Chapter 10
Mental Health in Vietnam

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Abstract French colonization had a profound impact on the development of mental health services well into the twentieth century. The mental health system has been, and continues to be, dominated by institutional approaches to treatment of mental disorders. Mental hospitals operated by the national and provincial government health authorities have been the main locus of treatment and care. Social care for persons with severe and persistent mental disorders is limited, with national and provincial social affairs authorities providing minimal subsistence and little else in large social protection institutions. Over the past two decades, the Government of Vietnam has devoted increasing attention to the mental health of the population and has initiated major programs of reform of both the mental health system managed by the Ministry of Health (MoH) and the social protection system managed by the Ministry of Labor, Invalids and Social Affairs (MOLISA). While the mental hospitals and social protection centers continue to be essential and major elements of the two systems, there is a strong and sustained move in both sectors to community-based programs. It is also particularly important that there is continuing improvement in the extent and quality of collaboration between the two ministries. These developments are supported by appropriate national policy and development of the legal frameworks for modern mental health service provision and for community-based social support. This chapter outlines these developments and

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H. Minas and M. Lewis (eds.), *Mental Health in Asia and the Pacific*,
International and Cultural Psychology, DOI 10.1007/978-1-4899-7999-5_10

identifies some of the continuing challenges and opportunities for sustained mental health system improvement in Vietnam.

Development of the mental health system in Vietnam may be productively considered in the context of several clearly defined historical periods (Nguyen 1996).

The first period considered in this chapter is from 1887 to 1954, when Vietnam was under French colonial rule, except for a brief period of occupation by Japan—with the French colonial government allowed to remain in place—from September 1940 to 1945. With the end of World War II in the Pacific, Ho Chi Minh proclaimed independence and the formation of the Democratic Republic of Vietnam. The First Indochina War, the armed struggle to end French rule in Indochina, ended with the Geneva Accords in 1954. French Indochina was split into Cambodia, Laos and Vietnam; a temporary division of Vietnam into North and South at the 17th parallel was made; and a roadmap for national elections in July 1956 and reunification and self-government was agreed.

The second period, from 1954 to 1975, is the period of the Second Indochina war. This deadly and massively destructive conflict followed the repudiation of the Geneva Accords by the political leaders of South Vietnam and the USA and ended with the reunification of North and South and the creation of the Socialist Republic of Vietnam.

The third period is from 1975 through to the present day. The first 20 years of this period were marked by extreme poverty and the early process of national reconstruction, which was considerably hampered by the American trade embargo from 1975 to 1994, when the trade embargo was lifted and diplomatic relations between Vietnam and the USA were re-established. During this period, Vietnam has played an increasingly active role in world affairs, gaining membership of key international organizations, including the United Nations, the Association of South East Asian Nations (ASEAN), the Asia Pacific Economic Cooperation forums (APEC), the International Monetary Fund (IMF), the World Bank, the World Trade Organisation (WTO) and the International Labor Organisation (ILO). In addition, Vietnam has signed and ratified many UN Conventions and Treaties, such as the Convention on the Rights of the Child (CRC), the Convention on the Rights of Persons with Disabilities (CRPD) and, most recently, the Paris Agreement on Climate Change. Through the World Health Assembly, Vietnam has endorsed the WHO Mental Health Action Plan 2013–2020 and many other global health agreements. This third period has also seen the most active attention given to the development of a national mental health system.

