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Prevention Strategies and Mental Health in Vietnam

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RESEARCH ARTICLES

Prevention strategies and mental health in Vietnam

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Abstract: This paper addresses the current state of mental health services in Vietnam and provides recommendations for improving the care of people with mental illness. Vietnam's mental health problems are as prevalent as anywhere else in the world. The country has recently begun an initiative to reform mental health care by improving community-based services for people with serious mental illness. However, mental illness has not been a part of public discourse in Vietnam. There is little recognition of prevalent common mental illnesses (such as depression, anxiety and alcohol abuse) and the care of people with serious mental illnesses relies on either overburdened families with few community resources, or on regional institutions that are not prepared to support recovery. A broad, population-based multi-pronged prevention and health promotion campaign is needed to increase awareness of the public about common mental disorders, address vulnerable populations who are at risk for having mental disorders, and prepare communities to better support people with serious mental illnesses.

Keywords: Mental health; prevention; Vietnam; social work.

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1. The Need for Prevention in Mental Health

In the field of public health, the prevention of mental illness is a very important activity. The United Nations 2030 Agenda for Sustainable Development lists, under one of its seventeen objectives, "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" (General Assembly 2015).

Prevention in mental health is concerned with reducing the incidence, prevalence, duration, and recurrence of mental disorders (Mrazek et al. 1994). Prevention activities address specific risks to populations (i.e. certain age groups, or people who are at risk

for new or re-occurring mental disorders). Mental health promotion, while closely aligned with prevention and may result in prevention of mental disorders, is concerned with removing the general societal and structural barriers to wellness, such as poverty, stigma, discrimination, and inequalities of access to services. Promotion activities often involve community education and community development. When considered at a societal level to address national public health problems, a variety of concurrent prevention and promotion approaches are often necessary at various levels of society, especially in places like Vietnam where the concepts of mental health and mental illness are not part of public discourse. Mental illness is still a "hidden" experience that is shrouded by a lack of

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understanding and social stigma (Van Der Ham et al 2011).

Being “hidden,” however, does not mean that mental illness is not an important public health concern. People with a mental illness experience subjective distress, impairment in psychological and social functioning, and other dysfunctional behaviors or thought processes that are at odds with the shared environment (Sands et al. 2012). Mental illnesses are as prevalent in Vietnam as anywhere else in the world. Results from a 2003 survey by the Ministry of Health indicated that as many as 15% of Vietnam’s population have experienced symptoms of a mental disorder (Vuong, D.A et al. 2011); this proportion may be even higher as suggested by more recent studies (Richardson et al. 2010). This is in line with global prevalence estimates for similar low/low middle income countries (Kessler et al. 2014). As in other countries, the most prevalent “common” disorders (from the 2003 survey) are alcohol abuse (5.3%), depression (2.8%) and anxiety disorders (2.6%). These illnesses take up a large share of the burden of disease, as measured in years of life lost due to premature death and years lived with disability. In Vietnam, mental disorders contribute over 16% to the overall burden of disease and are among the top disabling illnesses along with injuries, HIV/AIDS, cardiovascular disease, and chronic illnesses such as diabetes (World Health Organization 2011). In addition to these common disorders, the use of addictive drugs such as methamphetamines and opioids is increasing sharply, and the average age of drug use is decreasing over time (Nguyen, V.T et al. 2008).

There are no large-scale global or Vietnamese epidemiological studies of mental illness for children and adolescents, however there are local studies in several countries. A recent literature survey summarized 280

studies in 27 countries (Polanczyk et al. 2015), and found that the prevalence of having any mental disorder in these countries averaged over 13%, the most prevalent disorders being depression, anxiety, disruptive behavior disorders, and attention deficit with hyperactivity disorder (ADHD). Some studies have found the global prevalence of ADHD to be over 7% (Thomas et al. 2015).

