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I am happiest when I have my friends around.

In-depth interview, boy aged 16, An Giang

Mental health and psychosocial wellbeing among children and young people in selected provinces and cities in Viet Nam

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Acknowledgements

Abbreviations

ADHD	Attention deficit hyperactivity disorder
CBCPS	Community based child protection system
DCPC	Department of Child Protection and Care
DOH	Department of Health
DOLISA	Department of Labour, Invalids and Social Affairs
F	Female
FGD	Focus group discussion
GCC	Grand Challenges Canada
GSO	General Statistics Office
HCMC	Ho Chi Minh City
HHWs	Hamlet health workers
IDIs	In-depth interviews
JICA	Japanese International Cooperation Agency
KI	Key informant
KII	Key informant interview
LMIC	Low- and middle-income countries
LSS	Lower secondary school
M	Male
MICS	Multiple Indicator Cluster Survey (UNICEF)
MOET	Ministry of Education and Training
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
PHAD	Institute of Population, Health and Development
PTSD	Post-traumatic stress disorder
RTCCD	Research and Training Centre for Community Development
SAVY	Survey Assessment Vietnamese Youth
SDGs	Sustainable Development Goals
SDQ	Strengths and Difficulties Questionnaire
SPC	Social Protection Centres
SWCs	Social Work Centres
UNICEF	United Nations Children's Fund
USS	Upper Secondary School
VUSTA	Viet Nam Union of Science and Technology Associations

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Introduction and Background

Mental health has been recognised as an integral part of broader definitions of health (see e.g. WHO, 2001), wherein mental health is not equated simply as the absence of mental disorder, but includes subjective wellbeing, self-efficiency, autonomy, competence, and realization of one's potential.

Widening out the discussion to also include the notion of psychosocial wellbeing, a body of literature across various disciplines explores the causes of both mental ill-health and psychosocial distress showing that it is multifactorial and includes biological, psychological and social and environmental factors. It is the latter group of causes i.e. the social factors and environmental, to which this study contributes. Thus a range of social and environmental factors including rapid social change, migration, unemployment, poverty and changes in traditional values, have been recognised as being key drivers of mental ill-health and psychosocial distress and particularly amongst young people.

The purpose of this study is to provide an overview of the situation and context of mental health of children and young people in selected provinces and cities in Viet Nam. It does not seek to be representative of the whole of Viet Nam. Nevertheless, findings are valid in themselves and provide an important set of findings which will inform recommendations on how to address the challenge of mental ill-health and psychosocial distress amongst children and young people, also feeding into existing national level programmes.

Four overarching research questions guided the study:

- What is the prevalence of mental health and psychosocial problems, including suicide among Vietnamese children, adolescents, and youth?

- Which factors in the Vietnamese context place children, adolescents, and youth at risk and which factors act as protective factors for mental

health and psychosocial problems, including suicide?

- What laws and policies exist around mental health and psychosocial wellbeing in Viet Nam?

- What kind of mental health and psychosocial service provisions and programmes exist for children and youth in Viet Nam?

It is important to note, and as was reflected in the research team composition, and following the focus discussed above on social and environmental drivers of mental ill-health and psychosocial distress, the study does not focus on severe mental disorders. Rather it focuses on mental ill-health

and psychosocial distress at the milder end of the mental health disorder spectrum, also referred to as common mental disorders (CMDs), and largely to what have been defined internationally as internalising/emotional problems such as anxiety, depression, loneliness, sadness and somatic complaints, all of which can have a range of negative outcomes, including suicide.

To situate and present our findings, we adopt a socio-ecological framework, with children/young people at the centre, which explores factors at different levels of the social ecology – individual, family/household, school, community, institutional – and the ways in which they interact and contribute to both drivers or risk factors of mental health and psychosocial well-being as well as protective factors.

Two main approaches were used for this study: a regional and national review of secondary data and qualitative primary data collection. (A total of 110 interviews were carried out, respondents included service providers, parents, children and young people). Additionally, two internationally validated scales for measuring wellbeing were used with 402 school children (aged 11-14 and 15-17) : the Strengths and Difficulties Questionnaire (SDQ) and the Self-Efficacy (SE) and Resilience Scale.

Primary data collection took place in Ha Noi and Ho Chi Minh City and in the provinces of Dien Bien in the north and An Giang in the south; in these provinces data collection took place in both urban and rural areas.

Magnitude and prevalence of mental health issues in Viet Nam

Findings from the secondary literature. A review of the fledgling evidence base on mental health issues in Viet Nam found that the prevalence of general mental health problems in Viet Nam ranges from 8% to 29% for children and adolescents, with varying rates across provinces, by gender and by respondent and depending on the study methodology. A recent epidemiological survey of a nationally representative population from 10 of 63 provinces found that the overall level of child mental health problems was about 12%, suggesting that more than 3 million children are in need of mental health services. The most common types of mental health problems among children studied in Viet Nam are those of **internalizing (such as anxiety, depression, loneliness) and externalising problems (such as hyperactivity and attention deficit issues)**.

While there is increasing concern with the rates of **suicide** among young people in Viet Nam, Viet Nam's reported suicide rate is remarkably low compared to global estimates. In a 90-country study, among all adolescent deaths the suicide rate was 9.1% (Wasserman et al., 2005), while in Viet Nam it was only 2.3% respectively (Blum et al., 2012). **Substance abuse,** which includes using drugs, abusing alcohol, and smoking, can also be a driver or a risk factor for mental ill-health and psychosocial distress; tobacco use especially was common among Vietnamese adolescent males (almost 40%). Though **co-morbidity** is not a risk factor by itself, the literature indicates that one form of mental illness may act as a risk factor for another. Moreover, concerns

are emerging that these mental issues are indicative of additional psychosocial challenges below the surface that may require further study going forward.

Findings from the qualitative primary data collection. Despite the relatively low incidence of mental health problems reported in the secondary data there is a general perception amongst all study respondents that both psychosocial and mental health problems are both widespread and increasing, with some saying they felt that children face a greater mental health burden than adults and that different age groups face different kinds of problems. However, they also mentioned that challenges remain in terms of estimating more precisely these numbers and particularly in relation to children.

Respondents spoke about people with mental health difficulties in various ways: they were seen to be 'unknowledgeable', 'negative', or 'different.' Similarly, respondents believed that 'their way of thinking is different', they have some kind of 'disease', are 'an exception', or are 'unstable'. While respondents

thought that stigma towards people facing mental health challenges was declining, it was also mentioned that while people might not outwardly stigmatize, they do so inwardly and/or show indifference, and it was suggested that as a result of prevailing stigmas, people are reluctant to access services. Emerging strongly from many narratives was the fact that mental health issues are not well understood with this lack of understanding also leading to fear of those with mental ill-health. Narratives around 'social evils' were heard amongst study respondents, often linked to discussions about substance abuse and addiction to internet games and gambling, which in turn can also have implications for mental health and psychosocial wellbeing as well as other anti-social behaviour such as stealing.

In keeping with the literature on mental health, narratives are presented based on the following broad areas: psychological state of participants, cognitive disorders, emotional disorders, somatic complaints, behavioural disorders and substance abuse. Clearly, these disorders and complaints are not

mutually inclusive, with many coexisting and one often resulting in another. Similarly, manifestations can also be risk factors, also further driving mental ill-health and psychosocial distress. Thus in terms of the **psychological state** of study participants, two main feelings were expressed: on the one hand, **optimism about** the future, and on the other hand **sadness and worry.**

Children of all ages, particularly the younger age categories, had great optimism and aspirations for the future. Worries, sadness and general pessimism was expressed more frequently by older children. The reasons for worry and sadness ranged from parents fighting, a family member being unwell, performance in school, fear of dropping out of school, uncertainty about the future and early marriage. The older age group, particularly girls who had dropped out of school and who were already married, worried about their financial security and that of their child as well the marital discord they were facing with their husbands. Symptoms of this sadness and worry include stress, which led to skipping meals, headaches and anger.

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Emotional disorders, under which depression and suicide fall, were prevalent amongst study respondents. Generally, girls were perceived to be more susceptible to emotional problems than boys. The way children and young people spoke about and perceived **suicide** appeared to vary according to age and gender: while the younger age group (11-14) had heard of 'many' people who had attempted suicide, by the time they got to the next age group (15-17) there were several cases of suicidal ideation and amongst the older age groups, and some respondents also reported having tried to commit suicide themselves. There was a general perception that it was mostly young people and girls who committed or who tried to commit suicide, and the availability of poisonous la ngon or 'heartbreak' leaves in Dien Bien makes suicide relatively easy. Reasons for suicidal ideation and attempted suicide for males and females include failure of romantic relationships, marital discord, problems at school, problems at home, and reluctance to share feelings. For men, additional reasons include not being able to live up to expected masculine attributes and behaviour, including the ability to maintain the family/household.

Somatic complaints - headaches, loss of appetite, poor sleep and nightmares - were mentioned by many respondents. Reasons for these were largely related to the stress associated with academic pressure, but also, particularly for girls, as a result of stress from having to do housework. Finally, **substance abuse** – alcohol, smoking and drugs - was also mentioned by many respondents in our study and was largely associated with boys, young men and husbands. According to respondents, substance abuse results from peer pressure to 'drink to forget their troubles' or from sadness and general social pressure. Substance abuse can also lead to violence

and early marriage of drug addicts' children.

Preliminary analyses of the **SDQ and SE Resilience Scales** found that **in terms of mental health problems,** of the four domains of behavioural and emotional problems, this study found that the rate of children scoring 'Abnormal' in the Emotional problems Scale is more than twice as high as those in other Scales, which suggests that emotional problems are what children struggle with the most during adolescence. The rate of children having conduct problems in this study also appears to be quite high; the most common symptoms include getting angry and losing temper easily, and lack of self-control. The majority of the children in the survey sample showed problems or symptoms of hyperactivity. Very few of the children were confident that they possessed good attention, judgement and ability to analyse and complete tasks effectively. In terms of **children's self-efficacy and perceived self-efficacy,** analyses revealed a relatively positive perception of self-efficacy among the children in the sample, both in unexpected/unforeseen situations and especially when actively facing difficult problems, although the number of **children having good self-efficacy** in coping with unexpected events is a bit lower. Particularly, in the face of difficulties and challenges, many of the children believed in their coping abilities. They could keep calm to solve the problems, and were confident in their own efforts and abilities to focus on pursuing and achieving their goals.

It is important to note that overall, while the global literature highlights the importance of poverty, adversity, migration and family separation as causes of mental ill-being, these are not strong themes in the secondary literature on Viet Nam. The existing

literature on mental health issues in Viet Nam tends to be highly medicalized, and thus we try to draw more attention to these socio-economic factors in our analysis of the primary data which we discuss especially at the household level (see below). There are also likely to be a range of other factors which influence the mental health and psychosocial wellbeing of children and young people in Viet Nam including factors such as trafficking, sexual abuse and violence. These issues were not explored in the literature review since these are topics in themselves and worthy of separate studies. The primary data collection also did not focus directly on these issues, though some of these issues did emerge indirectly e.g. through stories of isolated young mothers being at the mercy of their husbands.

Risk and protective factors for mental health issues

The report explores both risk and protective factors (including coping strategies) of children and young people at four levels: individual, household, school and community. In the following sections we focus on the primary data; for further findings from the literature review please see the full report or the literature review report (Samuels et al, 2018).

Individual level

Risk factors. Three main individual risk factors emerged for young people, with some age and gender-specific variations. First, **emotional isolation / self-isolation** was an important source of risk, with children often reporting choosing not to share their feelings with anyone, often because they wanted to protect their parents from worrying. For older adolescents, especially girls, feelings of social

isolation result from early marriage. Other girls in this age group also attributed their social isolation to dropping out of school against their choice and/or to the burden of domestic responsibilities. A second driver of psychological ill-being is linked to **access to modern technology and the risks of addictive online behaviours,** with this access posing a threat to wellbeing since children tend to "*use it too much*". Boys tend to spend more time online, playing games in the internet shops and their sadness is attributed to losing games online. Over time, online gaming also appears to have negative spill-over effects on scholastic achievement. Respondents stated that boys are more likely to play computer games than girls, but girls are more at risk from cyber bullying and stalking. A third key risk factor relates to **negative perceptions of adolescent physical appearance.** These concerns begin in early adolescence, especially among girls, who are anxious about menstruation or who are perceived to be overweight. Other physical concerns revolved around being too short, which leads to teasing, name calling and discrimination in school sports activities.

Coping strategies. A range of both positive and negative coping strategies was identified for dealing with mental and psychosocial ill-being. The first key protective factor mentioned was **active participation in leisure activities (**e.g. sports, martial arts, reading, watching movies, joining school clubs or trips, learning through the internet). A second critical protective factor was **having or being part of good social networks.** The importance of having friends was noted across all interviews, irrespective of gender. There were also several examples of children having **good role models** to follow, although this was more commonly cited by boys. These are generally adults they know — older

brothers, teachers, uncles — who have qualities that they admire and who have been good to them.

Negative coping strategies included **crying alone**, **substance abuse** (especially drinking alcohol), **vandalism** and **suicidal ideation** — most commonly mentioned in Dien Bien and in relation to pressures around school drop-out and early marriage. All of which can in turn further fuel mental ill-health and psychosocial distress.

Household level

Drivers/risk factors. Three broad sets of factors at household level were identified: overly restrictive family rules (especially with regard to scholastic achievement and marriage), poor or declining household socio-economic status, and intra-household tensions. In terms of **family rules**, younger children emphasised that they faced high expectations from parents in terms of carrying out domestic chores and caring for younger siblings and were afraid of being 'scolded' by parents for not doing them adequately. Similarly, children are also fearful of parents criticising them for poor marks at school, and there have been some instances in which scolding for academic performance has led to suicide attempts. For mid-adolescents (i.e. around 14-16 years of age), when young people are increasingly trying to define an independent identity, parental "control" was seen as a key source of stress, with children reporting that their parents do not allow them to go out with their friends, disapprove of romantic relationships, monitor their cell phone use, and make them do chores around the house.

Poor or declining household socioeconomic status, can limit opportunities for socialising with peers, limit their scholastic achievement by leaving them

with less time to do schoolwork and fewer means for extra-tuition classes, or force them to drop out of school altogether. This leads to high levels of stress for children, who are not able to achieve their future aspirations. Parental migration, also due to financial reasons, can also have a negative effect on children's mental health, with children left behind facing sadness and depression. In addition, early marriage, often associated for girls with school-leaving, was also found to lead to sadness and depression.

Household tensions arise from a number of sources including: family pressure on children to excel in school, a general feeling that parents don't understand children, marital conflicts (which often spill over onto children), divorce, domestic violence from husbands, and lack of communication between parents and children, often as a result of changing family structures and the pressures facing parents in a competitive labour market leading to them often neglecting their children.

Protective factors and responses. Two sets of protective factors were identified: relatively better off household **socioeconomic status** mitigated some sources of stress experienced by young people, thus it was mentioned that children in better-off households were more likely to complete twelfth grade. And **emotionally healthy family relationships** or **family connectedness** were also a key positive factor in mitigating psychosocial stress and ill-being — children felt loved the most by their parents and grandparents, and felt happy when they were able to share their feelings and concerns with them.

School-level drivers

Risk factors. Three main sets of risk factors were identified: academic stress, inadequate support and/

or shortcomings of the school environment, and challenges faced in romantic relationships. Respondents agreed that the **academic pressure** they face is one of their main worries – concerns related largely to performance, with children placing very high expectations on themselves to do well, which was further exacerbated when comparing themselves with their peers and by pressure from their families to do well. While the secondary literature has paid considerable attention to the problem of after-school tuition putting additional pressures on adolescents (e.g., see Ko and Xing, 2009), in our sample, this did not emerge as a significant concern, likely due to very high levels of poverty and marginalization. **Shortcomings within the school environment** were manifested by high levels of bullying and peer conflict. Being away from family and in boarding school, is an added stressor, as is the lack of leisure activities and often unsupportive teachers. **Romantic relationships,** which often start in the school environment, were often associated with stress since, on the one hand, they have to remain hidden from parents and teachers who would forbid them and , on the other hand, break-ups and unrequited love lead to sadness, depression and sometimes even suicidal ideation or attempts.

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Responses and coping strategies. A number of schools, largely in urban areas, have **psychological counselling units**, and girls access them more than boys. Shortcomings of these units ranged from students not knowing about them and therefore rarely accessing them, to variability in the capacities of counsellors, to the location of the unit in a public space with no privacy, to the fact that there are sometimes only male counsellors with whom girls may be reluctant to share their feelings. The **life-skills** training and citizen education that children receive in school helps them deal with stress, as do clubs, other **extra-curricular activities** and the **internet**. **Teachers** are also an important part of students' coping repertoires, particularly in relation to studying and sometimes with family related issues.

Community level

Risk factors: Three main categories were identified: easy access to harmful substances; lack of access to economic opportunities; and harmful norms. Easy access to **harmful substances** was particularly prevalent in Dien Bien province, where access to drugs and to poisonous (la ngon) leaves was widespread. Alcohol abuse was also prevalent. Reasons for abuse range from people wanting to use them, to being tempted by their friends, to having cheap and easy access to substances. Since **opportunities (in terms of employment/future jobs and leisure activities) in rural areas are limited**, and limited knowledge

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of vocational options, this also causes potential stress for children and young people, with narratives in urban areas highlighting higher level career aspirations of children and young people. **Harmful norms** appear to be more prevalent in rural areas and largely in the impoverished northern highlands. These include norms around early marriage for girls - usually also resulting in a girl leaving school at an early age – what a girl should do with her life, how she should behave and look/dress and the domestic roles that she needs to take on. All of these can affect the mental health and psychosocial wellbeing of girls.

Protective factors and coping. Where there are **opportunities or services** focusing on mental health and psychosocial wellbeing, these have a positive effect on children and young people. Respondents also note the importance of holding **positive attitudes and beliefs,** many of which can be taught in schools.

Mental health service delivery

The provision of mental health services falls within the remit of a number of ministries, including the Ministry of Health (MOH), the Ministry of Labour, Invalids and Social Affairs (MOLISA), and the Ministry of Education and Training (MOET). Each ministry has a different paradigm of administration, with different areas of responsibility, roles and functions, and has their own programmes, proposals and models for dealing with mental health and psychosocial issues. For example, MOH is in charge of health-related matters, hospitals and health centres. Health centres and hospitals diagnose and provide treatment primarily for serious and persistent mental illness stemming from neurological conditions and developmental disabilities. In contrast, MOLISA, through its vertical system of DOLISAs in 63 provinces and cities, social protection and social work centres, deals with social support policies for social protection beneficiaries and provides services for serious cases. MOET provides psychosocial counselling units in schools and life-skills training. A growing number of non-governmental oranisations (NGOs) are also providing mental health and psychosocial related services

Service provision through MOH

In **Hanoi** mental health services are provided through a number of hospitals, including the National Institute of Mental Health, National Psychiatric Hospital No. 1, Hanoi Psychiatric Hospital and the Mai Huong Daytime Psychiatric Hospital. In **HCMC** mental health related services are also provided through several hospitals, including the **Paediatrics Hospital** No. 1.

In **Dien Bien Province** mental health services are provided through the government and through two hospitals in Dien Bien Phu City: the provincial general hospital, which has a mental ward and a **psychiatric hospital**. While there are a large number of private clinics and health care providers in Dien Bien Phu City, according to study respondents, none provide mental health services. Although there is no psychiatric hospital **in An Giang**, DOLISA supports the hospital wards and health centres by providing them with financial support to accept referrals of serious mental health patients. The national programme on mental health care for community and children is also being implemented in An Giang and

the Women's Union there has also been providing support to those with mental health needs.

Commune health centres and the **hamlet health workers (HHWs)** are usually the first port of call in communes and remote areas for people with any kind of health-related concern. While mental health issues are usually not part of the remit of HHWs, a sub-group of HHWs in Keo Lom (Dien Bien) attended a training session in which they were taught how to identify mental health problems and access drugs for the patients at the psychiatric hospital in Dien Bien. The **community mental health programme** appears to have been running for around ten years in Dien Bien province, whereby the psychiatric hospital distributed medicines to the districts and the responsible officers at district level then distributed to patients in their coverage areas.

Overall, however, there is very limited provision of mental health services within the public health sector, and what is provided is poorly integrated – especially at provincial hospital level.

Service provision through MOLISA

Key institutions under MOLISA through which mental health and psychosocial wellbeing services are provided include social protection institutions, social work centres, care and rehabilitation centres for people with mental health, and hotlines. In 2011, the Vietnamese Government has approved a programme for social support and community-based rehabilitation for people with mental health illnesses for the period 2011-2020 (Decision 1215). The programme aims at social mobilisation, especially from families and communities, to provide spiritual, material support and rehabilitation to people with mental illnesses and support them to integrate into the community,

preventing mental disorders and contributing to improved general social security.

Social protection institutions include: Social protection institutions taking care of the elderly people; Social protection institutions taking care of children in special circumstances; Social protection institutions taking care of people with disabilities; Social protection institutions providing care and rehabilitation to people with mental illnesses and disorders; General social protection institutions taking care of beneficiaries of social protection or those in need of social protection; Social work centres providing counseling services, urgent care or other necessary support for those in need of social protection; Other social protection establishments according to the law. Social protection institutions have the following responsibilities:

(i) Provide urgent services (receive those in need of urgent protection; assess beneficiaries' needs, screen and categorize beneficiaries. When needed, refer beneficiaries to health, educational, police, judicial or other relevant institutions or organizations; ensure safety and address urgent needs of beneficiaries such as: temporary accommodation, food, clothes and transport); (ii) Consult and treat mental disorders, psycho crisis, and physical rehalibitation for beneficiaries; (iii) Advise and assist beneficiaries to access social support policies; coordinate with other relevant units and organizations to protect and assist beneficiaries; search and arrange types of care services; (iv) Develop intervention and assistance plans for beneficiaries; monitor and review intervention and assistance activities, and adjust plans if needed; (v) Receive, manage, and care for social protection beneficiaries who are in seriously difficult situation, unable to take care of themselves and cannot live in a family and community; (vi) Provide primary medical treatment

services; (vii) Organize rehabilitation and occupational activities; assist beneficiaries in self-management, cultural, sport activities and other activities suitable for the age and health conditions of each group of beneficiaries; (viii) Take the lead and coordinate with relevant institutions and organizations to provide academic and vocational training and career guidance to promote comprehensive development of beneficiaries, physically, intellectually as well as in terms of personality. (x) Provide social education and capacity building services (Provide social education services to help beneficiaries develop problem-solving capacity, including parenting skills for those in need; teach life skills to children and adolescents; Collaborate with training institutions to organize education and social work training for staff, collaborators or those working for social work service providers; Organize training and workshops to provide knowledge and skills to beneficiaries who have demand. (xi) Manage beneficiaries who receive social work services to all beneficiaries of social protection and those in need of urgent protection.

Up to now there are 45 Social Protection Centres providing care and rehabilitation for people with mental illnesses and Social Work Centres that have implemented case management for 60,000 people with mental health problems in communities. These centres provide social work services such as organizing rehabilitation and occupational activities.

Most of these establishments collaborate with small businesses, organizations, and some individuals to provide production activities, vocational training, create jobs and generate income for people with mental illness through some simple occupations such as raising cattle and poultry, growing mushrooms, producing insent sticks and votive

paper, planting trees; contributing to the improvement of the beneficiaries' material and spritual life.

While there have been a number of telephone **hotlines** operating in Viet Nam dealing with a range of topics, the most prominent, longest-operating one (since 2004) that deals with young people and mental health issues is 'the Magic Buttons –18001567". The number of this hotline has been changed to 111 from December 2017. Housed in MOLISA headquarters in Hanoi under the Department of Child Care and Protection**,** it operates 24 hours a day, 7 days a week and has 20 staff and 10 collaborators /adjunct staff with backgrounds in psychology and special education. There is an advisory council of doctors and academics specializing in psychology and law to provide support in difficult cases. Between 2014-2015, the hotline received more than 2 million calls from children and adults throughout the country.

Service provision through MOET and schools

The mental health and psychosocial wellbeing of children and young people is potentially addressed through schools by i) **life-skills training** and ii) **psychological counselling units**. Additionally, in some schools, particularly in Hanoi, sessions on parenting skills are starting to be provided to parents. On 18 December 2017, the Ministry of Education and Training issued a circular guiding the implementation of psychological counseling for students in general schools with the purposes to: (i) Prevent, support and intervene (when necessary) for students who are experiencing psychological difficulties in their study and life so that they can find approriate resolution and mitigate negative impacts which may possibly occur, contributing to the establishment of a safe, healthy, friendly and violence-free school

environment; (ii) Support students to practice life skills, strengthen their will, trust, courage and appropriate behaviors in social relations; exercise physical and mental health, contributing to the forming and improvement of their personality.