Mental Health and Psychiatry in the Colonial Period

French Indochina was officially made a colony of France in 1887. It was made up of modern-day Laos and Cambodia, as well as the three territories that now comprise Vietnam. When the French first arrived in Indochina, they encountered a preexisting legal framework around mental illness that reflected both local forms of social organization and Vietnamese understandings of mental illness. Whereas Western biomedicine defines health as the absence of illness, in Vietnamese culture the particular influence of traditional Chinese medicine can be seen in a holistic notion of physical and mental health; emotional states are closely tied to physical disturbances and vice versa. Furthermore, understandings of psychiatric health and illness in Vietnam, especially in rural areas, are often linked to beliefs about the deep relationships between the living and the dead (Phan and Silove 1997). Traced to divine retribution for a prior sin, mental illness in Vietnam is attributed to the work of those gods, genies and divine creatures that populate Sino-Annamite mythology. Highly stigmatized in Vietnamese society, mental illness implies not only a condemnation of the individual but also an indictment of the honor of the family as a whole which is charged with the duty of caregiving. These responsibilities were formally recognized by Vietnamese law, also known as the Gia Long Code, introduced in 1810, which specified the judicial procedures by which families could gain legal guardianship of an individual judged to suffer from mental illness. The family was charged with exercising the appropriate oversight and would be held responsible for any crimes or disturbances resulting from poor surveillance (Reboul and Régis 1912).

In the late nineteenth century, the popular belief among colonial administrators in Indochina was that native populations did not suffer from violent forms of mental illness, and therefore, local disorders failed to meet the French legal definition of insanity. Instead, the colonial government relied on local forms of care in the community that predated French occupation. One could say that colonial policy around mental illness represented more of a social order response than a medical one with the hospital used to segregate and confine rather than to diagnose and treat. To avoid burdening, local budgets with the cost of minor and easily managed problems remained the paramount concern for colonial officials. Most mentally ill people therefore remained at home with only the most extreme cases sent to hospitals. It would take a combination of local and international pressures finally to persuade colonial officials of the need to seek a more permanent solution.

So what changed? First, the early twentieth century marked a broad expansion of Indochina's colonial administration, including its health service and hospital network (Monnais 1999). Much of this growth occurred in large urban centers at the expense of rural areas. By 1910, hospitals in Saigon reported treating upward of twenty psychiatric patients per year and were soon forced to convert cabins reserved for criminals to the care of the mentally ill. That patient numbers had begun to exert pressure on the limited hospital-based services in major cities suggested to some colonial officials that the previously "hidden" problem of mental

illness in villages was becoming a public, urban issue for the first time. They attributed the increasing visibility of mental illness among the thousands of vagrants who flooded into cities such as Saigon, Hai Phong and Hanoi to the effects of dislocation and social upheaval under French rule. The heightened visibility reflected the widespread social change and deepening poverty in the colony that formed the critical backdrop for the emergence of the mentally ill individual as a responsibility of the colonial government. At the same time, international calls for the development of a colonial psychiatric assistance program culminated in a 1912 meeting of French psychiatrists in Tunis. This seminal meeting emphasized the role of psychiatry in France's civilizing mission and the risk of falling even further behind other European powers whose own programs were thought to be "growing more and more refined every day." The meeting prompted Indochina's government to authorize the construction of an asylum in 1912, and the government dedicated funds to its construction in 1914 (National Archives Center 1 1928). Importantly, this coincided with the doubling of the colony's health budget. However, World War I delayed the realization of this project for another four and a half years. In 1919, French officials finally opened Indochina's first asylum, Bien Hoa, outside Saigon.

Eleven years later, in 1930, the French law of 1838 regulating asylum care was officially extended and adapted to Indochina. The law included provisions for a psychiatric assistance program that would grow to include a network of open-door, psychiatric services in major hospitals and the establishment of a second asylum in the north, outside Hanoi, in 1934. While Algeria has received much more scholarly attention, it was Indochina that in the 1930s earned the praise of international observers for having made the most 'serious efforts' at psychiatric assistance across the empire.

Asylums in Indochina received European and indigenous patients. However, the asylum population remained overwhelmingly Vietnamese and male throughout the interwar years. In British India, by way of contrast, psychiatric institutions were racially segregated. The Indochina case also forms an important contrast with French Algeria where hospitals served far higher proportions of Europeans than North Africans (Keller 2007).