Certain populations are more at risk for having mental disorders. There may be regional differences in Vietnam about which populations are defined as high risk, however research has focused on specific at-risk sub-populations. Maternal post-partum depression is a problem in many areas of Vietnam and an important factor in the subsequent health of infants and children (Niemi et al. 2010). Lesbian, gay, transgender and bisexual (LGBTQ) youth and young adults are especially at high risk for depression and suicide, as summarized in Haas et al. (2010). Children whose parents have a mental illness are at heightened risk for acquiring a mental disorder (Rasic et al. 2014). Victims of child abuse and other childhood adversities (such exposure to domestic violence) are at increased risk for mental disorders from childhood into adulthood (Kessler et al. 2010). The high co-occurrence rates of mental disorders with substance abuse (O’Brien et al. 2004) as well as with chronic illness (Ryu et al. 2016) require practitioners to do cross-disciplinary screening when these clients present themselves in clinics. As the population of older adults increases, the incidence of depression and other mental disorders is also likely to increase in that age group (Park et al. 2013). There are certainly other at-risk populations for which experts recommend prevention activities. In preparation for implementing a national prevention campaign, there may need to be broad stakeholder involvement in determining

the priorities for these sub-populations. This process should also include an updated review of the evidence supporting specific prevention activities for the priority populations. (A description of the evidence for these specific interventions is beyond the scope of this article.)

The estimated global prevalence of schizophrenia ranges from .14% and .46% of the population (Jablensky 2000) and the prevalence rate of bipolar affective disorder, another very serious and persistent mental illness, is estimated at 2.4% (Merikangas et al. 2011). The low rates for schizophrenia belie the human costs in terms of disruptive and disabling symptoms, caregiver burden, and financial costs. Bipolar affective disorder is equally as disruptive to clients, families and communities. In some regions of Southeast Asia, people with serious mental illness are receiving poor care. A recent Human Rights Watch study uncovered a high number of people with serious mental illness in Indonesia who are shackled to their beds or locked in outdoor shacks, often in unsanitary and unhealthy conditions, since family caregivers and service agencies have few resources (such as mental health professionals and appropriate medications) with which to treat disruptive symptoms and promote recovery (Human Rights Watch 2016). In Vietnam, despite recent efforts to establish community-based care and import effective western treatments, there are still workforce shortages, unavailability of appropriate medications, and a continued reliance on hospitals and residential centers for the care of people with serious mental illness (Humphries et al. 2015; Ng, C.H et al. 2011)

Research has consistently shown that people with serious mental illness can recover (Slade et al. 2015), which means that they can fully participate in employment, they can care for themselves, and they can contribute

meaningfully to their families and communities, even if some symptoms continue or lie dormant “in remission.” This implies that recovery can most effectively be supported outside of institutions, within communities. However, past efforts in western countries to reduce the inappropriate use of institutions (such as hospitals, jails, and shelters) for people with serious mental illness have taught policy planners that community resources must be improved so that people can continue receiving the help they need to avoid more restrictive institutional care, and the burden on caregivers in families and agencies is minimized. It is not enough simply to release people from institutional care, without such supports in the community. Vietnam can benefit from the lessons learned in western countries about the necessary components of a recovery-oriented approach to caregiving.

2. The Legal Framework for Prevention of Mental Illness

A recent legislative decision by the Prime Minister, “Decision 1215,” provides the legal framework for improving the care of people with serious mental illnesses (Vietnam Office of the Prime Minister 2012). The Decision was designed to enable improvements in the care of individuals in institutions as well as encourage the expansion of community-based social assistance and rehabilitation services, which would require workforce development and training. Justification of the Decision was bolstered by resource gaps identified by the Ministry of Labor, Invalids and Social Affairs (RTCCD et al 2011). The specific objectives of this policy are to a) to improve rehabilitation care in Social Protection Agencies-regional welfare centers that house people of all ages who are not able to live with their families, such as orphaned children, people with severe

mental illness, and older adults with disabling dementia; b) provide consultancy services from trained mental health practitioners; c) increase awareness about mental illness in families; and d) develop more community-based alternatives for care in local districts or towns. The legislation also encourages scientific research into prevention which would involve partnerships between universities, government ministries, and international experts in prevention strategies. These are broadly stated objectives, requiring comprehensive solutions addressing the treatment of people with mental illness, enhancement of the workforce of psychologists, psychiatrists, and social workers, and increasing the awareness of families and communities about mental illness. Accomplishing these objectives will require coordination of the various ministries that oversee mental health care and workforce development (the Ministry of Health, Ministry of Labor, Invalids and Social Affairs, and the Ministry of Education, among others).