The quality of service provided through these units, as well as the level of training and commitment of the counsellors appears to vary. Units provided through government schools and those outside of Hanoi and HCMC are generally of lower quality, with students rarely using the services. According to the school psychologists, there are a number of ways in which students are made aware of and can access the counselling units. They can be advertised during school activities, teachers can identify students who they think may be facing difficulties, and the psychologists themselves may identify students through walking around the school area. At one school, a Facebook page was created for students.

Service provision through informal providers

The use of **herbal medicines** as well as **shamanism** appears to persist in some areas. Due to a range of interrelated factors including remoteness from mental health service providers, lack of awareness, and adherence to ethnically based community practices, people will often take herbal remedies and perform certain rituals before going to formal healthcare providers – and this is true for mental health and other related problems, but possibly more so for mental health challenges

There is a sense that **the family** plays an important role in the provision of care for mental health patients and could provide more if they were trained. In the cities there is a move to both train and involve family members in improving parenting and dealing with children facing

mental health challenges. For example, a school in Hanoi provides sessions for parents on parenting skills. Parents are also a focus in some of the hospitals in the cities. A health worker in the national paediatrics hospital in Hanoi mentioned training classes held for parents with autistic and hyperactive children.

Challenges in service provision

Supply side challenges

Generally, service delivery is mainly concerned with a group of people facing severe mental health disorders, and pay relatively little attention to the provision of services

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for children and young people facing more common mental health disorders as well as psychosocial distress. Summarising the supply-side challenges:

Limitations in coordination among government departments. Our findings suggested that there is a mixed level of coordination among government departments, and although there are some good practices, there is still further room for improvement. Similarly, while the role of the DOH was seen to be critical to coordination, it was also see to be lacking and in need of revision. According to study respondents, in order to have effective programme

and policy implementation, improved coordination between government departments is critical in order to have effective policy implementation.

Lack of qualified, sufficient and appropriate (gender) human resources. The limited number of qualified staff was a challenge mentioned by all respondents, particularly at district and provincial levels and in relation to staff from a social work background and able to deal with less severe mental disorders and psychosocial distress. Additionally, there was considerably less capacity to deal with children and young people presenting with mental health and psychosocial

distress issues. Similarly, the majority of staff working at social protection centres are not trained in social work, or other relevant specialisations. Moreover, the number of social workers is still limited, especially those working directly with patients.

Self-learning and on-the-job learning in relation to mental health appears to be a coping mechanism given the lack of training provided. Even where there were qualified staff, as is the case in major cities, many were away on further training and short courses, and others still often left upon receiving training. It was also noted that currently in Viet Nam as a whole there are limited numbers of students in the specialisations

that are needed. Lack of sufficient (and qualified) staff also emerged as a problem in the provision of counselling / psychological support in schools. In particular, when comparing public schools with private schools, it was noted that teachers were less willing to take on and provide a counselling service to their students because of their workloads and the fact that class sizes in public schools were so large (50-55 pupils, vs 25-30 in private schools). Additionally, it was felt that there should be dedicated and qualified psychologists or counsellors in schools, ideally of each gender to facilitate confidence among the students.

Stress on existing mental health providers. Arguably mental health providers face a double stress burden. First, because there are so few mental health providers, the existing ones have large workloads and, consequently, high levels of stress. Second, providers speak about the high levels of stress because of the subject matter. In terms of remuneration, it was felt by some that their salary was not sufficient compared to that of other healthcare providers since psychologists have to devote much more time to a single patient.

Undervaluing /stigmatising of mental health services. Not only do people refrain from accessing mental health services because of the stigma associated with mental illness, but there is also a sense coming from providers that mental health is undervalued relative to other health areas. Given that mental health challenges are not as visible as are physical injuries, people do not treat them as seriously; similarly, mental health issues cannot be treated as quickly or straightforwardly as is often possible with physical injuries, whose treatments are concrete and often result in rapid, visible improvement. There is also the perception amongst the mental

health doctors themselves that mental health professionals do not enjoy the same status as doctors in the General Hospital. According to one respondent, working in mental health is seen as a last resort, and according to another, 'Psychiatrists suffer from inferiority complexes'.

Infrastructure. Infrastructure-related challenges are more frequently mentioned outside of Hanoi and HCMC. Challenges range from having no provincial mental hospital, to having poor infrastructure and equipment, to having insufficient space to expand to accommodate more beneficiaries. With school counselling services, the office sometimes has inadequate privacy assurances, thus discouraging students from seeking out the service.

Indeed, mirroring our respondent's opinions, a report from the Department of Social Protection (under MOLISA), found that limitations of the social protection centres include poor quality services, separation of the beneficiaries from their families, poor infrastructure, and lack specialised equipment and facilities, thus cannot meet the special demands of beneficiaries with regard to care, education, rehabilitation and psychosocial needs..

Demand side challenges

According to study respondents, either people: i) **do not recognise mental health challenges**; ii) even if they do see that their child might be facing difficulties, they **do not think they are important enough to seek assistance**; iii) even if they want to get help, they **do not know where to get it**; and iv) **will only access a service provider, rather than caring for them at home, if someone is seen to have a 'serious mental health problem'**. This is particularly the case in areas where there are limited service options

and availability, but even where there are appropriate services, people are reluctant to access them, often because of the associated stigma. Even if they do access these services either they do not see their importance or get disheartened when the individual does not appear to be improving.

In remote areas, people will resort first to herbal medicines and perform rituals, for both mental health and other related problems, which lead to delays in receiving efficacious treatment that can prolong the course of recovery. The gender of providers also creates challenges for uptake of services and stigma remains a barrier to accessing services

Political economy of mental health in Viet Nam

Currently Viet Nam has neither an explicit mental health law, nor any specific legislation on mental healthcare for children. No policy dealing explicitly with children's mental healthcare has been put in place, though general healthcare for children has been effectively encoded in the legal system, with multiple policies and programs related to healthcare in place for children.

To strengthen the social support system, a wide range of legal documents has recently been approved such as the Law on Children, the Law on Persons with Disabilities, the Law on the Elderly, the Government Decree No. 136/2013/ND-CP dated 21 October 2013 regulating social support policies for social protection beneficiaries; Decree No. 103/2017/ND-CP dated 12 September 2017 providing for the establishment, organization, operation, dissolution and management of social assistance facilities; Decree No. 28/2012/ND-CP dated 10 April 2012 detailing and

guiding the implementation of a number of articles of the Law on Persons with Disabilities; Decision No. 1215/2011/QD-TTg dated 22 July 2011 of the Prime Minister approving the program of community-based social assistance and functional rehabilitation for mental illness and mental disorders (2011-2020), which has provided care, support and rehabilitation to children with disabilities in general and children with mental health problems in particular.

The National Target Programme on mental health started in 1998 when the Prime Minister signed the inclusion of the Projectfor Community Mental Health Protection into the National target programme on prevention and control of some social illnesses, dangerous epidemics, and HIV/AIDS, now being a part of the National Target Programme for Health. Since its operation, the project has developed a model for the management, treatment and care of people with schizophrenia and epilepsy in the community. Since 2001 up to now, the Project for the Community Mental Health Protection has gone through three stages, each with different names. During 2001-2005, the Community Mental Health Care and Protection Project (under the National Target Programme on prevention and control of some social illnesses, dangerous epidemics, and HIV/AIDS. In the period 2011-2015, the project is named as "Protection of Mental Health for the Community and Children", which was under the National Target Programme on Health. The overall goal of the project is to develop a network and pilot a model for inclusion of mental healthcare with general healthcare of the commune/ward health station for timely detection, management and treatment so that patients can soon re-integrate into the community.

Additionally, in 2006, the Ministry of Health issued the "National comprehensive plan for protecting, caring and enhancing Vietnamese teenagers' and young people's health for the period 2006-2010 with vision to 2020". Among other things, "Mental trauma and other issues related to mental health" are seen as one of the main dangers to Vietnamese teenagers' and young people's health. There is also a push by the government to develop the social work profession with the Prime Minister Decision 32 in 2010 approved the Programme on development of Social Work profession period 2010-2020. Thus, MOLISA has issued the Circular (07/2013/TT- BLĐTBXH dated 24/5/2013) to provide instructions on how to improve commune/ward-level social work collaborators.

When study respondents were asked their views on mental healthcare policy, particularly for children and young people, it was generally thought that it was lacking and more attention needed to be paid to it, both within the health sector and the schools. There was also a sense that while there is policy on mental health, though not for children, there was little or nothing on psychological counselling.

When there are psychological services being provided, it is often through the private sector and is not regulated in any way. Generally, it should be noted that current mental health-related policies are scattered in various legal documents in which mental health is mentioned to varying degrees. Additionally, mental health is generally not considered a major issue in the provisions of these documents. Even in the People's Health Care Law, a very important legal document in the field of health, mental health issues are only mentioned in a cursory manner.

Looking forward, the draft document of the National Strategy on Mental Health in the period 2018-2025

with vision to 2030 expresses a commitment to provide healthcare coverage to all people, and it gives priority to poor regions, those in difficult situations, and ethnic minorities and other vulnerable groups. The document uses a life-cycle approach in which policies, plans and mental healthcare services should be structured to account for the specific needs that arise in each life period (from newborns, to children, teenagers, adults and the elderly). Notably, the draft has a target related to mental health protection for children and teenagers for prevention and early detection of up to 50% of mental disorders by 2025.

According to study respondents, a number of policy recommendations have been put forth to improve upon the national mental health program but are currently in draft phase. At the local level, our findings suggest that there are also some specific plans for future implementation of programming and service provision around mental health including more places to care for people facing mental health challenges. In other places, it appears that the policies and programmes have been agreed upon and they are just waiting for investment, including staff.

Recommendations

Based on our findings, the report proposes a number of recommendations:

1. Better and more coordinated policies on mental health psychological counselling, for children and young people

Consider **improving the laws and policies** related to mental health care in the social assistance and social security systems in Viet Nam, aiming at: 1) strengthening of human resources and 2) improving the quality of mental health care services

in social assistance establishments and in the community, and 3) development of specific policies explicitly targeting children and young people. This process would need to be led by MOLISA and MOH in collaboration with other key ministries.

School healthcare programmes also need to address more specific issues related to mental health care and psychosocial support for school children.

It will be important for the Government of Viet Nam to **approve the National Strategy on Mental Health period 2018-2025,** with its emphasis on providing healthcare coverage to all people, giving priority to poor regions, those in difficult situations, and ethnic minorities and other vulnerable groups. Adequate budget allocations from the Ministries of Health, Education and Labour and Social Affairs (MOH, MOET and MOLISA) will be required to not only increasing the number of social workers, specialised medical professionals, and community- and school- based counsellors, but also to set standards and guidance for tailored training and periodic retraining. Additionally, synergies should be promoted through the implementation of the Master Plan for Social Assistance Reform and Development for 2017-2025, vision towards 2030 (MPSARD), which includes attention to social assistance for particularly vulnerable groups, including those with mental health problems. In this regard, MOLISA will have a critical role to play in ensuring integrated policy and programme implementation.

Policy implementation will also necessitate **providing clear guidance and mandates to all relevant agencies** – MOH, MOET and MOLISA – to ensure that goals of the national strategy are reflected in their respective policies and programmes. Additional linkages

to ensure a holistic approach to supporting children and young people's mental health and psychosocial wellbeing would include the MOET's Department of Student Affairs, the Commission on Ethnic Minority Affairs, and the Women's Union.

Given the high level of unmet demand for support services and treatment among children and young people, **capitalising on existing NGO and private service providers by providing referrals** as well as clear guidance on practice standards will be an important short-term step.

2. Increase quantity and quality of human resources

There is an urgent need to **enhance training to develop a cadre of health workers,** from nurses to doctors, as well as specialist training. There is a **strong need to pay attention to developing training for more and better counsellors, social workers, psychiatrists, and psychologists** who could deal with less severe types of mental health problems and disorders. Moreover, **tailored training in each of these fields related to the needs of children and young people** is essential.

The role of the education sector and schools in particular is critical. **More training is needed to establish a cadre of dedicated and professional school psychologists and counsellors, along with the appropriate infrastructure (counselling units /centres).**

It is also essential to **develop a cadre of professional of social workers.** In addition, there is an urgent need to strengthen the **knowledge and capacities of the staff at Social Protection Centres.** Finally, there could be important dividends in developing **a cadre of para-social workers (commune collaborators).**

The **community health level model** appears to have been very successful in general, although not yet at scale, indicating that there is a need to revisit and support retraining for a cadre of community level health workers.

The **content of the training programmes** need to be developed jointly with mental health and psychosocial experts, drawing on international best practice, but also ensuring that the particular realities of the Viet Nam context are taken into consideration.

For all cadres of staff, it is important that on the one hand they **are incentivized** to work in this sector, and in particular in areas beyond large cities. On the other hand, it is also critical that all these cadres are provided with sufficient and good quality supervision and guidance.

3. More and improved awareness around young people's psychosocial and mental health care needs, as well as existing support services

Every year, MOLISA organizes training to raise awareness among social work staff, collaborators and families about mental health care. There is, however, need to increase these awareness raising activities in order to raise **public awareness around less severe mental health and psychosocial needs of children and young people.** In particular, it would be important to raise awareness about the linkages between discriminatory social norms and mental ill-health.

Awareness-raising can be done through: **developing training curricula** for different carders of workers and relevant to their sector (health, education); developing **communications activities** targeting communities; and through **providing information** at service points.

This **awareness-raising could be done at various levels,** starting at the commune level, providing communities also with more information about the role of the social workers as well as hotlines. The Women's Union as well as other grassroots political and social organizations at ward or commune level, could also potentially play a role in raising awareness.

Related to this, it would be beneficial to **support parents with parenting, caring and communication skills training and support,** including regular follow-ups in order to promote behavioural norm changes.

It is also vital to ensure that the approach is **inter-sectoral** - at the commune level working with teachers would be critical and training them to detect early warning signs and to refer students to school counsellors and relevant healthcare professionals, commune office staff, and social workers.

4. More and better coordinated services throughout the country

Through health and social protection facility systems, MOH and MOLISA should:

- **Increase the number and quality of mental health and psychosocial-related services** throughout the country, while at the same time ensuring that **appropriate and dedicated infrastructure** is in place for provision of specialized support related to mental health and psychosocial wellbeing.

- **Develop clinical diagnostics standards and activities for children and young people** thus allowing for the early detection and treatment of mental health challenges as well as psychosocial distress. This requires active support and

budget from MOH, MOET, and MOLISA.

(v) At the same time, establish collaborations and partnerships between line ministries for the provision of services to ensure complementarity and best use of resources. A cross-ministerial working group and collaboration regulations could be set-up to facilitate this at national level, which could also be mirrored at provincial and commune level. (iv) Capitalis on the connectivity of many young people, and ensure that there are strong online sources of information and support that can be accessed by mobile phones or computers, while at the same time ensuring that there are adequate safeguards in place to protect children from the negative dimensions of social media. Facilitate support groups for parents, especially for parents caring for children with specific and diagnosed mental health disorders; In addition, there is a need to invest in systemic counselling, i.e. working closely with families to help them provide adequate attention and care to their children.

In order for these changes to happen a **clear governmental champion is needed** to raise the profile of the specificity of children's mental health needs at national level and across sectors.

5. Ministry of Education should take on role for championing children's needs for better mental health and psychosocial wellbeing

MOET has a key role to play through both primary and secondary schools, to: i) Support a focus on **prevention** by teaching children the skills needed to respond to emotional and psychological difficulties faced in relationships with parents, teachers, friends and others; ii) **Relieve** study pressure by evaluating the volume

of knowledge children are expected to learn; iii) **Invest** in developing psychological counselling in all schools, especially for children of ethnic minorities; and iv) **Equip parents with skills** that can help ease the problems that children face at school and at home.

6. Further research and better data

Broadening the geographical scope in subsequent studies to cover a wider range of regions and ethnicities would be important. Specific areas of research to address paucity of data in this area include:

- Local level service mapping in order to inform local communities about what services are available. Prior to that, it is necessary to assess the quantity, quality, variety and density of service providers.

- National data collection on manifestations and prevalence of different mental ill-health and psychosocial problems

- Improved monitoring and evaluation reporting at all levels, from commune through to central levels vis-à-vis service provision for children and young people

- Improved data collection and databases on referrals and follow-ups

- Further analysis of the strong linkages with underlying gendered social norms that impinge on adolescents' mental and psychosocial wellbeing

- Studies on a larger scale and among particular groups, such as children and young people in special situations, or ethnic minority groups.

CHAPTER 1

Introduction and background

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Mental health has been recognised as an integral part of broader definitions of health (see e.g. WHO, 2001), wherein mental health is not equated simply as the absence of mental disorder, but includes subjective wellbeing, self-efficacy, autonomy, competence, and realization of one's potential

Widening out the discussion to also include the notion of psychosocial wellbeing, a body of literature across various disciplines, though largely from psychology, explores the causes of both mental ill-health and psychosocial distress showing that it is multifactorial and includes biological, psychological and social and environmental factors (see e.g. Chesney et al, 2015; WHO 2001; WHO and Calouste Gulbenkian Foundation, 2014). It is the latter

group of causes i.e. the social factors and environmental, to which this study contributes. Thus a range of social and environmental factors including rapid social change, migration, social isolation, conflict/post-conflict environments, unemployment and poverty, individual and family crises, changes in traditional values and conflict with parents, have been recognised by a range of scholars as being key drivers of mental ill-health and psychosocial distress and particularly amongst young people (e.g. Patel et al., 2007; Stavropoulou and Samuels, 2015; WHO, 2010)

It is also important to note, and as was reflected in the research team composition, and following the focus discussed above on social and environmental drivers of mental

ill-health and psychosocial distress, the study does not focus on severe mental disorders. Rather it focuses on mental ill-health and psychosocial distress at the milder end of the mental health disorder spectrum, also referred to as common mental disorders (CMDs), and largely to what have been defined internationally as internalising/emotional problems such as anxiety, depression, loneliness, sadness and somatic complaints, all of which can have a range of negative outcomes, including suicide. See also Box 1 for definitions of mental disorders and psychosocial distress.

The purpose of this study, therefore, which was carried out by UNICEF Viet Nam, with research and technical expertise provided by the ODI and IFGS, is to provide an overview of

the situation regarding the mental health and psychosocial wellbeing of children and young people/youth in selected provinces and cities in Viet Nam. The study was guided by four overarching research questions:

- What is the prevalence of mental health and psychosocial problems, including suicide among Vietnamese children and youth?

- Which factors in the Vietnamese context place children and youth at risk and which factors act as protective factors for mental health and psychosocial problems, including suicide?

- What laws and policies exist around mental health and psychosocial wellbeing in Viet Nam?

- What kind of mental health and psychosocial service provisions and programmes exist for children and youth in Viet Nam?

Findings from the study do not purport to be representative of the whole of Viet Nam; nevertheless, they do represent the situation in certain areas of the country. The age group of 11-24 was selected given the focus of UNICEF work relating to children and youth but also given the understanding that this is an age group facing particular mental health and psychosocial challenges both globally and in Viet Nam. Findings from this study will inform recommendations on how to address challenges around mental health and psychosocial distress and will feed into the existing national level programmes including the National Programme on Social Support and Rehabilitation for People with Mental Illness as well as the National Targeted Programme on Health. The main audience for these findings will, therefore, include MOLISA, the Ministry of Health, the

Ministry of Education and Training and other key stakeholders and service providers working closely with children and young people including social workers, teachers, health staff and parents.

This study also draws, builds on and complements ongoing work carried out by ODI in partnership with IFGS on gendered social norm change processes (e.g. around the value of girls' education; the gender division of labour and decision-making in the household, marriage, gender-based violence) with young people which we believe is vital to contextualise mental health and psychosocial wellbeing (Jones et al., 2013; 2014; 2015)[1]. Such discriminatory norms are typically influenced by multiple contexts (global discourses and international frameworks, national political ideologies and development trajectories, subnational context), but are also reframed through individual and community experiences and perceptions (see e.g. Munoz Boudet et al., 2012; Mackie and LeJeune, 2009; Petesch, 2012).

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1. There are many different definitions of social norms, but all of them emphasise the importance of shared expectations or informal rules among a set of people (a reference group) as to how people should behave. Most also agree that norms are held in place through social rewards for people who conform to them (e.g. other people's approval, standing in the community) and social sanctions against people who do not (e.g. gossip, ostracism or violence). Harper and Marcus (2015) define norms as the informal rules governing behaviour, distinguishing these from underlying values and from practices – regular patterns of behaviour – which they see as the manifestation of norms, values and of other factors. To understand the ways that different factors contribute, they suggest that it can be helpful to distinguish between three closely linked, but distinct elements: i) Underlying values – such as ideologies of male superiority, of men's right to women's bodies, and of girls' and women's place being in the home; ii) Norms of behaviour – such as it being acceptable for men to leer, wolf-whistle, make sexually explicit remarks or to touch women (without their consent) and iii) Practices (or regular patterns of behaviour), which are manifestation of norms and other drivers – in this case, sexual harassment.

In the remainder of this section we present an overview of the global and regional literature on mental health and psychosocial wellbeing, and also a short conceptual framework through which to provide an understanding on how we present and analyse findings from the study[2]. In Section 2 we present the study methodology and a description of the study sites. Sections 3 to 7 present the bulk of the primary fieldwork findings, also referring to findings particular to Viet Nam from the literature review where relevant. Therefore, in Section 3 we explore the manifestations and prevalence of mental health and psychosocial challenges facing children and young people; in Section 4 we examine the risk and protective factors at different levels; in Section 5 we describe the service environment around mental health, and in Section 6, we cover challenges in service provision. In Section 7 we discuss the political economy environment within which mental health programming and services are situated. We end in Section 8 with conclusions and recommendations.

1.1 Theoretical underpinnings of mental health

Several theoretical paradigms underpin understandings of mental illnesses, and the most commonly cited theories fall under three schools of thought: behavioural theories, cognitive theories, and psychodynamic/developmental theories. Behavioural (e.g. Skinner, 1938; Pavlov, 1902; and Watson, 1913) approaches suggest that all behaviours are acquired through conditioning, i.e. that learning occurs through repetition of behaviour. Cognitive theories suggest that how people think, perceive, remember, and learn are central

to understanding mental illnesses. Therefore, living in a home with a caregiver who suffers from mental illness may place a child at risk since he/she will learn behaviours that are maladaptive and will consequently perceive the world in maladaptive ways. Finally, psychodynamic theories underscore the dynamic interrelationship between the biological, psychological and social dimensions of life, with each continually influencing the other (Capetown Principles, UNICEF, 1997). Biological dimensions include genetic and physical factors with which each human being is born; psychological dimensions include emotions, behaviour, thoughts, memory and learning ability, as well as capacity to perceive and understand everyday situations. Social dimensions refer to people's relationships to each other, their community and the world around them from culture and belief systems to economics.

1.2 Global mental health

Mental health problems, (see definitions in Box 1), affect more than one in four persons, with disorders like depression affecting more than 350 million people globally (WHO, 2015a). Indeed, common mental disorders (CMD), which this study focuses on, comprising anxiety and depression, are the most prevalent psychiatric illnesses among adolescents and young people worldwide (WHO, 2001a). Additionally, suicide, linked strongly in high income countries with depression, claims the lives of over 800,000 people annually across the globe (WHO, 2015b). Between 1990 and 2010, the burden of mental and substance use disorders increased by 37.6% globally (Whiteford et al., 2013). This burden has a significant impact on the individual and has major social, human rights and economic consequences at country level as well (Bloom et al., 2011; Levinson et

al., 2010; WHO, 2015a). It has been predicted that over the next two decades mental illness will account for the largest proportion (35%) of global economic losses from non-communicable diseases (Bloom et al., 2011), with an estimated $16.3 million cumulative global loss of economic output between 2011 and 2030 (World Economic Forum, 2011).

1.3 Mental health and psychosocial distress affecting children and young people

Serious and persistent mental illness and developmental delay affect all populations and roughly 20% of children and adolescents globally (WHO, 2016). Psychosocial distress – which can lead to suicide, substance use, and poor educational outcomes – disproportionately affects vulnerable populations, including 'members of households living in poverty, people with chronic health conditions, infants and children exposed to maltreatment and neglect, adolescents first exposed to substance use, minority groups, indigenous populations, older people, people experiencing discrimination and human rights violations, lesbian, gay, bisexual, and transgender persons, prisoners, and people exposed to conflict, natural disasters or other humanitarian emergencies' (WHO, 2015c: 7). Children and adolescents are particularly vulnerable – 10%-20% of children and adolescents have been found to experience psychosocial problems (Kieling et al., 2011). Indeed, suicide rates are increasing; young people are now the group at highest risk of suicide in one-third of all countries, both developed and developing (WHO, 2007). In fact, suicide is a leading cause of death among young people in China and India (Patel et al., 2007). Apart from mortality, mental health problems have other negative consequences

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2.   See Samuels, et. al. 2016 for a full literature review.

for young people, such as lower educational achievement, substance abuse, violence, and poor reproductive and sexual health.