As in France, there were two principal ways people could find their way into the asylum. Placement could either be requested by the administrative authorities or initiated by the patient's family, relatives or friends. Each required a medical certificate confirming an insanity diagnosis and issued only on a temporary basis. At the end of six months, confinement could become permanent depending on the medical progress of the patient. Patients were diagnosed with a wide range of disorders, from chronic forms of dementia and depression to acute forms of epilepsy and mania. In terms of treatment, patients received a variety of drugs including sedatives and calming agents such as opium, chloral and bromides and were exposed to shock therapy and less intensive forms of hydrotherapy (Institut de médecine tropical (PHARO) 1934). As for those administering the treatment, asylum directors were chosen from among those French civilian or military doctors in service in the colony who had either served as a former chief doctor at an asylum

or psychiatric clinic in the metropole or had completed a "*stage*" or internship in psychiatry in a French asylum (National Archives Center 1). They were assisted by a corps of indigenous medical doctors trained at the Hanoi Medical University (where psychiatry was introduced into the curriculum in 1934), as well as a large staff of indigenous nurses, wardens and auxiliary staff of chefs, gardeners and maintenance workers.

Asylums in Indochina were organized as large agricultural colonies, where patients would work the land to promote healing and eventual discharge. These agricultural colonies offered a model of rehabilitation that connected strategies of social reform through labor across the imperial world. For colonial psychiatrists, agricultural colonies promised not only "cerebral hygiene" and discipline through physical labor but also a kind of moral re-education. Even for those with no hope of a cure, psychiatrists believed that approximating the habits of ordinary life would serve a kind of harmonizing function. This model of care was inspired by the efforts of Dutch psychiatrists in neighboring Java where French psychiatrists undertook a series of study trips throughout the early twentieth century.

Even at the height of psychiatric activity in Indochina during the 1930s, French experts continued to rely on family resources to support temporary or permanent releases for those patients deemed "sufficiently improved." Confronted with the pressure to treat more acute cases, psychiatrists grew anxious to relieve the serious problem of asylum overcrowding by getting rid of those patients who no longer seemed to benefit from confinement. Once the family agreed to assume responsibility for their care, the patient would be repatriated to their home village where they were put under a "medical surveillance" of either weekly or monthly visits by the local doctor who administered medicine, kept track of the patient's progress and eventually recommended a permanent release or reintegration back into the asylum. This period, referred to as a "test leave," was envisioned not as a break with asylum but rather an extension of it. While French psychiatrists relied on Vietnamese families, they also continued to compete with the services of indigenous healers well into the 1930s even as the colonial state worked to increasingly restrict the practice of traditional medicine and promote widespread and exclusive recourse to Western medical care (Monnais and Tousignant 2006).

With the Japanese occupation of Indochina in 1945, much of the activity of psychiatric hospitals ceased.

The period, 1949–1953, is marked by efforts at reorganization and rehabilitation with the assistance of American aid. At the conclusion of the First Indochina War in 1954, the French-trained psychiatrist, Nguyen Van Hoai was named the first Vietnamese director of the "Psychiatric Hospital of South Vietnam." The slow transition to clinical psychiatry began in the 1950s, and in particular the transition from hospitals as custodial wards to treatment centers. The advent of psychiatry as a medical specialty in Vietnam during this period is often associated with the emergence of socialist ideals which viewed mental illness as a national burden preventing individuals from fully contributing to the economic productivity of the country (Nguyen 2003).

Psychiatry in Vietnam After 1954

The period from 1954 to 1975 was marked by the Second Indochina War, concluding with the reunification of Vietnam. Despite continuing armed conflict and its impact on every aspect of social and economic life, there was substantial progress in mental health care in both the northern and southern regions of Vietnam. An example of that progress was the creation of psychiatric institutions, such as the Department of Neurology and Psychiatry of Hanoi Medical University, established in 1957 (Nguyen 1996), the Association for Neurology, Psychiatry, and Neurosurgery, established in 1962, and the National Psychiatric Hospital (now National Psychiatric Hospital No. 1), established in 1963 (National Psychiatric Hospital No. 1 2013). The government of the Democratic Republic of Vietnam also began building provincial psychiatric hospitals, for example the Hai Phong Psychiatric Hospital, established in 1960. These organizations enabled a more systematic approach to the provision of treatment services and training.