3. Prevention Strategies for Vietnam

Based on the most current epidemiological information available, what we know about risk factors affecting vulnerable populations in Vietnam, and what we know about how to support recovery from severe mental illness, the following objectives should be targeted by a broad, population-based national prevention campaign: a) increase public awareness and workforce training about common mental disorders such as depression, anxiety, alcohol/drug abuse, ADHD, and children's behavior disorders; b) target screening and treatment response for high-risk populations; and c) improve the conditions to support recovery of people with serious mental illness.

For low/middle income countries (LMICs), a major impediment to implementing comprehensive prevention activities is the

limited resources that are available. Another impediment is the general attitude that mental illnesses cannot be prevented, or that they cannot be cured. A drawback to implementing such interventions, such as public education, without at the same time enhancing the workforce and service infrastructure can result in reinforcing the attitude that treating mental illness is not feasible.

Petersen et al. (2016) summarize the research evidence for mental health prevention and promotion activities in countries at various income levels. The evidence supports population-based public education campaigns in many types of countries, however the research evidence for targeting high-risk populations is not as robust for low/middle income countries (LMICs) as it is for high-income countries. There are fewer health promotion evaluations in LMICs, and most LMICs have an under-developed mental health infrastructure. Recommendations for LMICs and similar regions should also include workforce development strategies so that efforts to change patterns of care (such as the implementation of early screening procedures) can be reinforced by a more viable network of practitioners. As for promoting recovery for those with severe mental illness, as discussed below the research evidence supporting such interventions (both at the individual and community levels) is growing.

A comprehensive national prevention campaign should meet the current needs of Vietnam while also be based on research evidence supporting the best practices of effective prevention of mental illness. Such a comprehensive campaign would include a combination of primary prevention activities—universal prevention targeting the entire population, indicated prevention targeting vulnerable populations, and selected prevention targeting those at especially high risk. Educating the public about mental illness

would increase awareness, which can then lead to more timely help seeking and screening, public acceptance of those who are suffering, and support for those in recovery. For those with serious mental illness, tertiary prevention activities (aimed at reducing reliance on institutional care and increasing community supports) would result in preventing relapse and improving the chances of being integrated into communities.

3.1. Addressing common mental disorders

Public awareness of the risks, symptoms, and treatment alternatives for alcohol and drug abuse, depression, anxiety, and children's disorders is a high priority considering their prevalence rates in Vietnam as well as the burden of disease associated with these disorders. As was true in many other countries, increased awareness about these problems is the first step towards encouraging early screening, seeking help, and reducing social stigma. This calls for a multi-faceted primary and secondary prevention campaign:

1. A public education campaign through the popular media and government announcements should be aimed at general education of the public about these disorders. An example of a successful national campaign in the U.S. is the "Depression, Awareness, Recognition and Treatment Program" (DART) which was funded and implemented by the U.S. National Institute of Mental Health (Regier et al. 1988). The DART program (implemented in 1991) involved universal, selected, and indicated prevention strategies: a national advertising and dissemination campaign to educate Americans about depression, implementation of depression screening in many healthcare settings, and technical assistance to states and local governments in increasing the capacity for treatment of depression in mental health clinics. In the decade after the campaign was initiated, the number of people screened and treated in outpatient clinics increased more than twofold as

a result of the campaign as well as the development of newer anti-depressant medications (Olfson et al. 2002).

2. Workforce development efforts should be aimed at training the staff of health clinics, schools, welfare agencies, and NGOs about how to screen for these disorders and the most effective psychosocial and biological interventions. There exist established validated screening instruments for use in various types of agencies, some of which have either been specifically developed for the Vietnamese population or have been translated into Vietnamese. In addition, non-mental health professionals can be trained to ask simple and direct questions to conduct basic screening. Protocols for referral and sharing of information to mental health professionals might also need development.