The cause of mental illness and psychosocial distress in children and young people is multifactorial with several identified contributory biological, psychological and social factors. Biological factors that are known to underlie serious mental illnesses (such as schizophrenia, developmental delays, and autism) and persistent mental illnesses (susceptibility to depression, anxiety, and paranoia) can include genetic background and brain abnormalities. Brain abnormalities may stem from abnormal brain growth and underconnectivity among brain regions, brain injury (prenatal or post-birth), and exposure to toxins, such as lead. Social factors include rapid social change, migration, social isolation, unemployment and poverty, increasing social pressures to perform well, peer pressure, individual and family crises, changes in traditional values and conflict with parents (Patel et al., 2007; WHO, 2010). Physical health and nutrition problems, maternal depression and lack of psychosocial stimulation, caregiver loss, deficiencies in the psychosocial environment, exposure to toxins, violence and conflict, migration or forced displacement, gender inequality, abuse and neglect have also been identified as causes of mental health problems (Kieling et al., 2011).

1.4 Mental health treatment and psychosocial support responses

Over the past 25 years, treatments for mental disorders in young people have improved. Several forms of psychosocial interventions that focus on the individual, family or group have also been shown to have encouraging results (Patel et al., 2007). For instance, various school-based programmes to

prevent mental health problems as a result of psychosocial causes have had positive outcomes (Kieling et al., 2011). Similarly, there has been growth in community based psychological support that complements psychiatric services, including medication (Bragin, 2014).

Many of these improvements are focused on developed nations, while mental illnesses are largely neglected, or even ignored in many developing countries (WHO, 2001b). Moreover, issues around mental health illnesses are absent from the Millennium Development Goals (MDGs) and other development-related health agendas (Samman & Rodriguez-Takeuchi, 2013). For adolescents in developing countries, mental health needs are neglected and unmet as a result of poor government mental health policy, inadequate funding, a shortage of professionals, the low capacity of non-specialist health workers and the stigma attached to mental illness (Patel et al., 2007; Kieling et al., 2011). For both medical treatments and psychosocial care, governments spend on average less than $2 per person annually and less than$0.25 per person in low-income countries on mental health care, and the majority of funds is allocated to psychiatric hospitals and institutionalised care (Whiteford et al., 2013; WHO, 2011). As a result, WHO estimates that over 75% of the global burden of disability due to depressive disorders occurs in developing countries (WHO, 2008). There is, however, a significant gap in the knowledge base concerning children's mental health despite the fact that almost 9 out of 10 children live in LMIC (Kieling and Rohde, 2012).

With rapid economic changes, psychosocial factors are leading to high burdens of disease and mental health conditions (Dzator, 2013), so the need to focus on mental health has became more urgent.

Thus, the Sustainable Development Goals (SDGs) declared the need to strengthen mental health by promoting "physical and mental health and well-being…for all" (Paragraph 26) with specific mental health goals in targets 3.4, 3.5, and 3.8[3]. In Southeast Asia, the World Health Organization (WHO) has begun to collect data on youth mental health – especially as a result of psychosocial factors – in countries such as Thailand, Sri Lanka, and India (WHO, 2005), but there is limited information on child and adolescent mental health in Viet Nam. Moreover, while suicide rates in the 15-19 age group is higher for males than females (e.g., in Kazakhstan, Russian Federation, Belarus, Estonia, Ukraine to name a few). This is not the case in China and Sri Lanka (Wasserman et al., 2005), suggesting that the Southeast East Asian contexts need to be further examined.

1.5 Rapidly changing context of Viet Nam

Since the 1980s, there have been vast economic changes in Southeast Asia, and Viet Nam has transformed from a socialist economy to a market economy over the past 40 years. This has resulted in, amongst other things, an annual gross domestic product (GDP) growth of approximately 7.4% between 1991 and 2009 (Giang, 2010). Viet Nam's rapid poverty reduction is recognized globally; current indicators suggest that only about

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3. From SDG paragraph 26: "3.4 – By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. 3.5 – Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. 3.8 – Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

11.3% of the population is below the poverty line, and there is a primary school enrolment rate of 100% (Databank, 2016). However, similar to other LMICs that are rapidly developing, Viet Nam's transformation appears to have been limited largely to physical infrastructure directly connected to economic development while sectors aimed at social development such as health have garnered relatively little attention (Stern, 1998). Moreover, economic reform coupled with widespread social change has put increasing pressure on families, which has contributed to emotional distress in a context that lacks social infrastructure support. This is quite similar to other fast developing nations, such as China, where 'Rapid social and economic change has been associated with a loss of social stability, and with it a rise of depression and suicidality' (Blum et al., 2012, pp. s37). Similarly, the overall neglect of the health sector has included lack of care for children and adolescents suffering from mental and neurological disorders and developmental delays.

Finally, with the increasing pressure of uncontrolled urbanisation in a largely rural country and inadequate support for those in need of mental health services, mental health problems appear to be on the rise.

Moreover, despite the social and economic progress made as a result of the Doi Moi programme[4], there remain large disparities in access to social and health services among different geographical regions and income groups (Dang, 2010; Vuong et al., 2011). Dang (2010) notes, for instance, that as a result of commercialising healthcare, those in poverty and of ethnic minority status have limited access quality health

care. Children and adolescents are yet another vulnerable group, and since 23% of Viet Nam's population is under the age of 15 (World Bank 2013), there is an urgency to understand the needs mental health and psychosocial support needs of this population.

1.6 Conceptual framings

To situate and present our findings, we adopt a socio-ecological framework which explores factors at different levels of the social ecology – individual, family/household, school, community, institutional – and the ways in which they interact and contribute to both drivers or risk factors of mental health and psychosocial well-being as well as protective factors. Given the focus is on children and young people, they are placed at the centre of the framework surrounded by a range of influences that affect their individual mental health and psychosocial wellbeing including and ranging from their education status, their relationship with their parents and peers, their body image, their access to modern technology and social media and the extent of their support networks as well as other coping strategies (both positive and negative). Individual mental health and psychosocial wellbeing is also influenced by the family or household level dynamics and status, the next level of the socio-ecological framework. Variables here might include the economic status of the household, the extent of parental control, relationships between parents and intra-household dynamics and tensions. Given that schools settings play a central role in the lives of children and young people, this is the next level up or tier when exploring both risk and protective facts for the mental health and psychosocial wellbeing of children and young people. Variables affecting children and young people are likely to include the school environment, relationships with

teachers and peers, and academic pressure. The next tier up is that of the broader community; at this level factors such social norms related to for instance early marriage, as well as income-generation opportunities for men and women and the broader environment are all likely to play a role in effecting the mental health and psychosocial wellbeing being of children and young people (chapter 4).

The next tier is conceptualised as the institutional level which includes both the service environment and provisions (chapters 5 and 6) as well as the policy and legal environment and frameworks (chapter 7). These can also be seen as the institutions, structures or routes through which national-level resources and priorities for addressing mental health and psychosocial wellbeing are refracted. Thus formal institutions include policy, legal and justice frameworks for addressing mental health and psychosocial wellbeing as well as formal service provision through government and NGO. Informal service providers or institutions may include family support or traditional or faith healers. All these institutions will also affect the mental health and psychosocial wellbeing of children and young people.

Finally, all these tiers are located within broader national and global contexts. At national level, country priorities, national level allocation of resources, as well as national and regional contextual factors (e.g. population dynamics, migration, climate change, etc.) may all affect the ways in which mental health and psychosocial wellbeing-related laws and policies are prioritised and then operationalised in national agendas. Global-level conventions and policies as well as donor attitudes and investments in responding to mental health and psychosocial wellbeing also are likely to play an important role in fostering an enabling

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4.   The name given to the economic reforms initiated in Viet Nam in 1986 with the goal of creating a socialist-oriented market economy.

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environment. This latter dimension, however, was not explored in this study and would be interesting to explore further in a separate study distress in a context that lacks social infrastructure support. This is quite similar to other fast developing nations, such as China, where 'Rapid social and economic change has been associated with a loss of social stability, and with it a rise of depression and suicidality' (Blum et al., 2012, pp. s37). Similarly, the to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. overall neglect of the health sector has included lack of care for children level, country priorities, national level allocation of resources, as well as national and regional contextual factors (e.g. population dynamics, migration, climate change, etc.) may all affect

the ways in which mental health and psychosocial wellbeing-related laws and policies are prioritised and then operationalised in national agendas. Global-level conventions and policies as well as donor attitudes and investments in responding to mental health and psychosocial wellbeing also are likely to play an important role in fostering an enabling environment. This latter dimension, however, was not explored in this study and would be interesting to explore further in a separate study.

Methodology

The study consisted of two stages: the first was a review of secondary materials, the second entailed primary data collection in a number of sites in Viet Nam.

2.1 Secondary data review

The aim of the literature review was twofold: i) to provide an overall picture of the situation and causes of mental health issues, including suicide, focusing on children and young people in Viet Nam and ii) to inform the preparation for the primary data collection and analysis, including identifying information gaps. Further details of the methodology used for the literature review can be found in Samuels et al, 2018. The first step of the literature review, conducted between January and February 2016, was to develop a clear search protocol that identified research questions, inclusion/exclusion criteria, appropriate databases, combinations of search strings to retrieve articles, and a key informant interview protocol. A combination of key words on topics related to our review that were used in different combinations of AND/OR/NOT in the database search function was also drafted. Keywords included: psychiatry, mental health, mental illness, mental disorder, psychosocial wellbeing/ill-being, mental disorders diagnosed in childhood, mental retardation, ADHD, anxiety disorder, posttraumatic stress disorder (PTSD), depression, mood disorder, suicide, substance abuse, personality disorders, stress, maternal depression, paternal depression, bullying, peer pressure, services, clinics, programmes, interventions, trials.

Specific research questions guiding the review, and which were also derived from the original proposal, are outlined below:

- What is the prevalence of mental health and psychosocial problems, including suicide among Vietnamese children, adolescents, and youth?

- Which factors in the Vietnamese context place children, adolescents, and youth at-risk and which factors act as protective factors for mental health and psychosocial problems, including suicide?

- What laws and policies exist around mental health and psychosocial wellbeing in Viet Nam?

- What kind of mental health and psychosocial service provisions and programmes exist for children, adolescents, and youth in Viet Nam?

Databases searched included: EBSCO, MEDLINE, PubMed, psycINFO, Social Sciences Index, Proquest, and JSTOR. Sources for reviews included peer reviewed journal articles and books, policy documentation from government and international agencies, and grey literature (including NGO, government reports and evaluations). For peer- reviewed journal articles, we also conducted a search in journals that were identified by experts in the field to be most relevant and credible to the topic. In addition, a search for articles was conducted on websites relevant to the topic. Finally, we interviewed (through Skype or email), eight experts in the field, to seek their opinion on seminal resources on mental health, both globally and in Viet Nam.

2.2 Primary data collection

To complement and triangulate findings from the literature review, and to address possible information gaps, primary qualitative data collection was carried out in selected provinces and cities in Viet Nam between March and June of 2016.

2.2.1 Site selection and description

The selection of sites was carried out in close consultation with the UNICEF Viet Nam team. Broad site selection criteria included: i) the importance of obtaining both an urban and rural perspective, given that there are likely to be differing risk factors in these areas and arguably, as the literature also shows, higher risk factors (e.g. substance abuse, unemployment, violence) in urban areas; ii) the importance of ensuring that the north and south of Viet Nam and their unique features are captured; and iii) the need to ensure a selection of areas where *a priori* there appeared to be relatively high levels of mental health issues or risk factors and/or where there are high levels of poverty, which, based on our previous work in Viet Nam, tends to translate into high levels of stress, anxiety, and other mental health risk factors (Jones et al., 2014; 2015).

With the above broad criteria in mind, it was decided to first focus on the two largest urban centres in Viet Nam: Hanoi and Ho Chi Minh City (HCMC) and then to select a northern and southern province – Dien Bien and An Giang, respectively. In both of these provinces, again in order to get a rural and urban/peri-urban dimension, interviews in the provincial capitals of each province took place (Dien Bien Phu city in Dien Bien and Long Xuyen city in An Giang) as well as interviews in the rural areas (Keo Lom in Dien Bien and Phu My town in a rural district of An Giang).

Hanoi, the capital of Viet Nam, has its own particular situation given the government presence. According to the 2014 mid-term population census (Ministry of Planning and Investment (General statistics Office), 2015), the city's total population is just over 7 million, divided amongst 12 urban districts, 17 rural districts, and 1 town, for an average population density of 2,126/km2. Hanoi has a high number of public health facilities and the non-public health facilities are also well-established, including international hospitals. In recent years, considerable investments have been made in healthcare, including medical equipment and the construction of hi-tech medical areas. Over the last decade or so, citizens, including vulnerable children and social welfare beneficiaries, have been enjoying better access to medical services. However, the healthcare needs of people are still greater than the capacity of the hospitals, resulting in frequent overloading of these facilities.

HCMC in the south, is culturally distinct from Hanoi and more ethnically diverse given very high rates of internal in-migration. The largest city in Viet Nam in terms of both population size and growth, its nearly 8 million residents are divided among 19 urban districts and 5 rural districts, for a population density of 3,796/km2 (ibid). HCMC is the key economic, financial, commercial and service centre of the country, its GDP comprising one-third of that of the whole nation. It is also the nucleus of the southern economic area – one of the three largest economic areas of Viet Nam – and an important driver behind socioeconomic development in the south and the country as a whole. Regarding healthcare, large investments in healthcare infrastructure and modern often hi-tech medical equipment have been made. Private healthcare services are also increasingly being developed in HCMC.

Dien Bien is a mountainous province in the Northwest region of Viet Nam. The only province in the country that shares borders with both China and Laos, Dien Bien's total population is divided into 10 district-level administrative units, including one city (Dien Bien Phu), 1 district-level town and 8 rural districts, with a total number of 112 wards and communes and commune-level towns. Presently, Dien Bien is home to 21 different ethnic groups, of which Thai people make up the majority (about 42.2%), followed by H'mong (27.2%), Kinh (19%) and Kho Mu (3.9%)(ibid).

Keo Lom commune in Dien Bien Dong district (one of the country's poorest districts) was chosen as the rural site in Dien Bien Province. Keo Lom commune has 25 villages, with 6,378 persons living in 1,210 households. The four main ethnicities include Hmong (59%), Kho-Mu (20%), Thai (20%) and Kinh (1%). The distance from the commune centre to the most remote village is 20 km, with many villages only accessible by car in the dry season. Services are limited and the poverty rate was 77.3% in 2015 (ibid). In the commune, there is one health station, one ethnic minority secondary boarding school, two primary schools, two kindergartens and a number of satellite primary schools and kindergartens in remote villages.

Most children manage to complete secondary education, but some still drop out due to family financial constraints or lack of motivation. While child marriage has started to decline in the past few years, it remains a common practice. The commune has a high rate of drug users and also recorded the highest number of child and youth suicide cases in Dien Bien Dong, a district known as a hotspot of child suicide in the province. According to the commune health station's data, there were 40 suicide cases between 2007-2015, including 35 Hmong, 3 Thai and 1 Kho Mu. Four out of these 40 cases

were older people who committed suicide by hanging themselves or taking pesticides; the remaining victims were aged 24 or younger and took poisonous "heartbreak" leaves. Annex 1 contains suicide data from Dien Bien Province, including at district and commune levels.

An Giang in the Mekong Delta region of Viet Nam, shares a border with Cambodia, and is the 4th largest province in terms of geographical area with a total population of 2,155,381 persons and a density of 609 people/km^2. An Giang has 9 rural districts, which are further subdivided into 156 communes and wards (including 120 communes, 20 wards and 16 commune-level towns). Long Xuyen city is the province's capital. The field study was carried out in Phu My town (one of the two commune-level towns of Phu Tan district). The town has 9 villages, with 5,617 households and a population of over 21,000 people. The majority of the population are followers of Hoa Hao Buddhism. The primary source of income is agriculture. The service sector remains underdeveloped. Due to agricultural mechanisation and limited farming land resources, many families have moved away, mostly to HCMC or Binh Duong to work in the industrial parks, or become masons or seasonal labourers (ibid).

2.2.2 Methods and respondent types

A range of qualitative data methods were used including In-depth interviews (IDIs), focus group discussions (FGDs), and key informant interviews (KIIs). Purposive sampling was used to ensure that the kinds of study respondents required to meet the overall study objectives were included in the sample. IDIs were carried with children and young people, mostly recruited through lower and upper secondary schools. FGDs were also carried out with children and young people, again mostly recruited

through schools, with some cases of attempted suicide and early marriage recruited through KIIs and snowballing; additionally, a number of FGDs with parents were undertaken at community level as well as with service providers. Finally KIIs were carried out with mental health and psychosocial service providers at central level and in the different provinces (psychiatrists, counsellors, mental health doctors); government officials from different line ministries (social welfare, health, education) at central level and in the provinces; and community level stakeholders (community leaders, village elders).

A total of 110 interviews were carried out and included 23 IDIs with children, 67 interviews with KIs and 20 FGDs (16 with children, 2 with parents, and 2 with officials). In terms of location, there are 57 participants in Hanoi, 40 participants in Ho Chi Minh City, 62 participants in Dien Bien province, and 51 participants in An Giang province (See Table 1).

Table 1: Respondent types and numbers by location

Location	IDIs	KIIs	FGDs	Total	Total of people
Hanoi	4	26	4	34	57
HCMC	4	14	4	22	40
Dien Bien Province					
Dien Bien Phu city	3	9	2	14	28
Keo Lom Commune	6	9	3	18	34
An Giang Province					
Long Xuyen City	2	5	1	8	14
Phu My Town	4	4	6	14	37
Total	**23**	**67**	**20**	**110**	**210**

As mentioned above, 23 IDIs along with 16 group discussions were held with children. The total number of children included in the qualitative study was 113, of which 39 were in the age group of 10-14, 69 in the age group of 15-17, and 4 were 18 years and above. In terms of gender, approximately equal numbers of boys and girls were interviewed: 56 girls and 57 boys (See Table 2).

Table 2: The age of children as the whole qualitative sample

Location	10-14 yrs	15-17 yrs	18-29 yrs	No of girls	No of boys	Total
Hanoi	13	14	1	15	13	28
HCMC	12	13		10	16	26
Dien Bien	1	30	2	18	15	33
An Giang	13	12	1	13	13	26
Total	**39**	**69**	**4**	**56**	**57**	**113**

Interview guides were developed by the study team in a participatory manner, drawing on existing tools and best practice in this area, but also adapted to the Viet Nam context. The interview guides were also piloted and refined following this pilot.

In addition to undertaking the above interviews, rapid assessment tools were carried out with school children across all study sites. A total of 402 children across the different site took part in this assessment. In each site, the team selected children at two education levels – Secondary (age 11-14) and High school (age 15-17) - 46.3% of the children were in secondary school, and the rest, 53.7%, were in high school. Girls make up 60.2% and boys 39.8%. Figure 1 contains a detailed demographic characteristics of children included in the assessment.

Figure 1: Demographic characteristics of the children took part in assessment (N=402)
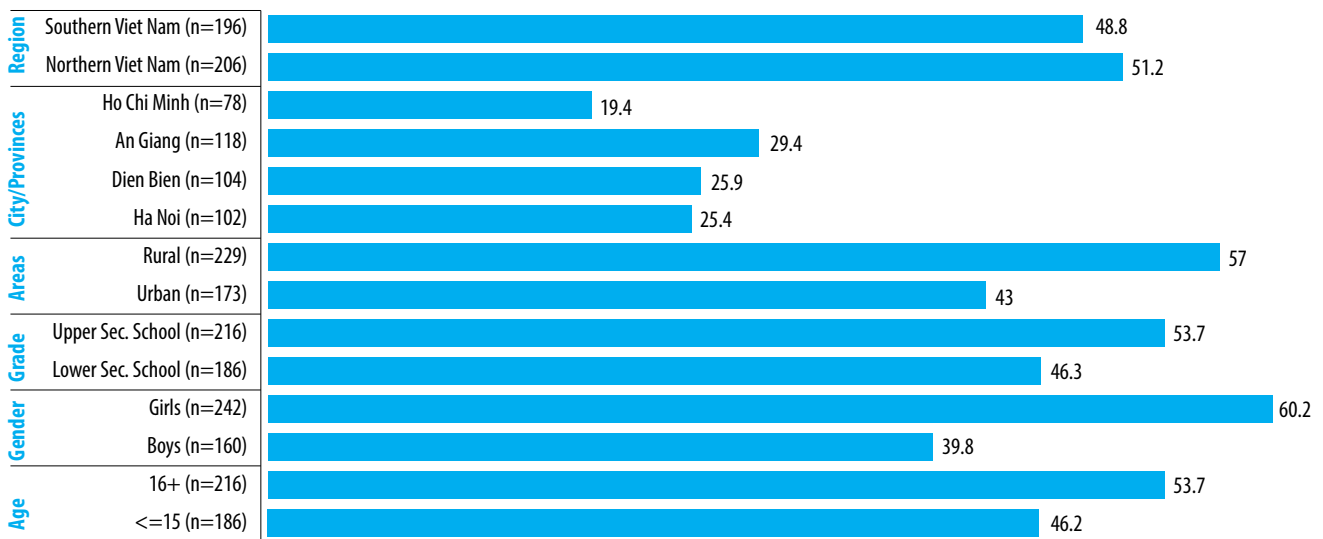
The aim of these tools was to obtain, in a fairly fast and efficient way, a relatively large number of responses from children on what they think about their own mental health and psychosocial wellbeing.

After consultation with a number of experts, it was decided to use two tools: the Strengths and Difficulties Questionnaire (SDQ) and the Self-Efficacy and Resilience tool. The SDQ had already been used in Viet Nam as part of the Young Lives Study,[5] and while the latter tool had not previously been used in Viet Nam (to the knowledge of the researchers), the content and ways of framing/ asking questions were deemed more appropriate for the study, its respondents, and the Vietnamese context than other tools. Both tools were reviewed for language related issues and some minor changes were made. According to respondents, the tools were easy to understand and complete. Box 2 below contains a summary of findings from these

scales and Annex 3 contains a detailed analysis of the findings.

2.2.3 Sample size

Table 1 below identifies the kinds of respondents and tools by site. As mentioned above, recruitment of respondents was carried out through schools, snowballing and KIIs. The large sample size was determined by a combination of resource parameters, the importance of triangulating findings across diverse informants as well as the principle of research saturation, i.e. reaching a point where no new insights were being garnered by additional interviews.

2.2.4 Analysis of qualitative data

After obtaining informed consent from research participants, all IDIs, KIIs and FGDs were recorded, transcribed and translated. When possible, two persons attended each interview which allowed for better debriefing and reflection after the end of each interview. A subset of the transcripts (both in local languages and translated) was also

read by the in-country study lead to ensure quality and consistency.

After the translation, a preliminary coding structure was developed based on the interview guides and emerging findings. Interviews were then coded using MAXQDA 12 software (a qualitative data analysis software package) following this preliminary coding structure, with additional sub-codes developed from the interviews as coding progressed Once all interviews were coded, the codes were reassessed based on emerging themes, the broader literature and the areas of interest for this study, after which several codes were grouped together and a set of meso-level codes were identified. Following this, the interviews were analysed by reading coded portions of interviews across participants.

For the first layer of analysis, we created groups of participants, that were based on a review of preliminary findings, areas where the researchers though interesting differences and similarities may emerge and in order to ensure that

5.

the study was reflecting context-specific issues emerging from the transcripts. Thus groups were created based on: age of respondent – 3 age categories were developed, also corresponding to schooling divisions, 11-14 (lower secondary school), 15-17 (upper secondary school) and 18+ (upper secondary school and beyond); gender of respondent – male or female; and location – rural (Keo Lom {Dien Bien}, Phu My town {An Giang}), semi urban (Dien Bien Phu city {Dien Bien}, Long Xuyen city {An Giang}) and urban (Hanoi and HCMC). For each group, all coded segments were analysed, paying particular attention to how patterns are emerging within each group. Wherever patterns pertaining to the above variables (age, gender and location) became apparent in the analysis they were highlighted and discussed. However, it should be noted that in many instances not a large amount of variation was found across these different variables. Counting the number of words related to a particular theme, in this case mental health and psychosocial wellbeing, is another approach to analyzing qualitative data. However, given that this language was not necessarily used by study respondents, developing the coding and sub-coding structure described above was a more appropriate and nuanced way of undertaking the analysis.

Unlike quantitative data, best practice in qualitative data advises that it is not appropriate to count number of responses to a certain topic or question. This is because qualitative data is not meant to be representative from the start so counting responses becomes irrelevant (see e.g. e.g. Bazley, P., 2004 and Abeyasekera, S., 2005)

2.3 Study limitations and ethics

Despite the step-by-step approach taken in the literature review, it has

some limitations. Due to limited research in the area of mental health in Viet Nam and the review's focus on the mental health challenges of Vietnamese children and young people, the pool of sources from which we could draw was relatively limited. Additionally, while we tried to ensure that our inclusion/exclusion criteria were neither too broad nor too rigid, we may have missed some grey literature that could add nuance to the trends that we discuss.