The Department of Psychiatry established in 1969 at Bach Mai Hospital became the National Institute of Mental Health in 1991. Efforts to develop a community mental health network were also initiated during this period. National Psychiatric Hospital No 1 piloted the network in Hanoi and the former Ha Tay province and subsequently expanded to other provinces.

Development After 1975

The unification of Vietnam in 1975 opened a new chapter for the whole country and facilitated the development of psychiatry. In addition to the continuing establishment of psychiatric institutions, development of the mental health sector included the consolidation and expansion of mental health services at the community level.

While the process of reform, or *Doi Moi,* initiated in 1986, created many problems for the health system, including the virtual collapse of the primary health care network and an initial decline in human development indicators (Read et al. 2000), the development of a market rather than a centralized economic system and the re-establishment of diplomatic relations with the USA and other countries opened up the possibilities for new forms of international exchange and cooperation. Multilateral and bilateral development support programs have included attention to mental health, accelerating the development of mental health services and mental health research in the country.

In 1998, the Ministry of Health (MoH) included mental health as one of the National Health Target Programs. The program focused on schizophrenia and epilepsy as priority disorders for attention at primary care level. The goal was to establish community-based mental health care for persons—schizophrenia or epilepsy at every commune health station (primary health center) across the country (Government of Vietnam 1998). The program has been implemented in more than

70% of communes (National Psychiatric Hospital No. 1 2015) and has laid the groundwork for a more comprehensive community-based mental health system. While a number of pilot projects have been developed to extend these services to people with depression and anxiety, the program has continued to be limited to a focus on services for schizophrenia and epilepsy. Nevertheless, implementation of these services has included community education about mental health and illness and about mental health services, training of community-based mental health workers and consolidation and expansion of mental health care facilities, resulting in some reduction of stigma and discrimination against people with mental disorders. The initiative has created a network of primary health care centers with some mental health expertise that can be further developed into a comprehensive community-based mental health service (National Psychiatric Hospital No. 1 2015).

Contemporary mental health services are managed by the MoH and the Ministry of Labor, Invalids and Social Affairs (MOLISA). MoH and Provincial Health Departments manage a network of national psychiatric hospitals, a National Institute of Mental Health, provincial psychiatric hospitals, psychiatric wards and outpatient clinics in general hospitals, and mental health services in primary care clinics. MOLISA manages a network of Social Protection Centers that provide residential care, rehabilitation and social support services for people with chronic mental disorders who do not have family or other social supports.

Mental Illness in Vietnam Today

While information on the prevalence of mental disorders is limited (Vuong et al. 2011), the contribution of mental disorders to the burden of disease is significant. An epidemiological survey conducted in 2000 showed that the ten most common mental disorders collectively affected 14.9% of the population, approximately 12 million people (National Psychiatric Hospital No 1 2002). Among them, the most prevalent disorders were alcohol abuse (5.3%), depression (2.8%) and anxiety (2.6%).

For depression, the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (GBD 2010) estimated that the point-prevalence of major depressive disorder was 4.0%. If its prevalence is applied to Vietnam, where good population prevalence data do not exist, it would translate to 3.6 million people in Vietnam who might benefit from mental health support for major depressive disorder alone. Depressive disorders account for close to 41.9% of the disability from neuropsychiatric disorders among women and 29.3% among men. Common perinatal mental disorders affect 15.9% of women during pregnancy and 19.9% postpartum in developing countries (Fisher et al. 2012) with adverse consequences for the infant's physical health, such as greater risk of low birth weight (Patel et al. 2004), mother–infant relationship, and for the child's psychological development. In Vietnam, 33% of women attending general health clinics in Ho Chi Minh City were found to have postpartum depressive symptoms and 19% explicitly acknowledged suicidal

intentions (Fisher et al. 2004). In northern Vietnam, 29% of pregnant women and mothers of infants in 10 communes were diagnosed with common perinatal mental disorder (Fisher et al. 2010). The prevalence was found to be more than twice as high in rural than in urban areas and among women exposed to intimate partner violence as compared with women who had not experienced such violence.