3. Considering the importance of these disorders, it is also recommended to adjust government policy to expand the list of available publicly-funded medications that have been found effective in treating these disorders. Psychoactive medications, in conjunction with psychosocial interventions, can be effective in preventing the exacerbation of symptoms in depression and anxiety (Cuijpers et al. 2012), as well as for people who have both mental illness and drug or alcohol abuse (the two problems often co-occur) (Kelly et al. 2012). Currently, the government allows public money to supply medications for only two mental disorders (Vietnam Ministry of Health 2010): schizophrenia, and epilepsy (the latter is not considered a mental disorder by western psychiatric standards, but instead categorized as a medical condition). Considering the cost of medications, effort may be needed to work with the private sector in making basic medications affordable and accessible in Vietnam. An analysis showing the economic benefits of making these medications more available, in terms of reducing the burden of disease (especially the cost offset related to the use of healthcare services and time away from employment), might help justify expanding the use of medications that have been

shown to be effective for depression, anxiety, substance abuse, and ADHD.

3.2. Targeting High-Risk Populations

Indicated prevention strategies should target specific populations for whom risk factors for mental illness are very high. A developmental lifespan approach would be helpful as a foundation to develop prevention activities to address these populations, which should include workforce training as well as dissemination of information to those at risk. This approach takes into account specific risk and protective factors associated with each developmental phase that may interact with specific social problems (Inge Petersen et al. 2014). Prevention activities can be targeted directly towards these developmental risks. For example, for LGBTQ youth, social stigma (as expressed by bullying and ridicule from peers, or by emotional reactions by family members) exacerbates the stress typically associated with adolescent sexual development. Since neural development continues throughout adolescence (i.e. the late completion of frontal lobe development), the developmental stage is characterized by heightened emotional arousal that can compromise rational thought. Added stress can result in impulsive behavior such as suicide attempts. Prevention activities would include heightening awareness of youth, their families, and their caregivers (such as teachers, doctors, and spiritual counselors) about the increased risk factors for depression and suicide for these youth, and how to identify the signs of potential self harm.

Practitioners and agency staff should understand the important role of trauma and childhood adversity as risk factors for vulnerable children and youth. Both the severity of the adverse event as well as cumulative adverse events are important components of assessment since they are so

predictive of emotional problems. Both the assessment and treatment phases should be “trauma-informed,” meaning that practitioners should ask specific trauma-related assessment questions, and that treatment be delivered in a way that promotes resiliency, is focused on establishing a safe environment, and helps build healthy attachments to adults (Conradi et al. 2010).

As another example, addressing postpartum depression would require increased awareness of the healthcare workforce to improve screening of the risk factors for potential depression, such as a family history of depression, previous depressive episodes for the expecting mother, a history of trauma, current environmental stressors, problematic family relationships, and other dimensions typically addressed in a biopsychosocial assessment (McDonald et al. 2012; Suzuki et al. 2011). Education to expecting parents about the risks and signs of depression would help sensitize them to the issue and enable more timely help seeking after the birth if concerns arose. Careful monitoring of the mother-child interaction after birth as well as the parents’ relationship would also be necessary (i.e. during well-baby checkups), since infant health is so dependent on the mother’s emotional responsiveness, which can be compromised by symptoms of depression.

3.3. Prevention and Recovery from Serious Mental Illness

Tertiary prevention activities are those that target serious and chronic illnesses. There are individual- and community-based prevention activities that can result in improved chances for recovery from serious mental illnesses. On an individual level, recovery is experienced as multi-dimensional—there are many aspects of a person’s life that are affected by serious mental illness, and which can be improved (Lieberman et al. 2005). In the U.S., experiencing recovery

has been defined along four main dimensions—health, home, purpose, and community (U.S. Substance Abuse and Mental Health Administration 2015). Recovery is often not experienced in all dimensions at the same time. For example, a person might succeed in obtaining housing stability, but still lack adequate social skills for a more meaningful social life in the community. Prevention activities for this population are aimed at improving recovery in certain individualized dimensions of a person's life so that relapse, or the return of disruptive symptoms and behaviors, is minimized.