In terms of the primary data collection, we also faced a number of limitations. Firstly, given that we carried out fieldwork in selected locations in Viet Nam, findings from this study are not representative of the whole of Viet Nam, nor do they intend to be. Similarly, because qualitative methodologies were used, again, the aim of such approaches are not meant to be representative of an area, let alone a whole country. Findings are, nevertheless, valid and present an important perspective of the mental health and psychosocial environment particularly facing children and young people in present day Viet Nam.

Secondly, initially we wanted to carry out interviews with children and young people who had accessed/used mental health and psychosocial related services. Given the highly medicalised nature of this sector in Viet Nam, with mental health associated largely with severe mental disorders and severe developmental delays (or severe learning disabilities), and relatively little attention given to psychosocial distress, accessing the kinds of respondents we were interested in proved extremely difficult. As such, rather than be presented with young people with learning difficulties so severe they were unable to respond to our questions (as happened in one urban site), we widened our scope and sought support from teachers to

identify children that they thought exhibited unusual behaviour at school.

Additionally, given that our prior research had shown that early marriage caused much anxiety and stress particularly amongst girls and young women, we sought help from community level key informants to identify these cases.

Finally, given relatively high rates of suicide and the particular interest in this phenomenon in this study, key informants also helped us identify respondents who had attempted suicide. Clearly, the selection of all these respondents was influenced by biases of the person selecting and relied on their interpretation of 'unusual' behaviour, for instance. Nevertheless, we sought to lessen this potential bias through careful in Viet Nam and the review's focus on the mental health challenges probing during the interviews

As mentioned above, given the composition of the research team and the focus of the research, the aim was not to collect and identify different kinds, and particularly severe mental health disorders. Rather it was to explore the drivers as well as risks and protective factors of more common mental health disorders and psychosocial distress as well as the policy and service environment. As such, a full spectrum and details of mental health disorders is not provided here and would be the task for another study.

In the areas in which the study team was working, there were very few NGOs and other civil society organisations working on mental health and psychosocial wellbeing-related issues. As such, we are aware that we may be missing more information related to this sector. A further exploration of existing services provided by the NGO sector

would be an important addition to this study.

Finally, in terms of the terminology used to discuss the concept of mental health and psychosocial wellbeing in Viet Nam, it is important to note that existing studies on mental health in Viet Nam often cite the WHO definition when referring to the concept of mental health.

However, both in daily language and written materials, the exact Vietnamese wording of this term has not been agreed upon; it can be worded as *"suc khoe tam than"* (literally "mental health"), "suc khoe tinh than" (health of spirit/mind), or "suc khoe tam tri" (health of mind). Dang Hoang Minh et al. (2015) note that the terms "suc khoe tinh than" and "suc khoe tam than" are used interchangeably, though both refer to the same concept of "mental health" in English. They also argued that in the Vietnamese language, the word *"mental"* carries with it a lot of prejudice, because it is often associated with serious mental disorders such as schizophrenia and epilepsy. Therefore, psychologists tend to use the other wording, *"suc khoe tinh than"* (health of spirit/mind) in an attempt to soften the social biases towards mental health. Fieldwork interviews confirmed that the word "suc khoe tam than" ("mental health") suffered prejudice; as such, sometimes the research team had to use the expression *"suc khoe tinh than" (health of spirit/mind)* in conversations, so that the interviewees would feel more comfortable to share more information about their common mental health problems.

The research proposal and instruments were reviewed and approved by the ODI research ethics committee. The study was also cleared by the Institute for Family and Gender Studies ethics review board.

TRỰC CẤP CỨU TÂM THẦN

Magnitude and prevalence of mental health and psychosocial issues in Viet Nam

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In this section we start with a brief overview of findings from the literature review on the magnitude and prevalence of mental health and psychosocial issues in Viet Nam. We then turn to explore primary data findings in this area.

3.1 Findings from literature review

Findings from our literature review show that the prevalence of general mental health problems range from 8% to 29% for children and adolescents, with varying rates across provinces and by gender (Samuels, et al, 2016). A recent epidemiological survey of a nationally representative population from 10 of 63 provinces found that the overall level of child mental health problems was about 12%, suggesting that approximately more than 3 million children are in need of mental health services (Weiss et al 2014). These different rates can largely be explained by the different sample sizes, the different research approaches and different tools used

to collect the data. For further details of different study findings please see Samuels et al., 2018.

The most common type of mental health problem among children studied in Viet Nam is that of **internalising and externalizing problems.** Several studies have attempted to account for the magnitude of these problems in Viet Nam. In 1999, McKelvey et al., found that in a sample of 1,526 children living in two neighbourhoods of the Dong Da district in Hanoi, 5.3% of boys and 7.7% of girls aged 4 through 11, and 9.5% of boys and 10.1% of girls aged 12 -18 years scored in the clinical range suggesting that they had behavioural difficulties (i.e. on a composite score of the subscales Attention Problems, Rule-Breaking Behaviour, and Aggressive Behaviour). A few years later, using the Strengths and Difficulties Questionnaire, Anh et al., (2006) found that among high school students in Ho Chi Minh City, 16% were experiencing significant affective problems, and 24% behaviour problems. More recently, Nguyen et al., (2013b) found that in their sample of 1159 school going children, 23% of students reported anxiety symptoms at a clinically significant level. Female students had three times the odds of having anxiety symptoms as compared to male students. High levels of depression were also found. Measuring depression using the Centre for Epidemiology Studies Depression Scale (CES-D), they found that the prevalence of being in a category at risk for clinical depression (a CES-D score of ≥ 16) was approximately 41.1% (ibid.). Of these, 26% were identified as having elevated levels of depression. According to the Survey Assessment Vietnamese Youth (SAVY I), 32% of 14-25 year olds reported feeling sad about their life in general (MOH, 2005).). The results of SAVY II, conducted in 2009 indicated that 73.1% of those aged 14–25 had ever

felt sad, 27.6% had ever felt so sad or helpless that they stopped doing their usual activities, and 21.3% had ever felt really hopeless about their future (WHO, n.d.; MoH, WHO, and UNICEF, 2010). More recently, in their national representative study, Weiss et al., (2014) found that there were more cases of internalising problems such as anxiety and depression than externalising problems.

One determinant or driver of mental ill-health is that of **child maltreatment.** According to MICS data on over 11,000 households (GSO, 2011), 73.9% of children in Viet Nam aged 2–14 had experienced violent discipline, meaning they were subjected to at least one form of psychosocial or physical punishment by their parents/caregivers or other household members. Moreover, 55.4% of children were subjected to psychosocial aggression. Severe punishment of children is more common in rural areas, as well as in less educated, poorer and ethnic minority households. In a cross-sectional study of over 2,700 school children aged 13-17, 40% of the sample reported emotional abuse, 47.5% reported physical abuse, and 19.7% reported sexual abuse (Nguyen et al., 2009). Males were more likely than females to be classified as experiencing physical abuse as a child, while females reported more emotional abuse and physical or emotional neglect (ibid.). Several household characteristics are associated with lower likelihood of child maltreatment in Viet Nam, including an older mother, parents with more education, greater income, and fewer children (Trang and Duc, 2014). Other studies in Viet Nam found that among children, child maltreatment is associated with higher levels of sadness (Huong, 2009; MoH, 2005), anxiety, depression and low self-esteem (Le et al., 2009), suicide attempts and suicidal thoughts (Huong, 2009), and smoking and drinking (Huong, 2009).

An increasing concern with suicide among young people has given rise to research on the topic, including suicidal ideation, (thoughts about committing suicide) and suicide attempts. Compared to global suicide prevalence (9.1% of all deaths of young people across 90 countries) (Wasserman et al., 2005), Viet Nam's suicide rate is remarkably low. In a cross-country comparison among Vietnamese and Chinese adolescents, Blum et al.'s (2012) study of over 17,000 adolescents and young people found that the prevalence of suicidal ideation in the past 12 months was 2.3% in Hanoi (n = 6,191), the lowest in their sample compared to 8.1% in Shanghai (n = 6,212) and 17% (n = 4,706) in Taipei. Similarly, less than 1% of Vietnamese youth had attempted suicide, compared to 1.3% in Shanghai, and 6.9% in Taipei. SAVY I also found low rates of suicide in Viet Nam — approximately 3.4% of the respondents reported that they had contemplated suicide in 2003. Six years later, SAVY II documented a suicidal ideation rate of 4.1% of those aged 14–25 suicidal ideation. In 2009, Huong conducted a study on 2,737 students from Vietnamese public lower secondary schools and found that 6.1% of the sample had attempted suicide in the past 12 months.

Another common problem relates to **substance abuse**, which includes using drugs, abusing alcohol, and smoking, can also be a driver or a risk factor for mental ill-health and psychosocial distress. According to the Global Adult Tobacco Survey in Viet Nam (MOH, Hanoi Medical University, GSO, CDC, & WHO, 2010b), the prevalence of current users of any cigarette (i.e. manufactured and hand-rolled cigarettes) among respondents aged 15–24 was 11.9%. SAVY II found that 20.4% of respondents aged 14–25 had ever smoked tobacco (39.5% of men and 0.6% of women). With regards to risk behaviours, Viet Nam is very similar in many ways to other regional

neighbours, with higher rates of tobacco and alcohol use among men compared to women (Pham et al., 2010).

Though **co-morbidity** is not a risk factor by itself, the literature indicates that one form of mental illness may act as a risk factor for another. Thus, studies revealed that those feeling depressed and sad were also likely to report suicidal thoughts (Huong, 2009; Nguyen et al., 2013b; Thanh et al., 2006). With respect to suicide, alcohol and cigarette use was found to be a risk factor (Blum et al., 2012). Finally, studies identified co-morbidity between substance abuse and other disorders, especially depression (Huy et al., 2015; Kaljee et al., 2005; Tho et al., 2007).

Given our focus on psychosocial wellbeing as well as mental health, we also explored indicators related to it, one of which is **self-esteem**. While it is a commonly monitored indicator, there is relatively little information on this factor in Viet Nam; available literature is restricted largely to the SAVY data. Thus SAVY I assessed feelings of self-esteem by asking participants about their self-worth and optimism regarding the future (MoH et al., 2010a). The findings indicated that overall, young people have high positive self-assessments. On a scale of 1-5 the majority of the participants attained relatively high scores, averaging 3.5 across all groups, with a score of 3.4 for young people of ethnic minority. Over 94.7% felt they were valuable to their parents, 98.4% felt they had good qualities and 71.3% felt that they can help other people. SAVY II found similar trends, where on a scale of 1-5, the average score for self-esteem of youth was 2.76, with higher scores for older and more educated youth. There were also high levels of optimism found among the youth surveyed. Within the 14–17 age group, more than 70% agreed that they would like to have

their own happy family, a job that they liked, and the opportunity to do what they wanted, though only 54.6% agreed that they would have a good income.

It is important to note that overall, while the global literature highlights the importance of poverty, adversity, migration and family separation as causes of mental ill-being, these are not strong themes in the secondary literature on Viet Nam. Through our [primary data collection we try to draw more attention to these socio-economic factors (see particularly at the household level (see below). There are also likely to be a range of other factors which influence the mental health and psychosocial wellbeing of children and young people in Viet Nam including factors such as trafficking, sexual abuse and violence. These issues were not explored in the literature review since these are topics in themselves and worthy of a separate study. The primary data collection also did not focus directly on these issues, though some of these issues did emerge indirectly e.g. through stories of isolated young mothers being at the mercy of their husbands.

3.2 Findings from primary data

In this section we focus on the manifestations of mental health and psychosocial wellbeing by exploring the narratives of children and young people in our study sites. We start by providing a brief overview of perceptions around prevalence of mental health issues in the study sites; we then explore some of the terminology that people use when describing mostly others' mental health problems; and then turn to explore the kinds or manifestations of mental health and psychosocial wellbeing facing these children and young people. Box 2 gives a summary of findings from the SDQ and Self-efficacy scales.

Box 2 - Key Statistical Analysis Findings of SDQ and Self-Efficacy Scale Scores

Preliminary analyses from a sample of 402 children aged 12-17 from secondary and high schools have allowed the authors to reach a number of conclusions as follows:

In terms of mental health problems
Of the four domains of behavioural and emotional problems, this study recognised the rate of children scoring 'Abnormal' in the Emotional problems Scale stood at as high as 19.7%, and this Scale's mean score (4.34; SD = 2.32) is also the highest among all Scales and is more than twice as high as those in other Scales, which suggests that emotional problems are what children struggle with the most during adolescence..

The rate of children having conduct problems in this study also appears to be quite high. The percentage of children having 'Abnormal' scores is 7.5% in the Conduct problems Scale. On the contrary, the number of children scoring in the 'Abnormal' band in the Peer problems Scale made up 7%. Nevertheless, what is the most noteworthy about this survey sample is that the percentage of children having Borderline scores in the Peer problems Scale was 2-3 times as high as that in other Scales (30.6% as compared to 10-15% in other Scales). This indicates that a sizeable portion of the children were on the threshold of suffering difficulties in developing social relationships. The most common symptoms include getting angry and losing temper easily, and lack of self-control. The majority of the children in the survey sample showed problems or symptoms of hyperactivity. Very few of the children were confident that they possessed good attention, judgement and ability to analyse and complete tasks effectively.

The behavioural and emotional problems mentioned above differed according to the children's demographic and social characteristics. The children of the older age group and higher education level face more problems than those of the younger age group and lower education level; girls appeared to have more difficulties than boys. The girls faced more emotional problems than the boys, while in contrast, the boys have more peer problems than girls. Hyperactivity seems to be more of a problem among older children and in urban areas and big cities.

Concerning Prosocial behaviours, the majority of the children in the survey sample had positive social relationships (80.6% scoring in the 'Normal' band), while only 14.9% and 4.5% were in the 'Borderline' and 'Abnormal' bands, respectively. There are significant differences between children living in different areas. The Prosocial score is higher among children in rural areas than urban areas (7.15 versus 6.71), and higher in Dien Bien and An Giang provinces than the rest, and in the North than in the South

Children's self-efficacy and perceived self-efficacy
The children's perceived self-efficacy levels were on a scale of 0-10, showing that children's self-efficacy is relatively high, with a mean score of 6.66 (SD=2.23). Only 18.2% of the children have lower-than-average self-efficacy scores (0-4), 41% have average scores (5-7), and 40% have mean scores of 8-10. These numbers imply a fairly high level of self-efficacy among the children, both in unexpected/unforeseen situations and especially when actively facing difficult problems, although the number of children having good self-efficacy in coping with unexpected events is a bit lower. Particularly, in the face of difficulties and challenges, many of the children believed in their coping abilities. They could keep calm to solve the problems, and were confident in their own efforts and abilities to focus on pursuing and achieving their goals. When faced with unforeseen/unexpected situations, only about half of the children believed in their abilities to handle the problems that arose: 45.3% thought they 'could deal efficiently with unexpected events', and 53% believed that 'Thanks to my resourcefulness, I know how to handle unforeseen situations. Correlation analysis results found statistically significant differences between self-efficacy levels of children by sex, province and region. The boys seemed to have higher self-efficacy than the girls. Self-efficacy also appeared to be higher among children in urban areas than those in rural areas, and in the South than in the North.

3.2.1 Prevalence / increase / decrease of mental health and psychosocial wellbeing in the study sites

All KIIs agree that both psychosocial and mental health problems are widespread across Viet Nam and increasing, but challenges remain due to *'insufficient or no data on children'* (KII, DOLISA, Phu Tan District, An Giang). Yet the consensus is *"the rate of children in school and preschool having illnesses in this field has increased. It's more common in urban areas…maybe too much exposure to information technology such as the internet, games, and other elements in school, such as stress, also affects children. In rural areas, perhaps a factor that needs to be taken into consideration is the attention of parents to their children, with cases of neglect especially among Hmong people. The attention paid to children is still limited."* (KII, DOH, Dien Bien Phu city).

Other KIIs also state that children face the major burden of mental health problems, with different age groups facing different types of problems: *'The 6 years old or younger usually have developmental challenges, for example retardation, autism, hyperactivities or eating disorder or sleeping disorder. Or at the early schooling age, 6 years, 7 years or 8 years have the problem of hyperactivities, fear of studying, fear of going to school, anxiety disorder regarding separation from relatives. Teenage children's issues often relate to depression, anxiety, poor adaptation to the society, studying environment (the wider exposure, the more relationship they have), or behavioural disorder, resistance and learning bad habits. And they also have sex-related issues. Teenagers have such as issues as Facebook, social network, making friends online and idolization, the issues are diverse and numerous'* (KII, Paediatrics Hospital No 1, HCMC).

This same KI reports that he sees about *'250 patients a week; the number of men is a bit higher than the number of women, accounting for about 60%. The men often have such issues as autism, mental diseases, oppositional defiant disorder, and conduct disorder. Women mainly have anxiety disorder or depression'.*

The numbers of mental health patients vary across sites. However, as reporting does not differentiate between serious and persistent mental illness and the type of psychosocial ill-being discussed in our study, further work may be needed to get a more accurate baseline for the purpose of service provision. For instance, a KII with a member of staff of the Division of Social Protection and Poverty Reduction in An Giang described the number of cases of mental health problems as *'Very large. We've got more than 3,000 subjects in An Giang province, of which 10-20% are children – people under 16 years of age. The most obvious forms include schizophrenia and other mild symptoms. But through my visits in some local areas, I see that the risks to children's mental health are*

> **'Once in a while when we meet them, they say they're stable now. In some cases, they still come for medicine for maintenance'**
>
> **(KII, Psychiatric Hospital of Dien Bien, Dien Bien).**

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psychological shocks due to living situations and life stresses' (KII, Social Protection Division, DOLISA, Long Xuyen city, An Giang). Similarly, in Dien Bien, a KII with the Division of Social Protection of DOLISA indicated, '*At of the end 2015, there are 5,081 people with disabilities in the province, including 2,881 males and 2,200 females. The law on disability defines six types of disabilities: movement, communicating, hearing, low vision, mental health, cognitive and others. The mental health people with disabilities accounts for the biggest proportion of 1,019. The people with cognitive disabilities account for 510'* (KII, DOLISA, Dien Bien Phu city).

3.2.2 Ways of speaking about / defining mental health / perceptions of mental health

There was a range of different ways that respondents spoke about and described people with mental health difficulties. There did not appear to be a large variation in these definitions according to age, gender, or location. Thus people who were mentally ill were seen as 'unknowledgeable', others spoke about them as being 'negative', or 'their way of thinking is different', or they are seen as 'different' with some kind of 'disease', are an exception' and as being 'unstable'. In Dien Bien a KI from the psychiatric hospital mentioned that people use the concept of 'madness' or people 'wandering around' to describe those with mental health issues: '*Actually people have always called them "mad"; those don't know anything and keep wandering around, or walk around naked are called lunatics. As for those with minor problems, maybe people don't know; they just call them "abnormal"'* (KII, Psychiatric Hospital of Dien Bien, Dien Bien).

Children also used the word 'depression' as it is taught, according to girls in Dien Bien (FGD, F, 15, Dien Bien Phu city) in biology and citizenship education. Depression is

also mentioned in the newspapers and television, which is also the reason why children know this term: *'We hear about depression many times in newspapers and on television that some children confine themselves in their rooms and blame both parents of indifference. They are under psychological pressure, suffer depression, so they can't live in harmony with other people and confine themselves in their rooms'* (FGD, M, 17, An Giang).

There were differing responses concerning the extent to which stigma around mental health exists. In an FGD with 15-year-old boys in Dien Bien Phu City it was reported that 'some' people stigmatise those with mental health problems, but 'most people treat them normally'. In Hanoi, 16-year-old boys explain that those with mental health problems are viewed as 'having a disease', as the following narrative from a KII in Dien Bien also highlights: *'They are not discriminated against. Local people consider that they have a disease and report the case to the authorities. The special cases will be sent to get proper treatment. In 2014-2015, we've sent seven cases to Viet Tri psychiatric hospital'* (KII, Dolisa, Dien Bien). On the other hand, and also in Dien Bien, while people might not outwardly discriminate, a KI reports that people tend mostly to show indifference: *'So far, there is still a lack of sharing and empathy in the community's perception of mental patients. They don't discriminate against these people, but it's quite common to turn an indifferent eye or consider it something abnormal'* (DOH, Dien Bien Phu City , Dien Bien). In Hanoi, however, there was a relatively strong sense coming from KIIs that stigma was still present, and particularly in relation to substance abuse and game addicts as the following narrative shows: *'The community still keeps stigma toward substance addicts and game addicts, as well as people with mental health issues in general. People*

stigmatize, don't get close to them and discriminate. They don't speak much, but they tend to alienate and avoid.' Such stigma often results, as the same respondent states, in a reluctance to access services: *'In general, the community stigma constrains the children from coming to hospital. People often worship or consult a fortune-teller before consulting a doctor'* (Health Worker, National Hospital of Paediatrics, Hanoi).

Also brought out strongly in the narratives, particular amongst KIs was the fact that mental health issues are not well understood by a majority of people and that similarly, levels of awareness are dependent on educational levels, which are often linked also to place of residence and ethnic minority status:

'The public's awareness depends on their intellectual standards. If a family has children whose levels of education are mostly 12th grade or above, through their access to newspapers and radio and such, they will know if their children are having problems or not. But the rest, the majority of the population are poor families who have to struggle to make a living, so they mostly don't care about their children's mental health. The children are left to grow up on their own, especially among ethnic minorities. People rarely care about prevention of mental disorders; they just care about how to have good physical health' (KII, Social Protection Division- DOLISA, Long Xuyen city, An Giang).

'I think that people's awareness has been better. In fact, it should be divided into two groups, one of which lives in the urban area with a high education level. To this group, psychological issues need treatment. While the group in remote areas or who has a lower education level doesn't understand how diseases can be cured by using words' (KII, Paediatrics Hospital No 1, HCMC).

This lack of understanding can also lead people to fear as this narrative shows:

'A child with mental illness lives in the house opposite to mine. He has had the illness for about 10 years, I don't know if neighbours stigmatize or not, but they are scared of him. He is gentle much of the time, but sometimes when irritated he becomes so frightening. The person in my neighbourhood is an example. Several nights he holds the lamp and his neighbours have to stay awake to keep eyes on him. Then he chases after his grandmother and beats other family members. That's why people often feel scared of people with mental illnesses' (FGD, provincial officers, Long Xuyen city, An Giang).

Narratives around 'social evils' were heard amongst study respondents, often linked to discussions around substance abuse and addiction to internet games including gambling, which, as seen above, also have implications for mental health and psychosocial wellbeing as well as other anti-social behaviour such as stealing. *'Sometimes after they've sold their houses to play pool, they even steal from other people'* (Village Patriarch, Keo Lom commune, Dien Bien District). For most, the narrative about social evils was learnt at school via life skills education. A male respondent in Hanoi sums up what social evils are as follows: *'Acquiring bad habits from other people, like smoking, having ideas of dropping out of school or skipping class hours to play online games'* (FGD, M, 13, Hanoi). In Dien Bien Phu City an an FGD with girls notes that *'Gambling, drugs, drinking, theft, and domestic violence'* (FGD, F, 15, Dien Bien Phu City) are seen as social evils. There is a sense that more boys than girls are addicted to gaming: *'More boys are addicted to it (gaming), because boys are more eager to win. It means that they want to conquer everything, surpass everyone, so they embark in playing games. Games are seen as the only way to upgrade their virtual*

Box 3: Reasons/causes for suicidal ideation

.. because of problems in school
'Back then, I was often made fun of by a classmate; when they teased me, back then I was crying a lot. When I cried, they laughed, and so I felt self-pity and sad, so I didn't want to communicate with them much. When he teased me, I reacted by telling him off. But he kept teasing me. And so I kept feeling sad, and I cried. From the 5th grade, whenever he teased me, I avoided him completely. And so I felt really sad because I thought everyone was just like him; they all liked to bully me and so I had the suicidal thought.' (IDI, M, 16, Hanoi)

'Back when I was young, I always went to school on foot. I didn't have any vehicle; many of my friends are good friends, but some of them spoke ill of me, saying I was too poor. They said many things that annoyed me, and so I went home and asked my parents to buy me a bike. But my mom said our family couldn't afford it. And then I said many things, and then my parents also told me off. I was upset, saying "I'd rather die than be so miserable". Therefore, I took them (poisonous leaves). After taking them, I realized I was afraid of dying, so I told my parents and then they took me to the emergency room.' (IDI, M, 28, Keo Lom commune, Dien Bien)

'..Maybe they went to school and had problems with their friends, and so they took "heartbreak grass" leaves; their parents didn't know and it was already too late when they found out about it.' (FGD, F, 15, Dien Bien Phu city)

.. because of problems at home
'In my area, usually the children suffer a lot of family-related stresses, [such as] violent fathers, or parents divorced, so they feel there's no one to protect them; they feel lonely.' (FGD, F, 15, Dien Bien Phu city).