Evidence is also increasingly available concerning the mental health of children and youth. In 2003, the MoH and UNICEF jointly conducted a national community-based survey of 5584 young people aged 14–25 years and found that 32% of youth felt bored with their lives, 25% reported feeling so sad or helpless that they stopped doing their usual activities, 21% reported feeling hopeless about their future, 0.5% reported having attempted suicide, and 2.8% reported having self-harmed. Among 18- to 21-year-old females, almost 8% had considered committing suicide (General Statistics Office 2005). Five years later, another survey was conducted to examine changes over time and trends. This study found that 27.6% of study participants reported feeling sad or helpless to the extent that it affected their usual activities, 21.3% reported feeling hopeless about their future, and 4.1% reported having had thoughts of suicide (General Statistics Office 2005, 2011; Nguyen 2012).

Among children aged 6–16 years, a nationally representative epidemiological study was conducted to determine the prevalence of childhood mental disorders and risk factors. The prevalence of mental disorder in this age group was found to be comparable to that in other countries (Weiss et al. 2014).

While epidemiological evidence on child and adolescent mental disorders is increasing, there is limited evidence for the older population (Teerawichitchainan and Giang 2013). In a rapidly aging society, evidence to inform strategies to prepare for and meet the increasing demands on the health and mental health care system will be critical.

Nevertheless, based on available evidence from Vietnam and imputations from international data, the latest estimates on the magnitude and impact of mental, neurological and substance use (MNS) disorders for Vietnam show that MNS disorders accounted for 8.2% of the disability-adjusted life years and 18.1% of years lived with disability in 2013 (Table 10.1) (Institute for Health Metrics and Evaluation 2013; Murray et al. 2013a, b; Whiteford et al. 2013). The significant burden of MNS disorders on the country's health and well-being, and on the national economy, demonstrates the urgent need for government investment for an effective mental health policy and practice that is informed by up-to-date evidence from epidemiological, health services and policy research.

Table 10.1 Proportion of total DALYs and YLDs attributed to mental, neurological and substance use disorders (2013 estimates)

	DALYs (%)	YLDs (%)
Depression	2.88	6.83
Anxiety	0.58	1.37
Schizophrenia	1.10	2.62
Bipolar	0.59	1.14
Alcohol use	0.37	0.61
Drug use disorders	1.24	2.11
Epilepsy	0.57	0.69
Autistic spectrum disorders	0.5	1.18
Conduct disorders	0.27	0.63
Eating disorders	0.05	0.11
Attention deficit/hyperactivity disorders	0.03	0.06
Intellectual disabilities	0.03	0.06
Alzheimer's disease and other dementias	1.26	1.11
Other mental and substance use disorders	0.58	1.37
Total	10.04	19.90

DALYs disability-adjusted life years lost; *YLDs* years lived with disability
The source(s) of the table needs to be listed here

Current Mental Health Initiatives

Despite efforts and encouraging progress, mental health care in Vietnam continues to face major challenges. These include insufficient hospital beds for mental health care, limited availability of non-pharmacological interventions such as psychotherapy and psychosocial rehabilitation, shortages in skilled human resources at all levels of the system, inadequate access to medications, insufficient infrastructure for mental health care, limited and fragmented funding, and gaps in policy making and implementation. The lack of a mental health law has been a continuing problem that results in insufficient protection of the basic human rights of people with mental disorders. The growing complexity of population mental health, in the context of economic and social change and rapid industrialization and urbanization, and the increasing recognition of the substantial contribution of mental disorders to burden of disease have contributed to a clearer and more sustained focus by government on the need to develop an effective, accessible and equitable mental health system.

