTING CLIENTS’ RIGHTS AND PROVIDERS’ RIGHTS-DUTIES (2007); MINISTRY OF SOCIAL AFF. VETERANS AND YOUTH REHABILITATION ET AL., KINGDOM OF CAMBODIA, NATIONAL PLAN OF ACTION ON FOR PERSONS WITH DISABILITIES, INCLUDING LANDMINE/ERW SURVIVORS 2008–2011 (2008), available at <http://www.apminebanconvention.org/fileadmin/pdf/mbc/MSP/9MSP/day4/9MSP-Item12d-27Nov2008-Cambodia-National-Plan.pdf>.
 378. See Interview with Ministry of Justice Official, in Cambodia (Jan. 15, 2012) (opining that Article 72 of the Cambodian Constitution is legally enforceable, although acknowledging that this remains true in theory, rather than in practice in Cambodia); see also *supra* Part I.A.2 (discussing Cambodia’s domestic legal obligations).
 379. LAW ON THE PROTECTION AND THE PROMOTION OF THE RIGHTS OF PERSONS WITH DISABILITIES art. 4 (2009) (Cambodia). Notably, Article 4 of the 2009 Disability Law defines “persons with disabilities” as “any persons who lack, lose, or damage any physical or mental functions, which result in a disturbance to their daily life . . . such as physical, visual, hearing, intellectual impairments, mental disorders and any other types of disabilities toward the insurmountable end of the scale.” *Id.* (emphasis added).
 380. *Id.* art. 60 (“All provisions contrary to this law shall be abrogated.”).
 381. Article 6 of the 1989 Marriage and Family Law, for example, prohibited “a person who has mental defect” from getting married. LAW ON THE MARRIAGE AND FAMILY art. 6 (1989) (Cambodia).
 382. See *National Assembly Discuss About the Disability Law*, CAMBODIAN DISABLED PEOPLE’S ORG. (May 29, 2009), http://www.cdpo.org/index.php?option=com_content&view=article&id=66&Itemid=60.
 383. The law’s purposes, outlined in Article 2, are to “protect the rights and freedoms of persons with disabilities; to protect the interests of persons with disabilities; to prevent, reduce and eliminate discrimination against persons with disabilities; to rehabilitate physically, mentally and vocationally in order to ensure that persons with disabilities are able to participate fully and equally in activities within society.” LAW ON THE PROTECTION AND THE PROMOTION OF THE RIGHTS OF PERSONS WITH DISABILITIES art. 2.
 384. *Id.* art. 12.
 385. *Id.* arts. 14–20.
 386. *Id.* arts. 27–32.
 387. *Id.* arts. 33–41.
 388. *Id.* arts. 44–45.
 389. See, e.g., *id.* art. 4 (defining “persons with disabilities” as “any persons who lack, lose, or damage any physical or mental functions, which result in a disturbance to their daily life . . . such as physical, visual, hearing, intellectual impairments, mental disorders and any other types of disabilities toward the insurmountable end of the scale”).

390. 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”).
391. 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).
392. See Interview with John Honney, Cambodian Trust, East-West Mgmt., in Phnom Penh, Cambodia (May 26, 2011).
393. 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 Imel of new laws.”).
394. See Interview with Human Rights Advocate, in Battambang, Cambodia (May 19, 2011).
395. See General Comment 14, *supra* note 33, at ¶ 37.
396. 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).
397. 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).
398. See, e.g., *id.* art. 16.
399. CRIMINAL PROCEDURE CODE (2007) (Cambodia).
400. CRIMINAL CODE (2009) (Cambodia).
401. CRIMINAL CODE, ch. 2, art. 31 (stating “[w]hen a person commits an offence right at the time where he/she suffered from [a] mental disorder [sic] dues as a result of using alcohols, addicted drugs or substances prohibited by laws[,] cannot be exempted from criminal responsibility”). Article 31 also states: “When a person commits an offence right at the time where he/she suffered from [a] mental disorder [sic] dues as a result of using alcohols, addicted drugs or substances prohibited by laws cannot be exempted from criminal responsibility.” *Id.*
402. Joint Field Visit, *supra* note 173, at 29.
403. See CAMBODIAN CTR. FOR HUMAN RIGHTS, FAIR TRIAL RIGHTS IN CAMBODIA 16 (2010), available at http://www.cchrcambodia.org/index_old.php?url=media/media.php&p=report_detail.php&reid=71&id=5.
404. Joint Field Visit, *supra* note 173, at 29.
405. See Stewart et al., *supra* note 10, at 22.
406. CRIMINAL PROCEDURE CODE art. 163 (2007) (Cambodia).
407. See Interview with Ministry of Justice Official, in Phnom Penh, Cambodia (Jan. 15, 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 had not allowed 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.
408. CRIMINAL PROCEDURE CODE art. 171 (stating in relevant part that “[c]osts of forensic examination shall be the burden of the applicant”).
409. 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).
410. 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, Att’y, Dir. of Lawyer Training Ctr., in Phnom Penh, Cambodia (Jan. 13, 2012).
411. 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).
412. Interview with Mental Health Professional 14, in Phnom Penh, Cambodia (May 27, 2011).
413. See Interview with Irmgard Schmitt, in Phnom Penh, Cambodia (May 24, 2011).
414. 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).
415. See Decision on Immediate Appeal Against the Trial Chamber’s Order to Release the Accused Ieng Thirith, Case No. 002/19-09-2007-ECCC-TC/SC(09), ¶¶ 4–6 (Extraordinary Chambers in the Courts of Cambodia 2011), available at [http://www.eccc.gov.kh/sites/default/files/documents/court/002/19-09-2007-ECCC-TC/SC\(09\)_1_7_EN-1.PDF](http://www.eccc.gov.kh/sites/default/files/documents/court/002/19-09-2007-ECCC-TC/SC(09)_1_7_EN-1.PDF).
416. See *id.* (concluding that Ieng Thirith suffered from a dementing illness probably caused by Alzheimer’s disease).
417. *Id.* ¶ 29.
418. *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).
419. *Id.* ¶ 49.
420. 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., Att’y, 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 Cambodia (Jan. 11, 2012); Interview with Mental Health Professional 8, in Cambodia (Jan. 9, 2012); see also generally Part II.A.2 (describing the lack of mental health infrastructure and human resources in Cambodia).
421. Interview with Dr. Ka Sunbaunat, Dir., Nat’l Program for Mental Health, in Phnom Penh, Cambodia (Jan. 11, 2012).
422. See Joint UN Statement Calls for Closure of Compulsory Drug Detention and Rehabilitation Centers, *supra* note 360.
423. *Mental Health: Strengthening Our Response*, WORLD HEALTH ORG. (Sept. 2010), <http://www.who.int/mediacentre/factsheets/fs220/en/>.



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