'In general, if he says something and I disagree with him, he will say, "If you don't like it, leave." Sometimes I think because I came to live with him, he doesn't respect me. And I'm not sure if I mean anything or if I am of any importance to him; after 1-2 sentences, he will say "just leave", and "such kind of person you are is nothing. I can just stand here and whistle, and they [women] will line up for me." I feel pity for myself, and then I think perhaps I'm like what he says. I came to live in his house, so that's perhaps why he doesn't respect me. I do have such thoughts. Sometimes I think I'm stuck with no way out, maybe I should just die. But I also think that if I were not here anymore, maybe my two children would suffer even more. If he married someone else, maybe he would have a wife, but my children wouldn't have a mother. Therefore I keep trying to live. I just hope that when he gets a bit older, he will change. Otherwise, if he doesn't change, I don't know what the future will be like.' (IDI, F, 18, Keo Lom commune, Dien Bien)

'..Another problem is that they committed suicide when they couldn't talk to (convince) their parents.' (FGD, F, 15, Dien Bien)

'The suicides mainly relate to the quarrels with family members and parent's addictedness. The second reason relates to love. Parents don't agree for their child to get married to this girl or boy, the child will attempt suicide' (KII, Hamlet Head, Keo Lom commune, Dien Bien)

.. because of love related problems
'In my area, many people in 8th or 9th grades committed suicide, mostly because of love-related problems, or their parents had many wives, their family members didn't get along, they didn't have a happy life, or any hope about the future, so they committed suicide.' (FGD, M, 15, Dien Bien)

'Many cases of suicide due to emotional issues from intimate relationships.' (FGD, F, 15, Dien Bien Phu city)

.. because of norms around expected masculine behaviour
'Another reason cited is masculine ideology around men being breadwinners that leads to financial pressure. Most men are under pressure from the responsibility to feed their wives and children, while in fact some are incapable of doing that.' (FGD, M, 17, An Giang)

.. because of reluctance to share feelings
'Local people say children should not act like that, that there are many ways to cope, that you should find a solution other than dying. You could have shared [your feelings] with other people. I think, in such a situation, when we felt too much pressure, if we shared [our feelings] with other people, we'd be afraid that they wouldn't believe us, and we'd feel that we would be no longer valued by the others around us.' (FGD, F, 15, Dien Bien Phu city)

characters, prove their class, instead of studying or doing something in reality' (FGD, M, 17, An Giang). Possible explanations could include more access, and the fact that culturally boys tend to have more free time, more autonomy and control over their lives.

The gendered pattern of gaming addiction was confirmed by a psychiatric doctor from Dien Bien:

'Gaming addicts are teenagers, and I have seen only boys.' He added, however, that lasting recovery is possible.

'Once in a while when we meet them, they say they're stable now. In some cases, they still come for medicine for maintenance' (KII, Psychiatric Hospital of Dien Bien, Dien Bien).

It was also noted in Dien Bien that whilst there has not been much change in either the types or prevalence of mental health issues, when it comes to games and substance abuse, there has been an increase: 'Since the hospital's establishment, I haven't seen many changes in this issue… (however) Children's addiction to [computer] games is tending to increase, and addiction to drugs, American weed, marijuana, in general addictive substances, is tending to increase as well. Actually, we've treated such cases here, but there are still a considerable number of patients out there who haven't been treated at the hospital' (KII, Psychiatric Hospital of Dien Bien, Dien Bien.

Though the overwhelming consensus was that those with mental health problems continue to be stigmatised, one KII in the psychiatric hospital in HCMC shares that approaches to care for those who are mentally ill are improving: 'The way of caring for mental patients nowadays has changed; they now bring patients back to their communities, to their families for

reintegration into society, instead of trying to put them into institutions like it used to be in the past, isolating them from society. When patients are successfully brought back into the community, the perceptions of mental illnesses become less serious. In the past, mental institutions just kept serious patients in there, so [people] only watched them from far away; they didn't dare go near because they were afraid. Now when mental patients can return to their families and local communities, and receive medicine from the local health staff, their images improve, which helps reduce discrimination' (KII, Psychiatric Hospital, HCMC).

3.2.3 Manifestations of mental health and psychosocial wellbeing

In keeping with the literature on mental health, in this section we present the narratives according to the following broad areas: psychological state of participants, cognitive disorders, emotional disorders, somatic complaints, behavioural disorders and substance abuse. Clearly, these disorders and complaints are not mutually inclusive, with many coexisting and one often resulting in another. Similarly, manifestations can also be risk factors, also further driving mental ill-health and psychosocial distress, as also discussed in section 4.

Starting with the **psychological state** of study participants, many of the feelings discussed under this broad category may clearly link to other disorders and complaints. Two main feelings were expressed by respondents: on the one hand, **optimism** largely in relation to the future, and on the other hand **sadness and worries**. Children of all ages, though perhaps particularly the younger age categories, had great optimism and aspirations for the future, summed up effectively in the following quote from an FGD

with girls in HCMC: 'I think that young people are strong, enthusiastic to work, they are creative, they follow their passion, they are dynamic at work; young people have much time and dare to think and dare to act, they have many big thoughts and big dreams' (FGD, F, 16, HCMC). Across all the sites, children spoke about wanting to become a maths teacher, a construction engineer, working in the medical field, a doctor, a sports coach, policeman and hairdresser. In the rural areas there was also a sense that the cities represent more opportunities and excitement as the following quote from a boy in Dien Bien shows: 'It's always more fun near the city, and children can enjoy a good educational environment and the living conditions are better' (IDI, M, 15, Keo Lom commune, Dien Bien). In the urban areas, children also stress the importance of studying for a good future, including further studies as the following quote from a boy in Hanoi shows: 'Maybe just like everyone else, I don't want a tough life in the future, I want to become a successful person, so I'm trying to study so that it will be easier for me in the university entrance exam, and I've also been learning about many things, so that when I make my way into society, I can familiarise myself better' (IDI, M, 16, Hanoi).

The flipside of this optimism was worry and sadness and general pessimism, with older children arguably mentioning this more than younger children, or being more quick to point out that despite optimism, worries were also often present. This can be explained by the fact that the older a child gets, and particularly girls, the more likely they are to have domestic responsibilities or experience early marriage, which may, amongst other things, interfere with schoolwork and negatively impact on their optimism and aspirations for the future. Moreover, for both boys and girls, the pressure of school work increases, making them question their abilities as a

student to be successful in the future (discussed in Section 4). The reasons for worry and sadness ranged from parents fighting, a family member being unwell, to performance in school, fear of dropping out of school, uncertainty about the future, and early marriage. For the older age group, particularly for girls, there was sadness and worries amongst those who had already dropped out of school and were married – they worried about their financially security and that of their child as well the marital discord they were facing with their husbands. Symptoms of this sadness and worry include stress, which leads to meal skipping, headaches and anger: '*When I'm angry, I often smash things*' (IDI, M ,16, Dien Bien). Another girl states that, '*I smash my phone if I am holding it*' (FGD, F, 17, An Giang). Another shares that when he gets angry, he '*Should keep calm. If I get angry, it's not good and [I can] inflict damage to myself*' (FGD, M, 16, Keo Lom commune, Dien Bien). Findings from an FGD in An Giang with girls suggest that respondents feel that girls and boys deal differently with anger. While boys may be more likely to turn their anger outward and '*beat something,*' they also seem to have more socially acceptable refuges from negative feelings, including '*games, football, or sport*' (FGD, F , 17, An Giang).

In terms of **cognitive disorders**, there was only one case of a mother of a child with a cognitive disorder in the study sample. She described the onset of her son's condition: '*At first, he was studying in Hanoi when he phoned me and said he felt something wrong in his body; he got goose bumps and felt shivering cold. Since then, he kept feeling anxious; he said he felt unwell. When he called, I was in Dien Bien so I couldn't visit him. Two days later, I went to see him and took him to hospital. He said there were voices in his head; he said there was someone who could read his thoughts and threatened him. Many people. He said many people jumped into his*

head and spoke to him.' After this, her son was hospitalised for 18 days and was diagnosed with 'acute psychosis disorder'.

Though there were no other cases of thought disorders, there were quite a few references to neurodevelopmental disorders such as autism, including by two 16-year-old respondents themselves (one boy and one girl in urban and semi-urban locations), who wondered whether they may be autistic. However, across all of these categories, it is unclear the extent to which respondents understand what it is, and there is a general sense that when someone is behaving differently or unusually, for instance not speaking much or engaging with other children, the common and current response is that '*they have autism*'. This was further emphasised during discussions with key informants — there seems to be a national push now to recognise autism as a mental health problem, though it's unclear whether this is a result of an increasing number of cases or whether this push comes from the fact that it is a relatively easily identifiable mental health disorder. Clearly, these reasons are not mutually exclusive. Furthermore, during the data collection period World Autism Awareness Week was celebrated, and the media picked up on this quite widely, all of which resulted in quite a few people speaking about it.

In another case, a child was taken to see a psychological doctor because he had struck his head and his mother was worried he had autism (cite); in another case a girl was taken to a psychiatrist because her mother had been worried that her '*living in silence without willingness to talk with anyone*' was a sign of autism (FGD, F, 17, An Giang). Finally, a girl in Dien Bien stated that her peers call her autistic because '*I often play with my phone in the classroom; I rarely talk to them. I'm very stubborn, and I don't*

listen to them' (IDI, F, 16, Dien Bien Phu city).

While **behavioural disorders** do not appear to be very common in our sample (only one boy's actions could perhaps be likened to him have behavioural problems, as he shared that he was pressured to 'make trouble' by '*ringing the doorbell, running away or sometimes by throwing a stone in a room where people are sitting and running away*' (IDI, M, 16, Long Xuyen city, An Giang), **emotional disorders,** under which depression and suicide fall, were much more prevalent. Generally, girls were perceived to be more susceptible to emotional problems (including suicide) than boys as the following two quotes from boys, one from Dien Bien and another from An Giang highlight:

Q: Do you think there are many other children around you who often face depression, stress and disappointment in life?

A: I see many are like that.

Q: Are there more boys or girls like that?

A: Both boys and girls.

Q: But who face such problems more often, boys or girls? A More girls. (IDI,M,16, Dien Bien Phu city).

A: "In terms of emotions, girls are more likely to get moved than boys" (FGD, M, 12, An Giang).

The way children and young people spoke about **suicide** appeared to vary according to age and gender. Thus while the younger age group (11-14) had heard of 'many' people who had attempted suicide, by the time they got to the next age group (15-17) there were several cases of suicidal ideation as noted in the exchanges below in An Giang and Dien Bien:

Q: Did you feel so disheartened that you no longer wanted to live? (noise)

A: I did in the past.

Q: What happened the last time?

A: That time people around me didn't listen to my idea, I felt angry, so I questioned myself, 'nobody listens to me. Does my life have any meaning?'(FGD, F, 17, Phu My town, An Giang)

Q: Did some people take "heartbreak grass" leaves to commit suicide?

A: Yes.

Q: Can you tell me about a case you know?

A: In my area, usually the children suffer a lot of family-related stresses, [such as] violent fathers, or divorced parents, so they feel there's no one to protect them; they feel lonely. They'll no longer have a goal to live' (FGD, F, 15, Dien Bien Phu city).

Amongst the older age groups, respondents reported having tried to commit suicide themselves (interviews were selected with this characteristic in mind). There was also a general perception from both girls and boys as well as key informants that it was mostly young people and girls who committed or who tried to commit suicide, as this quote from a boys' FGD in An Giang shows: *'There are more girls among those who commit suicide and do harm to their bodies like chopping their hands or confining themselves, as girls are more sensitive to their emotional issues. Their hearts are easy to be hurt, meanwhile boys are more steadfast and calmer when encountering a problem. So there are more girls in this group" (FGD, M, 17, An Giang).*

As a KII in Dien Bien states *'…children and young people account for a larger proportion (of suicides) because they are easy to have conflicts with their friends. It happens amongst girls*

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more than boys' (KII, DOLISA- Dien Bien Phu city). Other boys added that girls are more likely to commit suicide because of 'superficial thinking because they live in remote areas, they don't have much contact with the society' (FGD, M, 15, Dien Bien Phu city). And similarly, as the following narrative from an FGD with girls in Dien Bien shows:

Q: Those who committed suicide, were they boys or girls mostly?

A: Both boys and girls.

Q: Were there more boys or girls?

A: More girls.

A: I rarely hear about boys' cases.

Q: But girls tend to take poisonous leaves more often. Is it because of your traditional culture and practice, or why?

A: No. Maybe it's because boys don't share [their feelings] with their friends

as girls do. Girls share [their feelings] more often, because they're more sensitive, while boys don't want to share with other people; they only want to be stronger, to prove themselves, to show that they're men. (FGD, F, 15, Dien Bien Phu city).

The poisonous leaves, known also has 'heartbreak' or '**la ngon**' leaves, according to respondents, are abundant and are available to any age group as they grow in the forests in the surrounding areas:

*Q: How did you come to know about "**la ngon**" leaves?*

*A: Back when I was little, my parents took me with them when they went to work; I didn't know they were the "**la ngon**" leaves then. I pluck some to play, and then my parents said they were "**la ngon**" leaves; that was how I came to know about them.*

Q: Do they grow a lot around here? Are they easy to find?

A: Yes, a lot. (IDI, M, 28, Keo Lom commune, Dien Bien)

Reasons for suicidal ideation and attempted suicide include failure of romantic relationships (e.g. being abandoned/discarded usually by a boyfriend), marital discord, problems at school (including bullying, teasing and getting low scores), problems at home (e.g. being scolded by parents, lack of communication with parents, parents disagreeing with choice of marriage partner, early marriage also leading to school drop-out, conflict between parents, a violent father, financial pressure and parental addiction), and reluctance to share feelings. For boys, reasons also include not being able to live up to expected masculine attributes and behaviour, including an ability to maintain the family/household (see also Box 2). All this leads to young people feeling sad, upset and frustrated, which in turn leads them to attempt and sometimes

even succeed in taking their own lives. Moving beyond these more immediate reasons/causes of suicide and suicide attempts, respondents spoke about lack of knowledge and awareness, as stated by 15-year-old boys in Dien Bien Phu city, and 'shallow thinking' (FGD, M, 17, An Giang) as possibly being an underlying cause of this ideation.

Interviews with key informants added a further dimension to this — according to their perceptions, ethnicity was also a possible driver of suicide, with the Hmong in particular being seen as haughty and proud and thus easily tempted into suicidal actions. The availability nearby of poisonous leaves, particularly for the Hmong in Dien Bien, facilitated the process of committing suicide. The following narrative from a KII in Dien Bien captures both the perception of the Hmong people as being more prone to suicide than other ethnic groups as well as the issue of the

availability of poisonous leaves: *'Not all the ethnic minority groups are the same. It occurs only with the Hmong people. I haven't got the report of other ethnic minority groups. Hmong people have a bad custom of eating **la ngon** [poisonous] leaves to kill themselves. It happens a lot in Dien Bien Dong. The reason relates to the superiority complex of Hmong people. When a child has an urgent matter with classmates or disagrees with their parents, he or she is easy to commit suicide. And, it is also convenient to do so because there are plenty of poisonous leaves in the area. Only one or two leaves can kill a person. Only if someone knows about it, the child [who eats poisonous leaves] is cured in time. In Dien Bien Dong, there have been campaigns to root up poisonous plants, but it has yet to be done'.* (KII, DOLISA, Dien Bien Phu city).

Somatic complaints were mentioned by many respondents, irrespective of gender, age and

'There is also a kind of e-cigarette costing 60,000 dong (approximately £2). Some children here use designer drugs which also affect their mental health. They inhale glue, the 'dog' glue (a brand of glue), which is used to fix rubber tires but it smells like banana extract. Now the children inhale deep into their lungs'

(FGD, Parents, An Giang).

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location. These consisted largely of headaches, though loss of appetite, poor sleep and nightmares were also mentioned. These somatic complaints are also mentioned by a psychologist in the Paediatrics Hospital in HCMC who shares that '*A group we see here, which is quite important is children with physical disorders, in simpler words, pains – for example, belly pains, headaches, or arm or leg pain… basically pain in some part of the body, which can't usually be explained by physical examination – I mean they can't be explained medically, or there is not enough evidence of a disease, but usually there are associated psychological problems.*'

According to respondents, reasons for these headaches were largely related to the stress associated with academic pressure (school tests, bad marks), but also, particularly for girls, as a result of stress from having to do housework. These headaches were relieved through playing with friends (for the younger children) and through taking painkillers (the older children / young people) as seen in the following exchanges.

Q: Do you often have headaches? A Yes.

Q: Do you take any medication for your headaches?

A: Yes, I do, but it only reduces them a little bit. I've been having headaches lately.

Q: When are the headaches the most serious?

A: When there are tests; 15-minute or 45 minute tests. Q Since when have you had the headaches?

A: Only when I have to study too much. (IDI, F, 16, Dien Bien Phu city)

Q: Do you ever have a headache?

A: Yes.

Q: When do you feel headaches? A When I do a lot of tasks.

Q: What do you do when you have a headache?

A: Relax.

Q: How do you relax?

A: I call some friends to my house to play. Playing with them, I feel better. (IDI, F, 13, An Giang)

Substance abuse – alcohol, smoking and drugs – was mentioned by many respondents in our study, and was largely associated with boys, young men and husbands, though largely in the rural and semi-urban areas. In An Giang, parents report a dangerous trend among teenagers that involves smoking drugs: *'The children are smoking USA grass, which is aromatic and tasty, so several children can't recognize their parents. When their parents talk to them, they ask "Who are you?". Such things seriously affect the children's mental health in An Giang.'*

'There is also a kind of e-cigarette costing 60,000 dong (approximately £2). Some children here use designer drugs which also affect their mental health. They inhale glue, the 'dog' glue (a brand of glue), which is used to fix rubber tires but it smells like banana extract. Now the children inhale deep into their lungs' (FGD, Parents, An Giang).

According to respondents, substance abuse results from, on the one hand, peer pressure to 'drink to forget their troubles' or from sadness (also because of failed love relationships) or feeling pressure from society. The following quote from an FGD with girls in Dien Bien sums up the reasons why men predominantly drink: *'(Men drink to) forget their troubles, when they are having fun or when they have guests, when they're sad about their family, when they can't talk to anyone; or lovelorn or when the family breaks up'* (FGD, F, 15, Dien Bien Phu

city). Similarly, as a young man in An Giang recounts more in relation to drugs: *'I think that sadness leads them to look for the substance to relieve their sadness. After the substance has stopped working, they feel sad again, so they begin to use it as an instrument to relieve their sadness, they get used to the habit; and regularly using it, they become addicted to it unintentionally. There are many causes for it. A child may follow someone's example to become classy, "Hey, you can do it, I can do it, too." It is a normal thing'* (IDI, M, 17, An Giang).

Substance abuse can also lead to violence, with husbands seen to be '*shouting and swearing nonsense*' at their wives as well as children (IDI, F, 18, Dien Bien), while another girl in Hanoi recounts a story of a father who got drunk throwing a tray at his daughter when she made a mistake: *'When I was in the 9th grade, there was a girl who was living in the same village as mine. She was a child of a family who were doing ok (financially), but in the family, she got scolded all the time by her parents and then her boyfriend broke up with her. Once I heard that she went to buy tofu, while her father had told her to buy alcohol. When she came home with the tofu, her father threw a whole tray of food onto her face. After that, she didn't want to live anymore, and bought a bottle of pesticide and killed herself. The next day, her friends attended her funeral'* (IDI, F, 18, Hanoi).

Another consequence of substance abuse was early marriage *'According to the Government, men get married at 20 years old and women can get married at 18 years old, [but] this is not the case for children of parents who are addicted to drugs, where daughters often get married at 13-14 years old and sons get married at 16-17 years old' (KII, Hamlet Head, Keo Lom commune, Dien Bien).*

CHAPTER 4

Risk and protective factors for mental health issues and psychosocial distress amongst children, and young people in Viet Nam

Following our review of the secondary literature, which highlights that psychosocial dimensions have received the least attention in terms of research and practice in the Vietnamese context, and also reflecting our fieldwork methodologies, we focus primarily on the largely neglected psychosocial issues facing children and young people.We acknowledge that additional data collection on more serious neurological-related mental health disorders would require a more specialized and resource-intensive data collection approach. In each of the following sub-section we firstly present findings from the secondary data, followed by findings from the primary data. It should be noted that findings from the secondary and primary data do not necessarily mirror each other. Similarly, the analysis of the primary data can only be based on information received from study respondents.

4. 1 Individual level risk and protective factors

A number of variables at the individual level were identified in the literature on Viet Nam as being either risk or protective factors for mental health and psychosocial ill-being. For instance, being **female, living in urban areas, and being of ethnic minority status** was a risk factor for internalising emotional problems (Chan & Parker, 2004), externalising problems (McKelvey's 1999; Stratton et al., 2014), suicide (Blum et. al., 2012; Huong, 2009; Thanh et al., 2005), and substance abuse (Diep et al., 2013). **Age** effects were also found: being older acted as a protective factor for externalising symptoms, suicide and substance abuse, while conduct problems and hyperactivity scores decreased with age, suggesting a possible maturation effect (Stratton et al., 2014). Similarly, being younger was a risk factor for suicide, as according

to SAVY results, younger cohorts were more likely to report suicidal ideation.

Even though being **a migrant** itself is a risk factor, there were no studies that found links between migration and internalising symptoms or substance abuse. Migrant status emerged as a risk factor however, in Blum et al's (2012) work for suicide. Youth in rural areas who had never migrated reported a lower likelihood of suicidal ideation compared with urban natives in Hanoi in Blum's study of 6,000 adolescents and youth**.** Having **more family income** was a protective factor and associated with decreased likelihood of probable mental health problems for internalising symptoms (Amstadter et al., 2011). For externalising symptoms, in Weiss and colleagues' (Weiss et.al 2014) study of children aged 6-16, higher family income and **more parent education** acted as risk factors for both parent reported and adolescent reported attention/hyperactivity problems. With respect to suicide, in a study of 200 girls, Le (2009) found that parents' education level and occupation are associated with children's suicide behaviour. The majority of children (approximately 79%) who have thought of suicide live in families in which parents have low levels of education.

4.1.1 Individual level risk factors of mental and/or psychosocial ill-being

Three main individual risk factors emerged for young people from the primary data, with some age and gender-specific variations. It is important to note at this stage, that risk factors and manifestations are not mutually exclusive: manifestations can become drivers or risk factors for mental ill-health and psychosocial distress, and often it is unclear what came first. Arguably, however, the order is not so significant, what is more important is that they exist. Thus,

according to study respondents, emotional isolation was an important source of risk (though it, along with the other risk factors described here, can also be a manifestation of psychosocial distress). A number of children reported choosing not to share their feelings with anyone, preferring '*not to look for anyone*', especially with respect to sharing family issues or troubles with friends or extended family members. This is true even in situations where children are upset as a result of conflicts at home such that the child who was crying after being scolded but did not want to share his feelings with his grandmother (IDI, M, 13, An Giang).

In other cases, the desire to not share stems from wanting to protect parents from worrying about the child. This seemed to be particularly the case with mid-adolescents in our sample where a number of respondents noted that they intentionally isolate themselves when dealing with sadness or distress. For instance one boy stated: *'I just like to be by myself; I like keeping [my feelings] to myself'* (IDI, M, 15, Keo Lom commune, Dien Bien). Another boy who was bullied felt suicidal and refused to share his sadness with anyone, choosing to sit in a closet in his home to dream an *'Imagined world where everyone loved me and no one bullied me'* (IDI, M, 16, Hanoi). 'Self-isolation' was particularly prevalent among respondents in HCMC who commonly noted that they felt their distress emotions were too private to share with others. One mid-adolescent child noted: *'I am a bit isolated from the outside world, because I find it difficult to communicate'* (IDI, M, 17, HCMC), and another confided that he felt '*abandoned*' when his friend left town (FGD, M, 16, Hanoi).