In 2014, the Minister of Health announced the development of a National Mental Health Strategy 2015–2025. A Drafting Committee for the National Mental Health Strategy was established in March 2014 which included key stakeholders from across Departments within MoH and established a Technical Experts Group, the membership of which includes Vietnamese and international experts from MoH, the University of Melbourne, UN agencies (World Health Organization, UNICEF) and NGOs (e.g., Vietnam Veterans of America Foundation) to facilitate the process

(Ministry of Health 2014). The process of developing the strategy has included wide consultation with all relevant stakeholder groups from across Vietnam. The draft strategy is fully consistent with the WHO Mental Health Action Plan 2013–2020. It is expected that, after a process of internal consultation across relevant ministries is carried out, the strategy will be submitted to the Prime Minister for approval by mid-2016.

The drafting of the National Mental Health Strategy has also ensured its consistency with other related health initiatives. Within the health sector, in 2015 the National Strategy on Prevention and Control of Non-Communicable Diseases (NCDs) for 2015–2025 was approved. This is particularly important because of the fact that people with mental disorders are at substantially higher risk of developing cardiovascular and other NCDs and premature mortality, and because people with cardiovascular, respiratory and endocrine diseases such as diabetes are at substantially higher risk of developing depression and other mental disorders. A substantial pilot project in a province close to Hanoi is exploring integration of mental health and NCD service programs.

In the social sector, a Prime Ministerial Decision was announced in 2010 approving the development of social work as a profession and the development of social service facilities at all levels to build an advanced, community-focused social support system by 2020 (Ministry of Labor Invalids and Social Affairs 2010). In 2011, a Prime Ministerial Decision initiated an ambitious national reform to develop community-based functional rehabilitation and social support services for people with mental disorders and made available substantial funds to implement this reform (Ministry of Labor Invalids and Social Affairs 2011). Vietnam ratified the UN Convention on the Rights of People with Disabilities (CRPD) in 2014. The planning for implementation of CRPD includes people with disabilities associated with mental disorders and provides another platform from which to advocate for better health, social and legal support for people with mental disorders. While MOLISA has primary responsibility for managing these programs, there is increasingly clear recognition, by both MOLISA and MoH, that close collaboration between the two ministries and their respective service agencies is essential for successful implementation, and for a comprehensive and community-focused mental health system.

Intersectoral Collaboration

In Vietnam, the lack of intersectoral collaboration and coordination of mental health care between MoH and MOLISA in the past has led to disjointed, inefficient and ineffective systems of care. More recently, the two ministries have begun working together to develop and implement a coordinated, integrated and comprehensive mental health care system that is able to respond to the clinical, rehabilitation and social service needs of people with mental disorders. For instance, MoH and MOLISA have developed a draft Joint Circular on the roles and functions of the

Social Protection Centers for providing mental health care. This is due to be finalized by 2016. The development of the National Mental Health Strategy 2016–2025 has been led by MoH, but has had ongoing input from MOLISA and other sectors such as education, finance and justice. Collaborative discussions on an integrated community-based mental health care system are occurring and are likely to continue into the phase of implementation of the strategy.

The current national initiatives for mental health system development are ambitious. The government has committed to (1) developing infrastructure and equipment; (2) developing human resources; (3) developing and implementing integrated and sustainable community-based service delivery models for promotion, prevention, early detection, treatment and recovery; (4) raising community awareness and participation; and (5) increasing accountability of government at all levels. While intersectoral collaborations are improving, establishing formal mechanisms to ensure such collaboration will be necessary to advance ongoing initiatives to strengthen the mental health care system.