The improvement of coping skills is another important therapeutic activity to help prevent relapse. This might include a cognitive behavioral problem solving approach to help the person identify triggers (such as certain stressful situations or interactions) that may cause a return of disruptive symptoms, and then develop strategies to help the person strengthen their coping skills. Another type of prevention would also be helping the person attain certain concrete objectives, such as having completed job interviews, or finding a suitable housing situation. These examples are therapeutic interventions that also have a prevention focus. Working with available family members is crucial so that family members understand the challenges of recovery and how they can best support it.

Community-based tertiary preventions include developing community supports so that people with serious mental illness are able to thrive while living in their communities. An example of this is the development of affordable housing solutions for people returning to the community or for those wanting an alternative to being a burden on their families. In the U.S., “supportive housing” for people with serious mental illness, a promising practice for homeless people with a high prevalence of mental illness, includes

supportive services such as case management to ensure that a person is able to take care of him/herself and take advantage of the natural resources in the community (Brown et al. 2016). Such housing solutions should avoid locations in dangerous neighborhoods (which are often used in some urban areas due to the high costs of housing) since people with mental illness tend to be easily victimized, and they should function as normally as possible (such as apartments with typical lease arrangements distributed among neighborhoods, as opposed to clustering people with mental illness together in sub-standard buildings) so that people can begin to experience normal life.

Other community-based development activities include

Development of support groups so that people with serious mental illness can interact with, and learn from, peers who may be further along in their recovery (Siantz et al. 2016).

Development of daytime activities in non-hospital settings for people who are able to live more independently but still need skills training, help with employment, structured social interactions, meaningful community activities, or therapeutic education about their illness and treatments. An example in the U.S. is “The Village” in Los Angeles, a community setting that provides drop-in individualized services and intensive case management that are recovery-oriented (MHA Village 2016).

Since stigma about mental illness is prevalent in Vietnam, health promotion strategies should include general education to the community about serious mental illnesses, the potential for recovery, and how families can best support people with serious mental illness without becoming overburdened. An “anti-stigma” education campaign, modeled after similar information campaigns about people with disabilities, would include first-person accounts from people about their

experience with mental illness (both patients and caregivers), the personal impact of being stigmatized as a result of mental illness, and what was helpful to them in their recovery. It would also include general scientific information (aimed at the non-scientific community) showing that mental illness involves both biological and environmental causes, and that there exist tested treatments that can result in recovery and which can be used in conjunction with traditional healing alternatives such as acupuncture, spiritual counseling, and meditation.

4. Conclusions

A national campaign aimed at public education about common mental disorders, workforce development strategies to target people at high risk, and efforts to prepare communities to better support recovery from serious mental illness, would result in more timely help seeking, the de-stigmatization of mental illness, and improved chances for people to recover. Anecdotally, from his experience teaching and speaking to the public, the author has noticed a great deal of curiosity and interest from Vietnamese people about both common and serious mental illnesses. People are ready to share their concerns and seek help. The country has an opportunity to “break open” this dialogue with well-planned prevention and health promotion activities.

It is likely that the broad prevention and promotion strategies outlined here will be relevant and appropriate for Vietnam, given the preliminary assessments of the resource gaps provided by MOLISA, and the author’s experience with people’s willingness to discuss these issues, despite the nature of stigma attached to having a mental illness. The nature of public discourse about mental illness is an important indicator of help seeking behavior

and the readiness of the environment to support recovery.

Detailed implementation strategies, which might include prioritizing which interventions to begin with, the specific ways that information can be disseminated, and the specific populations to target, are beyond the scope of these broad recommendations, and best identified in collaboration with local stakeholders such as ministry staff, provincial community leaders, NGO providers, and consumer and family input. There is little documentation of comprehensive population-based national mental health prevention strategies in countries like Vietnam. For this reason, as the country embarks on a national effort to reform its mental health services, there is great potential for other countries with similar issues to learn from Vietnam’s experience in improving the mental health of its population.

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