For older adolescents, and especially girls, feelings of social isolation result because of marriage at an early age (and while the legal age

of marriage in Viet Nam is 18 for girl and 20 for boythe reality in places such as Dien Bien, is that girls marry earlier). A number of girls noted that their husbands do not allow them to return back to their natal homes to meet with their parents or to meet others socially, suspecting their wives of possible infidelity. As a result they lack a trusted confidant to whom they can turn. As one young wife explained, *'When I'm sad, I often go somewhere to sit alone. I'll feel more comfortable when I'm by myself'* (IDI, F, 22, Keo Lom commune, Dien Bien). Another described her situation as follows: *'I have no friends. If I go somewhere, I only visit my parents; I don't visit my neighbours often. If I go to them too much, they will say I'm an annoying woman. Up there they don't like people who wander about everywhere, so it's best not to go'* (IDI, F, 18, Keo Lom commune, Dien Bien). The desire to have someone to talk to is there, although she lacks social networks: *'If there was someone I could talk to, I would feel relieved. But there is nobody…because my parents don't have the rights to talk to him [her husband]. Because in our ethnic tradition, once I'm gone (married), the husband's family have more rights'* (IDI, F, 18, Keo Lom commune, Dien Bien). Substance abuse can further exacerbate this situation as husbands may emotionally and physically abuse their wives when under the influence of alcohol. Other girls in this age group also attributed their social isolation to dropping out of school against their choice and/or to the burden of domestic responsibilities. One young woman noted that in her *'free time'* she sows the field, plants vegetables, and waters and tends the crops – if she doesn't her husband *'scolds'* her (IDI, F, 18, Keo Lom commune, Dien Bien).

While the sense of isolation for older married girls was most acute, girls in this age bracket more generally put a strong emphasis on lack of social

connectedness as the root of their psychological illbeing. *'Overall I just stay silent, I don't dare say anything. I also cry, but overall, I just try to finish the work, and then go up to my room and sit alone in silence, feeling sad, and lying in bed crying; I don't know what else to do* (IDI, F, 19, Hanoi).'. Similar patterns of isolation and feelings of depression were also highlighted among respondents in Dien Bien. *'Pressures from other people around make that person feel that he/she is not cared about, that he/she is isolated, as if he/she has fallen into a world where he/she is all alone'* (FGD, F, 15, Dien Bien Phu city). Some girls also reported that they were unable to sleep well if they are sad.

A second driver of psychological ill-being is linked to **access to modern technology and the risks of addictive online behaviours**. There is a consensus among respondents that access to modern technology poses a threat to wellbeing since children tend to *'use it too much'*. In fact, one KII with a director of a mental health hospital likens game addition to drug addiction, stating that both are a serious form of addiction. As one 15-year-old girl in HCMC describes, *'It is the era of internet. The majority of children entertain themselves on the internet more than going out'.*

Other respondents also recognise the dangers of the internet and suggest that parent monitoring can keep a child from 'falling into traps' of the 'social network', but others emphasised that there is a gaming addiction in the community. Almost everyone who can 'afford it' owns a smartphone according to an FGD with 15-year-old girls in Dien Bien Phu city, and children find ways to use the internet even though the school 'forbids it'. This FGD also reveals that there is a need for more music (and sports events in the community which only take place

during Tet: *'They don't have a ground to play sports, and because their families mostly work in agriculture, there's no time for children or people my age, or older people; they have to work in the fields; and in the evening, they don't have much time either, so they have fewer chances to play. And music and sports events are not organized, either. Only during Tet holidays are music and sports event held'* (FGD, F, 15, Dien Bien Phu city).

Overall, boys tend to spend more time online, playing games in the internet shops and their sadness is attributed to losing games online. *'They [boys] are different from us [girls]. They go to the internet shops and so on'* (IDI, F, 13, Long Xuyen city, An Giang). In some cases, children emphasised that online games were their only way to interact with peers: *'As no one is around to talk, so I have the only way of playing game, I mean the electronic game. It makes me more dependent on the phone and computer'* (IDI, M, 17, HCMC). Another explained: *'It takes about 30 minutes of playing games online'* to forget their *'feelings of sadness'* (FGD, M, 13, Hanoi). Indeed, in many of the interviews, children do not report being interested in other leisure activities, stating that they *'rarely go out with my friends. I just stay at home and do my homework, or watch TV'* (IDI, F, 12, HCMC). Part of the problem is also attributable to limited leisure time infrastructure for children. Sometimes children are also hindered in their pursuit of non-online leisure activities by the fact that their friends live far and they are unable to afford the financial cost required to travel.

Over time, this focus on online games also appears to have negative spill-over effects on scholastic achievement as highlighted by this quote from a young adolescent girl in HCMC: *'There's a student who sits next to me; he's a little bit addicted to*

computer games, but he doesn't look tired; he still looks normal, but his performance in school has declined' (IDI, F, 12, HCMC). This propensity towards addiction is not helped by the fact that, *'Even though the game shop owner signed a commitment to close at 9 PM, in fact it is not closed until 11 PM or 12 AM because game players are still there, it means that they wait until the last player leaves to close'* (FGD, M, 17, An Giang).

Gender differences also emerged: respondents stated that boys are more likely to play computer games than girls: *'More boys are addicted to it, because boys are more eager to win'* (FGD, M, 17, An Giang). However, girls are at risk from cyber bullying and stalking. Negative comments on Facebook from peers or unwanted messages on Zalo (a messaging application) from unidentified cyberbullies can make adolescent girls feel angry and sad. One 12-year-old girl in Hanoi explained her experience as follows: *'I was playing on my phone when suddenly a message was sent to my number, and I replied. At first I was having a proper conversation, but suddenly he asked me about other stuff. I didn't like it, and told [him] to stop sending messages to me; it was bothering me; but that person kept sending me messages. And then I was afraid my mom would find out, so I deleted all those conversations, and then I asked my friend if there was a way to block that person. My friend said yes, that I should click the "Block" button on Zalo to block [him]. And so I've managed to block [him]'* (IDI, F, 12, HCMC).

A third key factor that emerged from our interviews related to **negative perceptions of adolescent physical appearance.** Some of these concerns were related to poor self-image and in other cases they were externally triggered by peers and/or adults. These concerns began in early adolescence, especially among girls who were perceived to be overweight, and in relation to fears

about menstruation. One 12-year-old girl in HCMC, for example, reported that her parents asked her to *'eat less'* because she is *'too fat'*. Others in Dien Bien lamented that they could be teased for being *'fat as a pig'* (FGD, F, 14, Dien Bien). A mid-adolescent boy also explicitly linked over-eating to feelings of sadness. He explained that he was called *'fat'* by his peers and that although he wants to improve his physical appearance he *'eats not only to fill stomach, but also to drive sadness out of my heart'*. Similarly, fear around being fat is compounded with fears of being bullied: *'Fear that friends say that I am as fat as a pig'* (FGD, F, 14, Keo Lom commune, Dien Bien). Other physical concerns revolved around being too short, which leads to teasing, name calling such as 'dwarf' and discrimination in school sports activities. Boys were also teased for being physically weak, as the following narrative from a boy in An Giang highlights:

Q: What are negative features about yourself? A I am not handsome. Like a pan cake.

Q: What do you mean by "a pan cake"?

A: I am not as strong as other boys. (IDI, M, 16, An Giang).

Another boy focused more on his lack of confidence in front of a group: *'When I speak or stand up in front of a crowd, I often feel that my body temperature rises, and then my face becomes red, and I feel very shy. I have that many times'* (IDI, M, 16, Dien Bien). Finally, several girls mentioned fears around menstruation with girls worrying that they will stain their trousers. However, in a focus group discussion, one 12-year-old girl in An Giang stated that she was not afraid of *'red light days'* since her mother *'bought books and newspapers to read'* and gives her advice on menstruation.

4.1.2 Individual level coping strategies

Young people in our sample identified a range of both positive and negative coping strategies when they are suffering from mental and psychosocial ill-being (whether it be related to self-image, lack of social connectivity, or due to the addictive properties of online activities). The first key protective factor mentioned was **active participation in leisure activities,** e.g. sports such as swimming or football, martial arts, reading, or watching movies. A 16-year-old girl in An Giang, for example, highlighted that martial arts gave them *'joy'* and *'better spirit'*. A 16-year-old boy noted feeling *'very happy when they score a goal in football'* (IDI, M, 16, An Giang). A 13-year-old girl explicitly stated that she engages in activities to feel better:

Q: When you feel upset, where do you often go to forget about it?

A: First, I'll go on the internet and maybe play [online] games, or when I'm too angry, I can do physical exercises, really tough ones. I'm not much into the habit of throwing objects, because I find it costly and it's also a nuisance to clean up. Now when I exercise, it helps me not only release my stresses but also build good health and a better body, so when I'm too angry, or when I play, when I feel too excited, like hyperactive, I'll also do exercises, or play shuttlecock kicking, or do something that is highly physically active. I find it quite difficult to sit still in such situations' (IDI, F, 13, Hanoi).

Others also mentioned joining school clubs or trips (e.g. to the botanical garden, zoo, gardening) or keeping a diary about their day-to-day activities and emotions. Some children also emphasised their proactive use of technology to find support – for instance, reading articles on the internet to help learn how to deal with feelings of sadness

or anger, watching entertaining videos or reading stories on 'science and technology' to relieve stress, and connecting with friends on Facebook. ('*Q: Where did you find information related to mental health? Where can you find it if you want? A It is available on the internet*' {FGD, F, 16, HCMC}). Using cell phones to call parents when feeling sad or lonely at boarding school was also another commonly cited coping strategy.

A second critical protective factor against psychosocial ill-being was **having or being part of a social network.** The importance of having friends was noted across all interviews, irrespective of gender. Children turn to friends to share 'happy and sad things', to 'forget' feelings of sadness that result from family conflict or from teacher-student conflict and to confide concerns about puberty and relationships. In fact, most children believe that 'having friends' is what makes them happy in life. Some choose to confide in their friends about their troubles, believing that their friends 'understand' them. In one case, a 13-year-old girl in An Giang felt that her stress headaches go away when she plays with her friends (quote in Section 3). Among the mid-adolescent age group, irrespective of location, friends were seen as pivotal to psychosocial wellbeing: '*I am happiest when I have my friends around, right now*' (IDI, M, 16, An Giang). '*If we lose our friends, we're done*' (FGD, M, 16, Hanoi). And indeed children were quite conscious of what a dearth of friends could mean in terms of dealing with psychosocial stress: '*Those who can't confide in anybody, they often look for quiet places to cry alone. After crying, they stand up and pretend to be happy, despite their pain and sadness*' (FGD, F, 13, Hanoi).

Interestingly, children were aware that online forms of support could have their limitations. One child explicitly stated that sharing with friends is '*more practical*' and '*faster*' than sharing on Facebook (FGD, M, 16, Hanoi). Children also explained that they share feelings on Facebook but do not post 'big issues or problems', choosing instead to seek out advice from friends or teachers instead (FGD, F, 16, HCMC). Similarly, students also noted that they preferred to talk to people their own age about concerns rather than send an anonymous letter to the school's mailbox, which is a channel to solicit advice from an adult counsellor or teacher.

Among the 18+ age group, there were fewer examples of young people feeling that they could turn to friends and relatives. Girls in particular noted that they do not share family issues directly, but instead '*Just talk in a vague way, just to make people care, and see how they will explain to me. I just collect [advice], but later I will think about what is the best thing to do*' (IDI, F, 18, Hanoi). Girls also talk to their family members such as mothers and older siblings, but are often cautious about showing their parents their sadness so as to not provoke parental worry. However, one girl who had attempted suicide because her parents made her drop out of school was saved because she told her friend that she had eaten poisonous leaves. '*She visited me, saying "I heard that you're very sad, right?", and so I cried, and told her that I had taken "la ngon" leaves already, and so my parents took me to the emergency room*' (IDI, F, 22, Dien Bien). Another male states that he turns to his friends both to discuss future plans and when he is angry since his friends '*comfort*' him and he feels '*happy again*'. '*Even if I'm very angry, I will just go with my friends; they are close to me and so they comfort me; after a while I will feel happy again and go back to my family. I let the past be the past*' (IDI, M, 28, Keo Lom commune, Dien Bien).

There were also several examples of children having **good role models** to follow, although this was more commonly cited by boys. These are generally adults they know — older brothers, teachers, uncles — who have qualities that they admire and who have been good to them: '*It was partly my own initiative, and partly because of my older brother. He was ahead of me, so I've observed him*' (IDI, M, 16, Hanoi). Another looked up to his uncle for support and advice: '*My uncle, because everyone respects him. He's nice to everyone. He often helps other people; he loves his family*' (IDI, M, 16, Dien Bien Phu city). A man in his 20s similarly noted: '*Some older men in the village; their economic situations are ok, enough to feed themselves, and they can talk (well-spoken) so that we can follow their examples*' (IDI, M, 28, Keo Lom commune, Dien Bien).

Not all responses to periods of stress or sadness were positive and included a number of negative coping strategies which could also further fuel psychosocial distress. A number of children highlighted **crying alone** to release their feelings. One child feels that he is unable to share his feelings with anyone and 'goes to sleep' when he is sad because '*My parents are busy all day. My relatives go to work. No one is available. My friends I don't trust*' (IDI, M, 17, HCMC). There were also considerable mentions of **substance abuse**, especially drinking alcohol, as a negative coping mechanism for some young people. '*One way to deal with "troubles" is to drink alcohol, though boys tend to drink more than girls. On the other hand, girls tend to take poisonous leaves more often because girls are "more sensitive*' (FGD, F, 15, Dien Bien Phu city). FGDs also highlighted that substance abuse was more likely to be part of the coping repertoire in less well-off households, while children from better-off families tended to opt for online gaming as it requires relatively more resources.

Another negative coping strategy mentioned several times was **vandalism**. A number of child respondents reported smashing things in anger. For example, one child from Hanoi explained that *'Many times, I can't confide delicate issues in my family in friends or parents or teachers, I will destroy my belongings'* (FGD, F, 13, Hanoi).

At the more extreme end of negative coping repertoires of young people was **suicidal ideation**. This appeared to be most commonly mentioned in Dien Bien and in relation to pressures around school drop-out and early marriage. FGDs highlighted that in Dien Bien girls who are pressured to drop-out and marry against their choice may even resort to suicide. In cases where it is against the girl's wish to marry, eating poisonous leaves becomes the alternate route: *'In my area, there was a family who forced their daughter to marry a man she didn't love. Therefore she sought death; she took "heartbreak grass" leaves but didn't die, because she was discovered and then taken to the emergency room'* (FGD, F, 15, USS, Dien Bien Phu city). One respondent also noted that there is a fear of '*being kidnapped*' into marriage in the area and recounted a story of a 16-year-old girl who was kidnapped and then committed suicide because she was so unhappy in her new marital home.

4.2 Household level risk and protective factors

The literature identifies a number of aspects at household level that are either risk or protective factors of mental health and psychosocial wellbeing. **Family living arrangements**, i.e. living outside the parents' home, was a risk factor for suicide (Blum et al., 2013; Nguyen et al., 2010) as well as for high levels of alcohol consumption (Diep et al., 2013). Moreover**,** indicators of **family conflict**, such as having

divorced parents, was a risk factor for both internalising symptoms and suicidal ideation (Nguyen, 2006), and **sibling conflict** was linked with increased alcohol consumption (Phuong et al., 2013). Having **a positive relationship** with parents emerged as a protective factor against internalising symptoms (Weiss et al., 2014), externalising symptoms (Weiss et al., 2014), and suicide (Blum et al., 2012; Phuong et al., 2013). For example, in their work with 972 school students, Phuong et al. (2013) found that father- bonding acted as a protective factor against thoughts about suicide for male and female students. Notably, female participants who did not receive emotional support at home had higher risk of suicidal ideation than those who sought emotional support from mother/father or brother/sister (ibid.). Further details and nuance to some of these findings are provided through the primary data collection carried out for this study.

Some factors, such as **family composition**, can be both a risk and a protective factor. For example, adolescents with higher numbers of siblings were more likely to suffer anxiety and somatic problems. For young children however, having more siblings was associated with fewer attention problems, aggressive behaviours, and fewer social problems (Weiss et al., 2014).

4.2.1 Household level factors

Three broad sets of factors at household level emerged from the primary data as putting children at risk of psychosocial ill-being – overly restrictive family rules (especially with regard to scholastic achievement and marriage), poor or declining household socio-economic status, and intra-household tensions – either between parents and/ or parents and children. In terms of **family rules**, younger children – especially girls in rural sites – emphasised that they faced high

expectations from parents in terms of carrying out domestic chores and caring for younger siblings and were afraid of being '*scolded*' by parents for not doing them adequately. In Dien Bien in particular, parents' rules around helping in the fields is normal and expected, as a hamlet head in Dien Bien noted: *'At the age of nine or ten, girls start working in the family fields. Boys at nine to ten often tend cows or buffalo. At 12-15 or 16 years old they start work in the fields.'* Other domestic responsibilities include *'Cleaning the dishes, sweeping the floor, feeding the chickens and pigs, and watering the vegetables'* (IDI, F, 12, Keo Lom commune, Dien Bien). Another girl from Hanoi noted that *'"Daughters have to do this work, daughters have to be good at doing housework, and sons are responsible for important work, so they don't have to do housework'* (FGD, F, 13, Hanoi). Girls report that they do not go outside with friends because they have to '*stay at home and do housework*' (IDI, F, 12, Keo Lom commune, Dien Bien). Another explained: *'Parents force me to stay at home, to look after younger siblings and not to go to school. After school I have to work on the farm. I have no way other than obeying. I am tired of working on the farm, as it is far from home'* (FGD, F, 14, Keo Lom commune, Dien Bien). In fact, even some boys were subjected to such family norms as noted: '*I'm afraid of not fulfilling my duties as an older brother in my family, not being able to look after my younger siblings'* (FGD, M, 12 An Giang).

As discussed further in the section on school-based factors, children are also fearful of parents criticising poor marks in school. In some instances, FGDs show that being scolded by parents for performing poorly in academics has led to suicide attempts.

For mid-adolescents when young people are increasingly trying to define an independent identity,

parental 'control' was seen as a key source of stress. *'They [young people] are under strict control of their families. It seems that extreme control deprives them of freedom to do what they want*" (FGD, M, 17, An Giang). There are several examples of children reporting that their parents do not allow them to go out with their friends, monitor their cell phone use, and make them do chores around the house. One girl responded that her parents are *'Often afraid of me going out with my friends, so they don't let me go out much'* (FGD, F, 15, Dien Bien Phu city). Another from Hanoi complained, *'Housework. For example, they make me climb up and clean spots that nobody sees. They make me clean them every week; or my mother, for example, I like things to be in a mess and to tidy them up later at the weekend, but my parents always require my study desk to be clean. It's the same at home; I clean the floor only once every two weeks, but my parents tell me to do it once a week, otherwise it will get dirty. And there are some other things, for example they even control what time I take a shower'* (FGD, M, 16, Hanoi). Family pressure to study and do well also means forgoing other hobbies as one girl passionately explained: *'There are some things that I want, but my family doesn't want me to do. It seems that they try to stuff me in a mould which I don't choose'* (FGD, F, 16, HCMC). This high level of monitoring was also observed in the case of a girl whose grandmother did not allow her to go alone to visit her mother who had migrated. A 16-year-old boy from Hanoi confided that he would like to run away from his parents as a result of this monitoring.

Interestingly, while part of this parental control was linked to concerns about their offspring's sexual and reproductive health, this was primarily directed towards daughters. The following exchange between a mid- adolescent boy and the interviewer highlight this point:

Q: Do your parents ever talk to you about reproductive health, for example about contraceptive methods? A: No.

Q: Never?

A: [They] only tell the girls.

A: My mother often talks to my older sister; she rarely talks to me [about it].

A: My parents don't talk [about it]; they only say that "whatever you do, you must know when to stop, otherwise etc."

A: Parents mostly just talk to daughters, such as my older sister. (FGD, M, 16, Hanoi)

Children, and especially girls, felt that their parents would disapprove of romantic relationships and thus refuse to tell them about any love interests. In extreme cases, children stated that girls who commit suicide may do so if their parents refused to let them marry their boyfriends.

However, parental monitoring of technology use – which was limited to urban areas – seemed to be less gendered. For instance, children state that parents *'pass by'* to see what the children are doing on Facebook. Similarly, with regards to cell phone use:

Q: Whose phone is under control of other people?

A: Mine.

A: My father used to do that, but now maybe my parents have realized that I'm already a grownup. In the past, they allowed me to use a phone, but forbade me to use a new password, and I must let [him] control it.

A: Keep the screen unlocked.

A: They even take the phone away from me at night, to prevent me from texting at night. They still do that now.

Q: Have you ever talked to your parents about what you want in using your phone?

A: Yes, because my phone is not a fancy one. I only use it for a number of purposes; it doesn't really affect anything. I also told my parents that I'm a grownup now, they shouldn't check [my phone] like that. My parents think I'm still a child. (FGD, M, 16, Hanoi)

For the older age group, there were fewer concerns expressed by boys, but older girls cited their domestic burden and care responsibilities as the most stressful. One 18-year-old girl in school in Hanoi, who takes care of her young siblings and cooks often gets reprimanded for making mistakes in her chores. For example, she says that if the food is not cooked properly, she gets scolded. As a result of her care responsibilities, she has had to miss school and even wrote a letter to the teacher herself explaining her challenges. Another pointed out quite emotionally that she would sacrifice her own school attendance out of responsibility towards her younger sisters who, without her, would be left home alone. *'I'm very sensitive in the sense that, honestly if my younger sisters stay at home and play by themselves, I won't feel at ease; I'm also worried, and so, for example, when I go to school, on the way to school, I'm just worried about them staying at home by themselves, so I'll just skip the class in the end; I don't want them to stay at home alone (getting emotional); my mother works at the market, so sometimes the teachers called and asked why I was absent from class, and so I said that I skipped the class because I had something to do at home; I stay at home to play with them; if I let them stay home by themselves, my mind is not at peace (Crying)'* (IDI, F, 18, Hanoi). Another girl shared that her mother did not allow her to continue her education because *'My mother said there was nobody to help her; as a daughter, I*

"

'In the last school year, 2014-2015, there was a girl who had been recognized as very good student for five consecutive years. When entering grade 6, her parents didn't agree to let her study in a lower secondary school in her residential area, they wanted her to go to a high quality school. Two days after entering the school, she killed herself by jumping off a high building. She left a few words in her notebook "Parents, I told you many times that I want to study with my friends." That's all, very simple. […]I see that parents still pay attention to their children, but their consideration makes the children study for parents, not for the children. Parents want their children to study in quality schools.'

KII, Child Care and Protection Division- DOLISA, HCMC

must help her, so I was very sad' (IDI, F, 22, Keo Lom commune, Dien Bien).

The second set of factors that emerged among respondents as key household-level factors related to **household socioeconomic status,** for a variety of reasons summed up in this quote in a KII FGD:

'Poor parents force their children to drop out of school to sell lottery tickets, work, cut grass for hire, work as masonry assistants against the children's will. Secondly, the children are not allowed to play or relax like other children, so they can't develop well psychologically, they may have to improvise actions, without foreseeing consequences of the actions. So the group of poor children is at high risk. Take for example, An Giang has 10,000 children in extremely difficult situations, the social protection officials say that many people in the group have mental health issues, but there is no concrete data' (KI FGD, Provincial officers, Long Xuyen city, An Giang).

For children in less well-off households, inadequate financial resources can **limit opportunities for socialising with peers**. For instance one early adolescent girl stated that she does not go out with her friends because 'It costs a lot of money and because my mother is attending a bachelor's degree course, which costs 10 million dongs each semester. I don't want my parents to spend more money' (IDI, F, 12, HCMC). Similarly, an older adolescent girl, already married, said that while she would have liked to travel outside her immediate environs, 'Firstly, it would cost money to go, and I would never earn enough money to do that. Secondly, when I ask him (husband) to let me go, he says "a woman should just stay at home, why wander about?", so I give up' (IDI, F, 18, Keo Lom commune, Dien Bien). Another girl only finds time to do her homework 'After she comes home from selling lottery tickets at 7pm' (IDI, F, 13, An

Giang). Education took a backseat for another girl who had to drop out to work in the fields: 'My parents said our family was poor, so no more school, but working in the fields instead' (IDI, F, 19, Keo Lom commune, Dien Bien). This girl attributes the reason for dropping out as financial stress on the family since it 'Is in a difficult situation and lacking in hands', adding that 'Many children drop out of school to help at home. Even if girls are able to attend school, financial constraints of the family make it difficult for them to access the resources needed to do well' (IDI, F, 19, Keo Lom commune, Dien Bien).

Even for children in well-to-do families, perceptions of household poverty were seen as a risk factor as one school psychologist pointed out, 'Last year for example, due to the economic downturn, a number of children come to us because their families have problems. They used to live in rich families which then broke, affecting the children. Or their parent's marriages are in trouble. I have just handled the case of a 6-year-old child whose parents are going to divorce. It is a clear trend.' (KII psychologist Hospital of Paediatrics' Hanoi). The link between inadequate financial resources and scholastic pressures was also made a number of times by both girls and boys, especially with children feeling stressed that, unlike their peers, they were unable to attend extra-tuition classes to bring up their grades in school. An older adolescent girl from Hanoi explained the situation as follows:

'I understand my family's situation, so I just study at school and asked my parents to allow me to attend extra classes in literature only in secondary school, and then [maths] in high school to prepare for the exams. Firstly, there are a lot of children in my family, and I'm the eldest daughter. Now if my mother goes out all day (for work), who will stay at home? In the past, our family worked as farmers, but now my family has only one sao

(360 m2) of farm, so we can't do much. In the past, we could rent one acre (3,600 m²), I mean it was a separate one-acre farm we rent from someone else, and the one-sao farm was a share of land given to my family by my grandparents. But one sao is not enough for us to make our living, so now sometimes I have to stay at home to help my family out. There are a lot of children in the family, and they all need money for their studies' (IDI, F, 18, Hanoi).