International Collaboration

Numerous international collaborations in mental health have contributed to the advancement of the mental health services, training, policy and research. These include partnerships with universities, e.g., the Karolinska Institute in Sweden, Vanderbilt University in the USA, the Universities of Melbourne and Queensland in Australia, and with psychiatric hospitals and institutes in France, Australia and several other countries.

The University of Melbourne has collaborated with colleagues and institutions in Vietnam since 1994 (Hung et al. 2001; Minas 1994, 1996, 1997, 2007, 2009). In 1996, the University of Melbourne organized in Hanoi a collaborative workshop between the National Institute of Mental Health and the Royal Australian and New Zealand College of Psychiatrists (Minas 1996), the first significant international psychiatry conference to be held in Vietnam. The Vietnamese presenters at the conference gave a comprehensive overview of the state of mental health research, psychiatric training and mental health services in 1996 (Minas 1997).

Over two decades, the university's commitment has included collaboration in developing policies, research, training, funding and political support for the design and implementation of Vietnam's mental health care system (Minas 1997, 2007). Two major programs of work led by the University of Melbourne are the National Taskforce on Community Mental Health System Development in Vietnam Project (2010–2015) and the Vietnam Mental Health Consortium Project (2013–2015), which together have focused on strengthening the capacity of government to develop and implement mental health policy and plans, including community-based services, and develop the evidence base needed to inform policy and practice, strengthen research capacity, develop training programs and strengthen the mental health service network.

Through these two projects, the University of Melbourne and other national and international stakeholders have worked with MoH and MOLISA to mobilize additional funds for the program of work, develop the National Mental Health Strategy 2016–2025, conduct a comprehensive national survey on the mental health care system, develop and deliver together with NIMH a training program for decision makers and managers to develop community-based mental health care, develop and pilot service delivery models for mental health, and contribute to the better engagement and collaboration of key stakeholders from government, hospitals, UN agencies, non-government organizations, and universities to tackle the numerous challenges related to the mental health care system.

Work that began at the University of Melbourne nearly two decades ago and is now based at Monash University has built a substantial evidence base on women's mental health and perinatal mental health (Fisher et al. 2007, 2012, 2013a, b). The Queensland University of Technology has played an important role in strengthening research capacity, particularly in the area of adolescent and men's mental health (Nguyen et al. 2012, 2013; Phuong et al. 2013; Van Huy et al. 2015). The Karolinska Institute has had a long-running program in which many Vietnamese students have completed a PhD. Vanderbilt University has worked closely with the Ministry of Education and Training for many years and has contributed to the establishment in 2009 of a Master Program in Clinical Psychology and a doctoral program in 2015 at Vietnam National University. Vanderbilt University in collaboration with Vietnamese colleagues has also conducted many research projects on mental health, with a particular focus on children, adolescents and women (Do et al. 2013; Ngo et al. 2014; Weiss et al. 2012, 2014).

Non-government organizations have also contributed to numerous achievements. For instance, the Vietnam Veterans of America Foundation—International Centre has collaborated with mental health leaders in Da Nang and Khanh Hoa provinces to develop community-based mental health services for depression. Basic Needs, a UK-based NGO, launched a program in Vietnam in 2010 to support community-based mental health care.

Finally, Vietnam is a member of the ASEAN Mental Health Taskforce, which is a network of ASEAN member states that work together to address mental health in the region. Their work plan focuses on (1) developing an advocacy strategy for mental health; (2) facilitating the integration of mental health into the health care system and strengthening the capacity; (3) facilitating and strengthening the mental health information system; and (4) establishing an ASEAN network on mental health.

Mental Health Research

Mental health research has grown significantly in the last two decades with a greater understanding of mental health issues of women, especially during the perinatal period, children and adolescents, risk factors for mental disorders and mental health

services research. However, knowledge gaps and the still limited research evidence to inform mental health policy and practice remain a significant impediment to strengthening the mental health care system in Vietnam. Particularly important in this regard is the lack of a comprehensive mental health information system, making it impossible to systematically evaluate the impact of mental health policies and programs.