Another 12-year-old boy in HCMC stated that his parents do not have enough money to pay for extra classes and so he worries about his household financial situation, and in fact, reports that his parents fight over money. These sentiments were also echoed in FGDs in An Giang with boys whose financial constraints were linked with children's struggles to thrive in school:

Q: From your observation, if there are some students who often look sad and don't talk to others often, what makes them sad? What are their family situations like?

A: I think their family situations are a bit difficult.

Q: Is it difficult financially, or because their parents don't have time? A Financial difficulties. (FGD, M, 12, An Giang)

Several instances in which **parental migration** had a negative effect on children's mental health also emerged, with several KIs noting that children left behind are at risk for sadness. Parents migrated due to financial constraints on the family. Children report missing their parents and wanting to see them again, with sadness stemming from wanting to spend quality time with parents. Those from a '*difficult family situation*' (FGD, F, 15, Dien Bien Phu city) were thought of as most prone to sadness or depression in school. An FGD with parents in An Giang indicated that

parents who migrated were thought to be '*inattentive*' towards their children with '*grandparents often indulging the grandchildren too much and spoiling them*' (FGD, Parents, An Giang). Children also reported that they feel that they need their parents' advice and can only call them via phone, but also feel pressure to show that they are '*grown up and becoming independent*'. Another boy who lives with his grandparents in impoverished conditions worries that they will not be able to afford medication for his grandmother, and has skipped meals in his worry: '*I was worried about my grandma's health, so I didn't eat*' (IDI, M, 13, An Giang).

Looking longer-term to their futures, some children reported feeling high levels of stress because they were coming to terms with the fact that they would be unable to achieve their dream due to their *'family's financial situation'* or participate in activities due to the costs involved. One young man looking back on his adolescence and thwarted educational opportunities due to poverty still experiences psychological stress, which suggests that these mental pressures may persist over the life-course: '*I intended to continue my studies, but my family situation was too difficult; my parents didn't have money. Only if my family had been better off could I have continued studying. We didn't have enough money for me to continue*' (IDI, M, 28, Keo Lom commune, Dien Bien). Since the cycle of poverty did not break for this man, he continues to feel the psychological burden of being poor in adulthood: '*For example, I don't have anything, but sometimes, as I told you earlier, my friends ask me out while I don't have anything, my family is poor so I don't have anything (money) to go out with them, so I feel sad. I feel that I don't have any economic [resources]'* (IDI, M, 28, Keo Lom commune, Dien Bien). In many cases children felt that their parents chose a different career path for them than

the ones the children wanted for themselves. This is particularly the case for boys more than for girls as this FGD in Dien Bien highlights:

Q: Do social norms or parents' expectations put pressure on boys and girls differently?

A: Yes. Boys suffer more from the pressure for their career path. (FGD, F, 15, Dien Bien Phu city).

Another sixteen-year-old boy from Hanoi summarised the tension between parents and adolescents as follows: '*In my opinion, parents always want good things for their children, but those good things are not necessarily what the children want; moreover, children are under [parents'] control regarding their dreams as well as thoughts*' (FGD, M, 16, Hanoi). There was also lot of comparison with other '*successful*' family members. As a girls' FGD in An Giang emphasised:

'*Some children are forced to take too many extra classes and don't have time for social activities. I think that it causes too much pressure, making students feel disheartened. The pressure comes from an extended family full of good students and successful members. The child is incompetent, but he is put under pressure from those people and his family who wants him to make the same achievements. He is incompetent, so he is under much pressure*' (FGD, F, 17, An Giang)

Children also suggest that socioeconomic difficulties could be related to suicide in the future, as one adolescent male in An Giang stated: '*The majority of those who commit suicide and use substances are from poor families*' (FGD, M, 17, An Giang).

A third key household-level factor contributing to children's psychosocial ill-being is **household tension**. The overwhelming pattern was that of **family pressure on children to excel**

in school (see also school level risk factors and box on the right). Parents had high expectations of children and wanted them to attend university and get high marks in tests, 'scolding' them when they underperform. One child termed these expectations from parents as those who have the '*achievement disease*' (IDI, M, 13, Hanoi) and explains that '*When parents have high expectations and the children can't live up to them, they [children] feel very sad and depressed*'. Another 13-year-old girl in Hanoi states that her parents tell her that they will be 'ashamed' if she underperforms. In fact, children reported feeling scared and worried to share their marks with their parents if they got low scores.

'*When I get bad marks, I'm afraid my parents will tell me off*' (FGD, M, 12, An Giang)

'*If you get low scores, you can be punished, beaten*' (FGD, M, 13, Hanoi).

While most children reported that parents' expectations were equally high for both girls and boys, one child described that '*Some families don't expect much from their daughters. It's like they still have gender prejudice. [In such families,] Girls mostly can't do things that boys do. For example, in conservative families, they think that girls should only stay at home and do housework, while only boys can go to school, and do jobs, such as being a boss*' (IDI, M, 13, Hanoi).

Parents tended to compare children to other children but FGDs indicated that this '*Only hurts the child's self-esteem*' and 'makes the situation worse' (FGD, F, 13, Hanoi). For instance, one girl explained that her parents even involve her much younger sister to put emotional pressure on her, and as a result she has '*headaches when she has to study too much*' and when '*my parents keep calling me, telling me "you should try to study better," and then they give the phone to my younger sister, who*

is only three years old, and tell her to tell me "big sister, come on, bring your certificate of merit home"' (IDI, F, 16, Dien Bien Phu city). The stress from studies was causing her to think about dropping out: '*I do feel stressed. Sometimes I think maybe I won't go to school anymore; it would be better to stay home, because here I'm not close to my parents; and I'm doing poorly in school, so I'm not sure I can find a job after graduation*' (IDI, F, 16, Dien Bien Phu ity). Some children even reported being beaten by their parents when they failed to get good marks. In extreme cases, children stated that they had heard of cases of suicide when parents scolded the children about poor performance.

There was also a general feeling that **parents '***don't understand***' children** (FGD, M, 16, Keo Lom commune, Dien Bien). This was heightened by the fact that parents and children have many problems communicating with each other. '*There is difference between our thoughts and those of parents. There is conflict in conversation. For example, parents insist that they are absolutely right, meanwhile I have different idea which I think is good for me, but I can't argue with them*' (FGD, F, 17, An Giang). Children stated that reasons why parents and children often cannot communicate is being '*afraid*' of parents' high expectations of school performance, perceiving that the parents don't have enough time to talk to children, and feeling that parents always '*disagree*' with what children are saying. Being unable to talk about '*love affairs*' because of parents' opposition to them is another challenge. Accordingly, '*Unbearable words by parents*' were identified as a risk factor for suicide: '*There was a case in which the parents said a few scolding words, and then the child ran to the forest and took "heartbreak grass" leaves*' (FGD, M, 15, Dien Bien Phu city). While most cases pertained to girls and stories related to early marriage pressures, a few boys also discussed suicidal ideation.

Children were also scared when their **parents fight,** especially in the case of alcohol-fuelled fights. '*In my area, usually the children suffer a lot of family-related stresses, [such as] violent fathers, or parents divorced, so they feel there's no one to protect them; they feel lonely*' (FGD, F, 15, Dien Bien Phu city). Marital conflict between parents sometimes also spills over directly on children as well: '*For example when something happens in my family that makes my parents quarrel, I turn out to be the one that my parents scold the most*' (IDI, F, 19, Hanoi). Another child attributed stress he feels when his parents fight to the fact that if parents fought, there was a concern they could get divorced. '*I am worried that they would go too far with quarrelling and divorce. If they do so, I won't be able to live with one of them. I won't enjoy adequate care as I do before that*' (IDI, M, 12, HCMC). Concerns about child abuse within the household emerged most strongly in interviews in Dien Bien Phu city as this extract from a FGD with mid-adolescent girls highlights:

Q: Have you heard about a child being beaten up and then committing suicide?

A: Yes.

Q: Did it happen in your commune?

A: Yes.

Q: How many cases?

A: Many cases.

Q: Who abused them? Who caused the violence, their parents, or husbands?

A: Parents and husbands.

Q: Usually the father or the mother, or both?

A: Both. In some cases, the father is addicted and is sent to jail; the mother stays at home and finds another

lover so she doesn't love her children anymore. Or in some cases, the mother passed away, and then the father got a new wife, and the stepmother treats the children cruelly. In the village, a lot of children have very difficult situations; they live with their mother and stepfather, but the stepfather doesn't love them, and doesn't let them go to school, but forces them to stay home to work.

Q: Did someone commit suicide because of this reason?

A: Yes.

Q: How many cases like that have happened in recent years?

A: As for children [cases], must be 2-3 cases. As for married ones, must be 5-6 cases.

Q: How old were these 5-6 people?

A: Around 16-17 years old.

Q: What about the 2-3 cases of children?

A: From 10-15 years old. (FGD, F, 15, Dien Bien Phu city).

In several KIIs, divorce between parents emerged as a risk factor with school administrators reporting that children from divorced families were at higher risk for mental health problems: *'But the most worrisome thing is the children live in the families with divorced parents. Some divorced parents are not very responsible to their children, especially after they remarry, the children are abandoned and feel sad. I observe a number of school girls, they rarely smile in a school year. How can they smile when their life is such misery?'* (KII, Teacher, An Giang).

In the case of already married girls, **domestic violence with husbands** also emerged as a key source of stress. For example, one interviewee said that the husband *'does not beat her*

but slaps her face' once in a while (IDI, F, 18, Keo Lom commune, Dien Bien). Another young woman explained *'I'm very sad sometimes, because he never asks his wife what she thinks, or if she wants to go somewhere, or what she eats or what she does. I want to have someone to share [feelings] with, but he seems not to care, so I feel very sad sometimes'* (IDI, F, 18, Keo Lom commune, Dien Bien).

One cross-cutting factor across these family tensions was a **lack of communication between parents and children –** a factor that emerged from interviews with KIs as well. A host of reasons were stated: on the one hand parents were seen to not have the time to talk to their children (see quote in text box above). This was also explained by some KIs as being a result of the transition to a market economy, where parents, being faced with competitive work-related pressures, can lead them to neglect and leave their children unattended. This 'being left alone', combined with increasing access to social media (see above), can lead mental ill-health and psychosocial distress, including amongst children from richer families. Parents are also seen to be 'impatient' with children while on the other hand children's own schedules were often too busy leaving them no time to talk to their parents. Additionally, children worry that their parents will feel sad about the child's psychological state and therefore prefer not to share with them. Finally strict parental monitoring (see discussion above) was also a cause of family tensions.

There was also a sense that the dynamics of families was changing and largely as a result of the transitioning from a traditional family model (consisting often of different generations) to the nuclear family model in which often children and adolescents felt isolated and which in turn affected their mental health and psychosocial wellbeing. Girls in particular reported difficulty

'In the past, family members had dinner together, and spent time with each other; now the time for it has decreased. People are getting busier and the time spent with each other is less. The children are left watching television or playing ipad; adults spend less with the children to teach them the social skills. Some parents think that is it fine to let the children play alone or entrust someone else with the task of raising their children. Sometimes if you love your children too much or overprotect them, the children will be slow to become self- reliant or unable to interact with the outside world. Parents solve the children's problems, so they can't learn problem solving. It is one of the risks of psychological and mental disorders,'

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> **'In practice, the curriculum of our education system is too much. For instance, students have to study the whole day at school and go to extra classes in the evening until 10 PM. That makes students too tired but they still have to stay up late to complete homework.'**
>
> **KII, Teacher of USS, HCMC**

in communicating with their parents; girls in an FGD in Hanoi explained that a '*generational gap*' is to blame for communication problems (FGD, F, 17, Hanoi) One girl emphasised that she cannot communicate with her mother: '*It's very hard to talk to my mother. If I'm to make comments about her, my mother is a difficult person, hard to talk to. If she's not pleased about something, she will shout and swear, very scary, I won't want to talk to her anymore. And now my mother works in the market all day, and she brings home with her the affairs at the market, and words that are not very nice, and so I don't want to talk to her about anything*' (IDI, F, 18, Hanoi). Other children emphasise the importance of parents spending time with their children to avoid communication breakdowns:

'*I think, now, to make the family members understand one another better, I think, firstly [parents] should only work from Monday to Friday, those who work as employees, they just need to work from Monday to Friday, and spend time for family on Saturdays and Sundays. Now if they're too absorbed in their work, they won't know how their children are doing, what they need and what they're thinking*' (IDI, F, 18, Hanoi).

Similarly, another boy confides:

'*What makes me saddest is feeling lonely. At school I have friends to hang around, but at home I am alone all the time. My parents don't live in one house, so talking with parents is a luxury thing. I feel uncomfortable. The loneliness makes me feel uncomfortable. Not pressure from studying. Pressure from studying makes me really uncomfortable, but it doesn't matter*' (IDI, M, 17, HCMC).

An inability to listen to their children on the part of some parents also seems to be a key concern:

'*For example, many of my classmates who sit next to me [in the class] never like to talk with their parents, never confide in [their parents], because every time they discuss things or talk to their parents, they (parents) seem to disagree, and do not want to talk with them. And so they are not motivated to talk with their parents about anything anymore. And another reason is that they (parents) don't have time to care for their children. In many cases, the parents cannot take care of their children, so they have to hire housemaids, and so the children only get to see their parents once a week or so. The maid could be considered a father or mother*' (FGD, M, 16, Hanoi).

4.2.2 Household level protective factors and responses

Overall, there were was a much higher volume of responses related to household risk rather than protective factors. However, two sets of protective factors emerged from our data: relatively better off household socioeconomic status mitigated some sources of stress experienced by young people and was associated with emotionally healthy family relationships. In terms of **socioeconomic factors**, children emphasised that peers in better-off households were more likely to complete twelfth grade which is a prerequisite for higher learning and, in turn, better future opportunities. However, overall rising levels of education has also been contributing to more equal opportunities for all at a community level according to some children: '*I think the positive aspect is that young people can live in an educated community. I think that environment and conditions enable all people to go to school, without discrimination between rich and poor, male and female. Their characters are well trained. They learn knowledge, humanity and solidarity from teachers*' (FGD, M, 13, Hanoi).

Emotionally healthy family relationships were also a key positive factor in mitigating psychosocial stress and ill-being.

Across interviews, children felt loved the most by their parents and grandparents, and felt happy when they were able to share their feeling and concerns with them. *'My parents spend time with me in the evening when they tell me their sad and happy stories, and also ask me about my studying at the school. I think that the time with me is enough'* (FGD, F, 12, An Giang). They also reported feeling happy when their parents praised them for getting good marks. Generally, adolescents feel that they can get advice from their parents on most matters in their life, but are most comfortable talking about studies with them:

'Having my dad and mom with me has made me happy. My maternal grandparents love me, and my paternal grandparents love me, too. … My dad gives me lessons in maths and physics at home. My dad was quite good at maths in the past, so now he still remembers. When I have difficult homework, I ask my dad for help and he will show me. In class, the teacher talks so fast that I can't understand very well. At home, I understand better when my dad explains to me' (IDI, F, 12, HCMC).

Several boys also reported high levels of family connectedness. For instance, one boy shared that *'Going home and eating with my family'* makes him happy (IDI, M, 15, Keo Lom commune, Dien Bien). Another boy reported that he is *'happiest when his parents don't quarrel'* (IDI, M, 12, HCMC). Children report feeling *'grateful'* to *'have been born to their parents'*. In fact, one boy said that at a time when he thought of self-harm, *'I almost put an end to everything. Because I lost the trust in life. It was not as good as I thought. At the time I felt so tired and so sad. But many things were there to keep me alive. Parents are the best things in my present life'* (IDI, M, 17, HCMC).

Children feel that they can turn to their parents in times of need. Though

one boy felt worried about causing his mother sadness if he shared his sadness with her, he did find that when he shared a situation with his mother that required advice, he felt *'relieved'* (IDI, M, 12, HCMC). Others also say that they turn to their parents when there is a 'difficulty'. As one mid-adolescent boy explained *'Most parents, I feel, if we are serious when we talk to them about our issues, our parents will listen, I think; they will understand my problems. My parents are like that. It depends on the parents; not all parents are the same'* (FGD, M, 16, Hanoi).

Moreover, while many had deep concerns about parental control in their lives, some children did also acknowledge that parental monitoring is an important way in which adolescents stay out of trouble. For instance, one child is not allowed to go to the internet cafe alone, and another child's mother noticed the child's unusual behaviour and took him to a doctor. Family connectedness is also noted in the way in which boarding school children miss their family and reach out to them via mobile phone when possible, with some doing so daily: *'I talk to them every evening by phone'* (IDI, F, 16, Dien Bien Phu city).

4.3 School level risk and protective factors

In this section we explore risk and protective factors that affect the mental health and psychosocial wellbeing of children and young people. As in the other sections, before exploring our primary data we briefly present findings from other studies carried out in Viet Nam that also highlight risk and protective factors at the school level. **Academic pressure** stood out in many studies as being a key risk factor to the mental health and psychosocial wellbeing of children and young people. Pressure coming from parents, teachers, and from

students themselves to perform well academically was identified as a risk factor for both depression (Nguyen et al., 2013b) and suicide (Nguyen et al., 2013a). Another risk factor identified for depression was having serious **quarrels with teachers** or other school staff members, while anxiety was associated with physical and emotional abuse from teachers or other staff members at school (Nguyen et al., 2013b). **Bullying and peer pressure** was also found to be linked to poor health outcomes such as higher levels of suicide (Phuong et al., 2013) and more drinking and smoking behaviours (Jordan et al., 2013; SAVY II). Finally, **school location** i.e. being an inner city, urban school was linked to higher suicidal ideation for both males and females (Phuong et al., 2013; SAVY I and SAVY II results). For instance, 16.1% of children in urban schools vs. 4.6% in suburban schools had suicidal thoughts (Phuong et al., 2013).

In terms of protective factors, one study showed that having **an after-school tutor** acted as a protective factor against depressive symptoms, reducing the likelihood of having depression by 28% (Nguyen et al., 2013b). **School connectedness,** or feeling a part of or belonging to the environment also acted as a protective factor against suicidal ideation (Phuong et al., 2013). Finally, school connectedness and **peer support** was found to be a strong protective factor for children's mental health and wellbeing – in a sample of over 2,500 university students, friends were the main support for over 40% of the sample (Huong, 2009).

Many of these findings are echoed in the primary research carried out for this study, though arguably our study goes further and provides further details and insights. In addition, our findings are further supported by the results of the SDQ and the Self-Efficacy Scale that we undertook in four study sites with

school children from four lower secondary schools and four upper secondary schools with 402 school children. The mean age was 15.07 years, and the youngest child was 12 years, while the oldest was 17 years. Girls made up 60.2% of the sample. Some 46.3% of the sample were in the lower secondary schools and rest in the upper secondary schools. 43% were living in rural areas, the remainder in urban areas, while 51.2% were in the North, and the remainder in the South.

In terms of overarching findings from these two scales, we found that of the four domains of behavioural and emotional problems, the number of children having 'abnormal' emotional symptoms made up as many as 19.7% of the total sample. The rate of children having conduct/behavioural problems in this study also appears to be quite high; the most common symptoms include lack of self-control – getting angry and losing temper easily (21.4%). It is noteworthy that only 8.2% of the children affirmed that they were not incited by other people into doing things.

Only a few of the children reported to have conduct disorders such as fighting, bullying, or dishonesty, but that many of the children are somewhat prone to these behaviours is a matter of concern to families and schools, because children with such conduct disorders will face difficulties not only in building social relationships, but also in their personal development.

The majority of the children in the survey sample showed problems or symptoms of hyperactivity. 8.5% of children had hyperactivity scores in the 'abnormal' band, which calls for attention. Very few of the children were confident that they possessed good attention, judgement and ability to analyse and complete tasks effectively. These signs are often ignored by parents and schools and

rarely addressed with appropriate education methods.

By contrast, the study found that only 7% of the children have 'abnormal' symptoms of peer problems, considerably lower than the figures provided by some other studies. However, the percentage of children having borderline scores for the Peer Problems Scale was 2-3 times higher than that for other domains of problems. A significant portion of the children seemed to be rather solitary, had few friends, were not liked by other children their age, preferred hanging out with adults, and especially, some of them were even victims of or at risk of being bullied by their peers. This suggests that peer relationships are a difficult problem for school-aged children.

The behavioural and emotional problems mentioned above differed by the children's demographic and social characteristics. The children of the older age group and higher education level face more problems than those of the younger age group and lower education level; girls appeared to have more difficulties than boys. The girls face more emotional problems than the boys, while in contrast, the boys have more peer problems than girls. Hyperactivity seems to be more of a problem among older children and in urban areas and big cities.

Regarding prosocial behaviours, the majority of the children in the survey sample had positive social relationships, with 80.6% scoring 'normal' and 4.5% 'abnormal', respectively. Overall, no significant differences were noticed between the different children's groups in terms of prosocial behaviours. Nevertheless, the mean prosocial score is higher among children under 15 years of age, girls, secondary school students, and children living in rural areas.

Similarly, the study also discovered differences in the rates of children

having 'abnormal' symptoms by age and residence area. This rate is considerably higher among children aged 16 or older, girls, children in rural areas, and in the North. Noticeably, the percentage of children having 'abnormal' symptoms is highest in Dien Bien – a Northern mountainous province and An Giang – a province in the Mekong Delta. Please see Annex 3 for further details on these findings.

4.3.1 School level risk factors

Three main areas stand out amongst respondents both from IDIs and FGDs as being potential risk factors for mental health and psychosocial wellbeing related to the school environment: academic stress, inadequate support and/or shortcomings of the school environment and challenges faced by romantic relationships which for many, are likely to start in and be associated with the school environment.

Across a majority of the interviews, children and young people from the three age categories (11-14, 15-17, and 18+) agreed that the **academic pressure** they face in school is one of their main worries. For the younger group, they were particularly concerned about certain subjects that they reported being not good at – mostly English or Math; for the older groups (15-17, 18+), similarly, they felt under pressure when they did not perform well, got low marks or when faced with important (e.g. university) exams. All groups also felt they placed very high expectations on themselves to do well, thus further fueling feelings of stress and anxiety. This was exacerbated for many students when they compared their marks with those of their peers; in one FGD with older (15-17) children, respondents noted that '*jealousy in studies*' was currently one of the most stressful parts of their life.

For all students, getting into advanced classes is highly

competitive and once in that class, students feel even more pressure to continue being part of that class. In one FGD (15-17) it was also noted that children from ethnic minorities have to score even higher to get into gifted schools, though this was contradicted when other students noted that they could perform less well and still pass. As mentioned in household risk factors above, many students also spoke about pressure from family to do well in school and this came out possibly more amongst the older age groups: *'Most parents want us to be good or excellent students, and we want parents to be proud of us, so we spend all the time studying, consequently we alienate from friends and become autistic or so on'* (FGD, F, 16, Hanoi). Similarly, one girl in Dien Bien Phu city feels pressure from her father: *'When my parents took my score report to the People's Committee for a stamp, they would see that my scores were poor, so I'm reluctant to give it to my parents. My dad said that I couldn't keep up with others. My dad said a lot. My mother said that if I couldn't study, I should drop out. I told my friends that my mother told me to drop out, and then my cousin advised me that I should drop out, so that my parents wouldn't have to work hard for me to go to school'* (IDI, F, 16, Dien Bien Phu city).

In the older age categories respondents also spoke about the fact that problems at home also affected their performance in school, and in one case an 18+ year old girl, spoke about worrying that her family could not pay for her extra classes and also having to carry out domestic tasks alongside her school work, which was putting pressure on her studies.

In terms of gender differences, both girls and boys appear to feel equally the stress and pressure related to being at school, including peer pressure and the pressure from parent/family members to

do well. However, the way it is perceived and the responses appear to be gendered. Thus, on the one hand, girls are seen to not have the strength to cope with tougher studies: *'We [some girls] belong to Group A and Group B, which consist of Maths, Physics, Chemistry and Biology. People say only boys have enough strength to deal with these groups. That's what I heard. I heard people say that in high school, girls had better choose lighter groups; they should not study subjects that are too tough because it will affect our minds'* (IDI, F, 18, Hanoi). Girls report feeling that they need the most support in certain subjects (English and math). Boys note, however, that *'girls study harder and are like programmed machines'*, and they *'tend to cry when they get bad marks'* (FGD, M, 15, Dien Bien Phu city). Girls also appear to feel extreme pressure from parents to perform well, often being compared to other siblings: *'Parents think that if they compare their child with other children, the child will follow the good examples and the situation will be improved, but in fact, it only hurts the child's self-esteem, causing psychological injuries and making the situation worse'* (FGD, F, 13, Hanoi).