The national mental health system survey mentioned above will make a significant contribution to the understanding of the system and provide impetus for change. However, more targeted efforts to strengthen academic partnerships and research capacity are necessary to ensure up-to-date and high-quality evidence to inform policy and practice in Vietnam and to share lessons from Vietnam with the global mental health community.

Future Directions

Vietnam has made substantial progress in achievement of the Millennium Development Goals (MDGs), being an early achiever in a large number of indicators, and is on track to achieve most of the rest. Recent progress in mental health system development has been substantial. The progress that has been made in the past five years is illustrated by a comparison of the current situation (Luong et al. 2015) with that in 2010 (Niemi et al. 2010).

The inclusion of mental health in the Sustainable Development Goals (SDGs) of the United Nations 2030 Agenda for Sustainable Development presents substantial opportunities for acceleration in the development of a comprehensive, equitable and effective mental health system in Vietnam. Mental health leaders in MoH and MOLISA are increasingly aware of the opportunities that lie ahead and are actively seeking opportunities to build on existing achievements in developing the national mental health system and to improve the lives of people with mental disorders. A key goal of the new global development framework is to promote integrated development rather than the vertical programming that was a central feature of the MDGs. This goal is consistent with the fact that mental disorders, NCDs, disability and poverty are all closely interrelated (Eaton et al. 2014; Minas et al. 2015) and of the need to establish close collaboration between programs that are the primary responsibility of Ministries of Health, Social Affairs and economic development (Minas et al. 2015) and disaster response (Tsutsumi et al. 2015). The Vietnamese government has already embarked on a process of development that clearly recognizes these emerging development imperatives (Fig. 10.1).

There is now increased capacity in terms of the ability of mental health leaders to develop and implement policy, develop services, and to support mental health research and evidence-informed policy and practice. Mental health system governance is being improved. There is increased government investment in mental health, and increasingly strong intersectoral and international collaborations are being developed. It Includes an explicit commitment to protection of the rights of

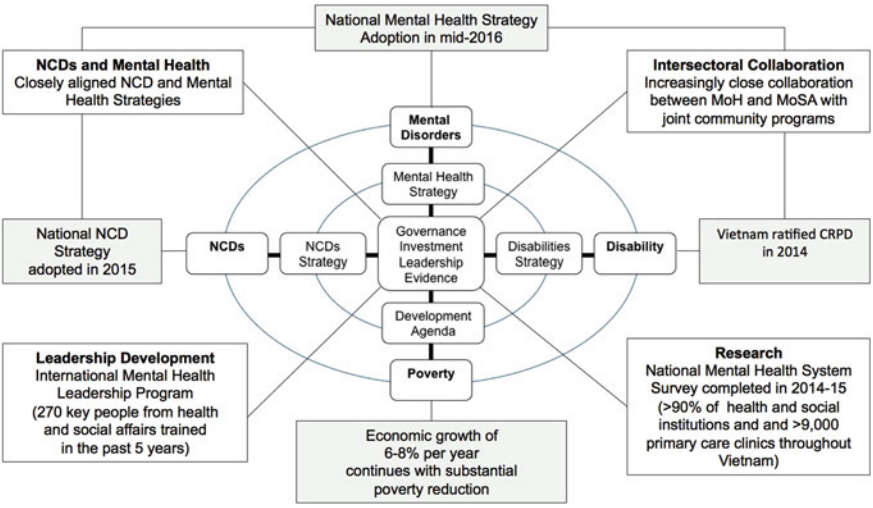

Fig. 10.1 Integrated mental health, NCDs, disability and economic development in Vietnam

persons with mental disorders. The more integrated model of mental health system development that is emerging in Vietnam may well prove to be an exemplar for other low- and middle-income countries in how to build strong, comprehensive, equitable mental health systems within the broader objectives of health, social and economic development.

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