As mentioned above in the household level risk factors, there appears to be more pressure on older girls rather than boys to undertake domestic tasks whilst studying. While boys feel pressure from parents, the pressure from peers and teachers appeared to be relatively stronger. Boys also note that rather than hanging out with friends at home and attending the Tet festival, for instance, they have to study. This also points to possible gender differences / expected gender roles since, arguably, girls, whether studying or not, would be less likely to hang out with friends and have free time to attend holiday festivities.

While it was difficult to tease out differences among children residing in rural, semi-urban and urban areas, a few tentative differences are discussed below. In the rural areas, there was a sense that pressure to perform well alongside peer competition was extremely high, because if children did not do well they would very likely return to their villages with very limited options for the future. Thus, education can give children a way out. Peer pressure related to issues around poverty also comes out more in rural settings, with one boy noting how he felt inferior to his peers because he went to school 'on foot' and his friends made fun of him for being '*too poor*'. Also emerging more strongly in rural areas compared to the other locations, were the domestic chores competing with studies, though this could also partly be explained by the fact that children interviewed in semi-urban and urban areas were mostly at boarding schools.

In the semi-urban areas, children spoke about wanting to drop out because they did not like studying and because their performance was compared to other children and other relatives. This did not come out in rural areas; one interpretation could be that in semi-urban areas children felt they had more opportunities and thus dropping out was an option compared to the rural areas where there are fewer options and where education is seen as a pathway out of these areas. In these areas it was also noted that because of the need to pass subjects like math and English they had to stop other extra-curricular activities according to a girl in Dien Bien Phu city, for instance: *'There's too little time to do what we're passionate about. For example, this girl may like painting, but because her study timetable is already full, she can't paint'* (FGD, F, 15, Dien Bien Phu city).

The notion of staying up to all hours to study came mostly from these

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'Sometimes, I told parents to cut the internet supply to change the behaviours of children. I kept my eyes on a student of grade 11 when I taught him. He is a game addict. He looked dull when he was in class. When he entered grade 12, I asked him to agree with me not to play games so much. In practice, he still played games, but he improved. His face looked vital and fresh and he paid attention to lessons well. It's different from his previous demeanor when he didn't listen to what teachers said because he just always thought of games.'

KII, Teacher in HCMC

urban areas, and it is notable that girls mentioned this. According to a girl in Hanoi, '*The teachers say that we should not stay up late too much, otherwise we won't be able to go to class the next day. So I stay up until 1 or 2 o'clock at most, or half past 12 if I can finish earlier*' (IDI, F, 18, USS, Hanoi). A similar sentiment is expressed by a girl in HCMC:

Q: Why do they feel worried and scared and isolate themselves?

A: I think the first reason is that studying in school is too much, putting much pressure on us, then we spend much time on studying, we even won't come home from school and classes until 9 PM. We also have to do homework. If we don't finish the homework, the next morning we will be punished. When you go to school with unfinished homework, you will feel scared and worried, and the feeling keeps lingering. We constantly live in worries of what will happen if we go to school without finished homework, my friends will sneer at me' (FGD, F, 16, HCMC).

Like all other students, the urban based students also felt pressure from their parents, but possibly given the middle class status of many families in these urban areas, the expectations of their parents appear to be higher, and according to respondents, the highest amongst parents who are doctors and teachers: '*You want to choose a vocation, but your parents don't want you to choose that vocation, they may prevent you, for example*' (FGD, F, 16, HCMC).

All of the above has resulted in children reporting feeling a range of emotions such as anger, sadness, worry, stress, anxiety, jealousy, disappointment, regret, inadequacy, inferiority and shame – with different emotions emerging in varying circumstances. For instance, children feel anger, regret, disappointment and inadequacy upon receiving test scores or report cards. On the other hand, they feel inferior and jealous due to peer competitiveness (see section on school risk factors below). Children also experience anxiety, worry, and shame when they have to share their test scores with their parents. Physical symptoms have included and ranged from crying, to missing meals – '*some girls are known to even skip lunch when they get bad marks*' (FGD, 15, Dien Bien Phu city) – to having nightmares (in relation to a boy having to give his mother his report card to sign, and presumably fearing her reaction to his results), to getting headaches, to getting depression, to fainting because of working so hard and late at night. This peer pressure, according to the older age cohorts, also leads to negative coping strategies, including smoking and drinking. Boys in particular also noted that these feelings of stress can lead to children feeling like dropping out of school and some said that academic stress is a risk factor for suicide.

The second major risk factor at the school level, as expressed by many

respondents, was **shortcomings within the school environment including inadequate support** for children. **Bullying** emerged as one such major risk factor affecting the mental health and psychosocial wellbeing of children and was seen to be pervasive across all interviews, with some slight variations according to age, gender and location. This is summed up in a quote from a 13-year-old boy in Hanoi who says *'I'm very sensitive, so being made fun of by other people affects my feelings the most'.* Bullying usually takes the form of children being teased and sometimes beaten, often by older children at school, who also often demand money from their juniors. More often it is boys who are beaten and girls teased. Reasons for teasing range from being teased about one's height, about *'liking a boy'* (clearly affecting girls), about being anti-social, quiet and having no friends, about having to be in a leadership position in class and report on others' behaviour to the teacher, and about underperforming in school. This latter reason was brought out particularly in the urban settings where it seems that pressure to perform is even higher than the other sites. One girl from Hanoi shared that her classmates teased her because of her family's financial struggles and her inability to pay for health insurance and school field trips. In some cases, when it came to beatings, teachers intervened. In other cases, children hesitated to tell teachers for fear of further fuelling the bullying. In one extreme case, one boy in HCMC said that in one class he wrote down name of children who had been naughty and as a result, that group *'waited for the teacher to leave the classroom, and then closed the door and beat him up'* (FGD, M, 13, HCMC).

In addition to bullying, in all locations, and across all age groups, there were instances of **peer conflict** where children reported being talked about *'behind their back'*, being

'misunderstood by friends' and *'being isolated'*, leading to the children to report feeling sad, stopping talking to their friends, sulking, and not being able to trust their friends. In some cases, children, especially girls, were insulted with derogatory terms, as in the case of a 13-year-old girl in Hanoi: *'Children in my class said "yeah, she's very mean", and "she's a slut", and "she often talks behind people's backs", that sort. But actually I wasn't like that at all; for example, they exaggerated my girliness into sluttiness'.* It was also suggested by a 13-year-old girl in a FGD from Hanoi that being *'ill-spoken-of'* behind one's back or being the subject of a rumour was a potential risk factor for suicide. Children also reported feeling sadness when friends were short tempered with each other, with some reports, particularly in one school (in Hanoi), of children using foul language and *'terrible words'* against children from *'poor families'.* *'Misunderstanding between friends'* (FGD, F, 15, Dien Bien Phu city) was one of the most commonly cited problems among peers across all sites:

Q: Apart from that, what else makes you sad?

A: When friends misunderstand one another, and when they think things that are not true (IDI, F, 16, Dien Bien Phu city).

Being away from family and in **boarding school**, which is relevant largely for the older age cohorts in the study and those mostly in semi-urban and urban areas, is an added stressor. This results, on the one hand in, children missing their parents (*'crying when they talk to them on the phone'*), while on the other hand, in friendships becoming more important. When these friendships result in conflict or bullying, children take it even harder. While both boys and girls miss their home and parents, according to boys, girls feel more homesick, with some boys

in an FGD in Dien Bien Phu City narrating a story of a girl who fainted because she was homesick.

Another component of the school environment that children found inadequate was the **lack of leisure activities**, with children feeling that more extra-curricular activities are necessary to de-stress, while at the same time their packed schedule in the day makes it hard to have time for leisure.

The mental health and psychosocial wellbeing of these children was also affected by **how their teachers behaved** with them. Many respondents in all age groups and across all locations felt that teachers were unsupportive – according to them, teachers did 'not listen to them', girls talked about teachers discouraging them from following their career aspirations and telling them to give up their ideas; they also often scolded them for making mistakes or being late. Girls in particular also spoke about feeling shaky when teachers interrupted them and when they had to speak in public. This resulted in children reporting feeling sad when teachers were unsupportive; additionally, they were also scared when teachers punished and scolded them, sometimes beating them (mostly the male teachers) with a ruler or twisting their ears, and in extreme cases using a belt, though this occurred most with boys. According to an FGD with 13-year-old girls in Hanoi: *'Girls are rarely beaten. They are gentle and weak, so they are rarely beaten'.* Students rarely reported these beatings, fearing that the teachers would subsequently penalize them through giving them low marks in the future. While unsupportive teachers were present in all areas, the children in the urban sites were more vocal both in terms of the punishments they meted out as well as their almost untouchable status, as these quotes from two girls in Hanoi show: *'When I was*

on the way to school, I saw a male teacher using a ruler to strike heavily on a student's legs. Sometimes male teachers drew their belts to strike' (FGD, F, 13, LSS Hanoi). Similarly, *'Now even if the teacher is wrong, I still have to say that I'm wrong. We can't argue; the teachers are gods'* (FGD, M, 16, USS Hanoi).

The final risk factor that children spoke about was in relation to **romantic relationships**. The reason this is discussed in this section is that often these relationships start in the school environment and are often, though not always, associated with stress. Generally there was a sense across all age groups and all settings, though perhaps particularly amongst the younger group since they are considered too young to have such relationships (parents and grandparents will say, according to 14-year-old girls in Keo Lom commune, Dien Bien *'You are too young to know, don't fall in love early'* to children under the age of 15), that parents and teachers do not approve of these relationships and that they are forbidden, largely because they feel (a view that is also shared by the students) that they will distract them from their studies. Several students note that teachers *'think that we can start a relationship, but studying should be guaranteed, otherwise, intervention will be needed'* (IDI, F, 15, HCMC). In her school in HCMC, the same girl explained that, *'In the beginning of the school year, there was no prohibition on emotional affairs or showing it at the school, but then some couples showed too much intimacy and tended to have sexual relationships, so the school was too worried and imposed a prohibition to stop the trend. Friendship is advised to be innocent'.* Despite this, relationships continue, which provides fuel for stress if a parent or teacher finds out. In the case of one boy, for instance, a teacher found out that he had a girlfriend and told his parents; this resulted in the boy breaking up with his girlfriend,

causing much anger to the boy, who reported feeling he had *'lost the joy'*, and also fuelling the sentiment of unsupportive teachers (see above). Sadness was also triggered amongst children when relationships broke up, all of which also distracted them from their studies.

Girls in urban areas in particular spoke about issues of love as being one of the biggest misunderstandings between children and parents as this narrative from a young girl in Hanoi shows: '*Q: What is the biggest misunderstanding between children and parents? A: In foreign countries, children our age are not forbidden from falling in love, it is a very common thing. Children are allowed to love, but not to rely on others, they have to perform well in school, and parents equip their children with knowledge about psychology. In our country, love between boys and girls is seen as worse performance in school, children are required to study day and night, love is forbidden, so pressure is put on the children'* (IDI, F, 13, LSS, Hanoi).

Many children, in all settings, also spoke about romantic relationships as being risk factors for suicide. According to respondents, possible suicide triggers could include unrequited love; parental discovery and disapproval or forbidding of the relationship; and, for girls in particular, feeling jealousy. Girls in particular shared stories about people who had attempted suicide, with some using poisonous leaves in Dien Bien, where they grow in abundance.

Upsetting also for many respondents, and particularly girls, was when gossip and scrutiny ensued after people jumped to the conclusion that their friendship with a boy was a romantic involvement. This results in some children also feeling shy to talk to members of the opposite sex, since it often leads to gossip among their peers.

4.3.2 School level protective factors, coping and responses

A number of protective factors, responses or coping strategies were identified at the school level, many of which also overlap with individual level protective factors, coping strategies and responses.

One critical response at the school level are the **psychological counselling units**. These were found mainly in the schools in the urban areas and many are associated with / get support from NGOs in addition to funding from DOLISA (see Section 5 below). According to study respondents, girls tend to go to the psychological unit more than boys and find it helpful. One boy who visited the counselling room explained that the counsellor *'Was just talking with me; he guided me through my difficult stage when I was suffering emotional abuse from other students'* (IDI, M, 13, Hanoi). Another respondent, an older girl (18+ in Hanoi), accessed the psychological unit, which helped her deal with issues of bullying and teasing resulting from being unable to pay for extra tuition fees, go on school trips, or buy health insurance; she also said that no one else she knows had accessed these units. A KII with a school psychologist revealed that in cases in which the counsellor is available, they work towards creating a safe and accessible environment for students to share their feelings: *'I create an open relationship with students so they feel very relaxed. Sometimes, it is just a walk together around the school playground and talk. They can tell me that we do not want any consultation at all, we just want to talk to you to ease our sadness'* (KII school psychologist, Hanoi).

However, respondents also noted a number of shortcomings of these units. Shortcomings ranged from students often not knowing about these units and therefore rarely accessing them (in one case in An Giang the psychological unit was

turned into a classroom because it was not being used), to girls in Hanoi mentioning that the counsellor was often male, and as such, they felt unable to share their feelings with him, to the psychological counselling unit being housed in a library, which did not afford children the privacy necessary for them to share freely (Hanoi). It was also noted that even if students do go to seek support from the counsellor, which appears to be more likely in urban than in rural and semi-urban areas, they only share issues related to school and do not share 'private issues'. '*Most of the students don't share their family issues there; they only go there if they are under pressure from friends or studying*' (FGD, F, LSS, Hanoi). In urban areas it was also not by children that they would rather seek advice from their peers: '*who have the same point of view as them*' (FGD, F, 16, HCMC). The following quote from HCMC sums up the shortcomings of these units: '*I see that many students visit the unit, but most of the students share their thoughts with friends. Many students even don't know who Mrs. Hoa [the counsellor] is. But the unit is much needed. Meanwhile some students don't know about its existence at this school*' (FGD, F, 16, HCMC).

A number of respondents spoke about the **life-skills training and citizen education** that they receive in school which, according to them, helps them deal with stress. According to respondents, the life-skills they are taught, which are usually taught in biology class, includes controlling negative emotions, communication skills, dealing with violence, learning to deal with stresses and sadness, being confident, problem solving, physical health, and protection from '*social evils*' such as alcohol, drugs and smoking. These clubs are often supported from NGOs such as World Vision, as illustrated in the KII with an officer of World Vision :

'I create an open relationship with students so they feel very relaxed. Sometimes, it is just a walk together around the school playground and talk. They can tell me that we do not want any consultation at all, we just want to talk to you to ease our sadness'

(KII school psychologist, Hanoi).

'*In addition, in some localities, we have done it in a more systematic way, that's in the commune level community child protection system, we establish children's clubs that are outreaches of the system. When participating in the clubs, the children are trained on life skills and social and scientific knowledge of their interests, besides, they also take part in another kind of operation called the locally based World Vision's kid partnership to detect any issues and needs of their friends. The World Vision statistics show that there are over 800 such children's clubs.*

They [children] are trained on how to respond to tension, build relationship or how to say no. It means that we base on the research on the age group of lower secondary school, teenagers to know what skills are needed and divide them by regions.'

Being members of **clubs** (e.g. English, art and Young Leaders' Clubs) and taking part **in extra-curricular activities** was also mentioned by various respondents as a way of unwinding and coping with the stresses faced at school; in urban areas in particular, children also mentioned being part of the youth and children's union, which carries out activities that, according to this girl from HCMC, '*help us to understand each other better*' (FGD, F 16, HCMC). In particular, respondents mentioned the Young Leaders' Clubs, in which both girls and boys participate, though '*Usually the boys rarely participate in the school activities, such as music or other activities. Very few boys participate. Among the students who applied for the school's Young Leaders' Club, when I applied, I saw that there were only a few boys, only ¼ were boys, while the rest were girls. There are only nearly 10 boys in the Young [Leaders'] Club*' (IDI, M, 13, Hanoi). These young leader clubs '*provide knowledge to future leaders about violence, gender and gender-related issues*' (IDI, M, 16, Hanoi) and also help children learn about and deal with bullying, often

through use of drama. According to a boy from Hanoi, joining this club has made him more confident: '*Since I joined it, I've met many other friends, who have a lot of things that I need to learn from. They are very self-confident. Since I joined it, I also feel that I've become more self-confident.*'

Amongst HCMC and Hanoi respondents, the NGO Plan International was also supporting these kinds of activities in schools, and especially in helping children to deal with bullying. The downside of this was that often due to limited time or clashing time-tables, children were unable to participate in these clubs and extra- curricular activities. Moreover, in one school in Hanoi, the activities of Plan are ending, leading the headmaster to worry about being left without any capacity to handle psychological problems of the students: '*I'm worried. For a good result, school consultation should be carried out by staff with expertise in social psychology. If schools have no consultation activity, conflicts and violence at school might increase. Second, there will be no one dealing with the psychological problems of students. This will make the number of students having psychological problems increase. School consultants are not necessarily full-time staff. A staff can work on part-time basis for two-three schools and on shift duty. The school consultants must expertise in student psychology*' (KII, Co Loa LSS, Dong Anh District, Hanoi).

When in school, children also reported using **the internet** as a strategy for coping. This tended to be more common amongst the older children but was equally prevalent in all locations. Facebook was a frequently mentioned resource – and possibly more by girls amongst our respondents – with children using it as a vehicle through which to voice their feelings. For example, children spoke about posting to a confession site that is monitored by a 'former student who is studying economics'

and helps students get advice on life issues. The internet and Facebook were also seen as being positive for study purposes: '*It (the internet) is good for studying. If you don't understand some points in the lesson, you can ask friends or post questions on the teachers' Facebook pages*' (FGD, F, 16, HCMC). Other respondents mentioned another website (ASK14) which could provide support on these issues, and a few children, mostly boys in urban areas, also knew about a hotline for counselling, though no study respondents had ever called it.

Teachers, as well as causing students' stress and anxiety (see above) are also an important part of students' coping repertoires, particularly in relation to studying: '*They really pay attention to my schoolwork; if I make a mistake in my notebook, they will show me*' (IDI, F, 16, Dien Bien Phu city). According to respondents, in some cases the teacher seeks out the child to give advice, and in other cases, the child seeks out the teacher, and in yet other cases, the teacher reaches out to parents, as seen in the box above. Children spoke about teachers encouraging children not to drop out of school. In another example, a head teacher spoke to parents of a child who was stressed out, which led to the parents '*caring*' for the child more: '*Last year I met with my class's head teacher to talk about my stresses from studying. She explained to me that my parents were really serious about my studies, so when I got a bad mark, my parents often told me off, which put a lot of pressure on me. Therefore, I was too stressed; as a result, my studying didn't improve, but even got worse. Therefore, I talked to my class's head teacher, and she helped me talk to my parents* (IDI, M, 16, Hanoi). Respondents also reported teachers as supportive in issues beyond studies, thus a girl who lives with her grandmother and faces economic difficulties, reported how the teacher advised her how to

take care of her grandmother, who was not well and also '*gave a school bag, 5 pens and a dozen notebooks*' (IDI, F, 16, An Giang). Teachers were also seen to be supportive when it came to bullying, telling children to report the bullying and also trying to ensure that children from poor families were not discriminated against: '*Discrimination used to be there, but the head teacher and head master talked about the behaviour and it has changed. It used to be there in the past*' (FGD, F, 17, An Giang). Some children also felt comfortable enough to discuss their 'love relationships' with their teacher, suggesting that help- seeking and sharing of more personal feelings may also be dependent on the quality of teacher. The important role supportive role of teachers is summed up in on quote: '*Most of teachers at this school listen to us. Teachers are also psychological doctors*' (FGD, F, 16, HCMC). Students also spoke about enjoying being praised by teachers and teachers caring about them.

Having supportive teachers in leadership positions also promoted a healthy and positive school climate: '*Our point of view is that teachers should have true affection for the students. Criticising the students under the flag rarely happens at my school. Offenders are often invited here or to the teacher's room for a person-to-person talk. When we see that the talk works, that's all. In the examination season, I invite doctors to advise the students on how to eat and rest, what food gives them enough nutrition. They shouldn't stay awake too late every night, instead they should have reasonable sleep. We also look for ways to reduce stress and pressure on them. Though this is a quality school, I always remind them that university is not the only way. A number of people like them learn vocational skill and succeed. We invite successful former students to talk with them*' (KII, USS, An Giang).

Other protective factors, or aspects of life which children spoke about that make them feel happy included and ranged from feeling happy about being at school/in class and with friends, to (especially girls in boarding schools) going to the pagoda with their friends on Sundays, to discussing and sharing their thoughts with friends, to having romantic relationships.

4.4 Community level risk and protective factors

Relatively few studies have explored factors at community level that may create risks for children and young people with respect to mental health. The few articles on community level risk and protective factors identify stigma against mental illnesses as the main risk factor that places those already burdened with mental illnesses at further risk since they are less likely to seek care (Do et al., 2014). Additionally, lack of knowledge about mental illnesses was found to be one contributing factor to increase stigmatisation (van der Am et al., 2011; Vuong et al., 2011).

4.4.1 Community level risk factors

Three main categories were identified at community level as posing a risk for mental health and psychosocial wellbeing of children and young people. These included: easy access to harmful substances, lack of access to opportunities, and harmful norms.

Easy access to **harmful substances** included, particularly in Dien Bien province (in all locations), access to drugs and access to poisonous **(la ngon)** leaves, which are taken with the aim of committing suicide. For instance, a KI with the Social Protection Division of DOLISA in Dien Bien reported that the high level of drug problems can be attributed to,

'*The natural conditions in this area are good for growing this plant. It is also easy to buy this plant from Lao. The drugs are often trafficked from Lao.*'.

Parents in Dien Bien also spoke about the dangers of these poisonous leaves and suggested a solution: '*If there's a project that buys poisonous leaves from people and then burns them, after 2-3 years, there will be no more [poisonous leaves]. If they mobilize the whole village to dig up [these plants], the plants will be cleared. It will reduce the problem of suicide*' (FGD, Parents, Keo Lom commune, Dien Bien).

There is a consensus across interviews that abuse of both alcohol and other substances is occurring. Alcohol abuse was mentioned particularly among older (15-17) male youth as shown in the FGD: '*They drink wine when they are happy and when they are sad. It is seen as a way to show their personality and internal strength*' (FGD, M, 17, An Giang). A KII with DOLISA Dien Bien laid out the trends among young people's consumption of alcohol:

'*Children at secondary school age start drinking wine. Older children drink more and it is the same with children and young people in the mountains and river deltas. Students at secondary school ages drink the most. Ethnic minority students of secondary school don't drink as much as college students. In community, students of secondary schools don't drink wine because they don't have wine to drink. They don't have money [to buy it] and nobody drinks with them at that age. It is thought that people in the mountains drink a lot but it is just common amongst those who are employed. These people have money to buy wine. Local people also make wine at their homes but only the adults in the family drink*' (KII, DOLISA, Dien Bien Phu city).

Reasons for such abuse occurring range from people wanting to use it, to being tempted by their friends, to it being available easily and cheaply.

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'young generations learn from their grandparents', often by observing. Similarly, stereotypes around ethnic groups are a reason stated for high numbers of suicides – one respondent was asked whether his area is mostly occupied by Hmong people, and he replied, 'Yes, they lack knowledge. Those with better awareness [in other areas] are less likely to commit suicide'

(FGD, M, 15, Dien Bien Phu city).

For instance, one interviewee stated: '*The substances they use are cheap and they can buy it easily. The glue is very cheap, costing some thousand dong, so most of the users are from poor families. The children from rich families don't think of it and don't use such cheap things. So it happens more often to the children from poor families*" (FGD, M, 17, An Giang). Another reason for drug abuse is that '*many fathers pass it on to their children*', as was noted particularly in Dien Bien. Easy access once again underlies this problem since Laos, which is where opium is most easily available is only 'an hour from Dien Bien by motorbike'. A KII further corroborates this and shares that, '*To buy heroin, they drive motorbike for two hours, then walk in the forest for a day. It takes them a day to go to Laos and a day to return. They start in the morning and reach Laos in the evening, they spend a night there and buy heroin, return home the next morning. Border guards and police have caught several people [going like*

that]. In my neighbourhood, nearly 40 people, both men and women have been detained'.

There is a general view held by both those in rural and semi-urban areas, **that opportunities in rural areas are limited** and are therefore causing potential stress for children and young people. In urban areas the narratives were more around higher level career aspirations of children and young people, which were misaligned with what their parents wanted for them (see above in household risk factors). There was also a limited knowledge of vocational options, especially for those who did not feel that their scores were enough to get them into highly competitive universities in the future: '*My classmates have determined their career direction; I haven't determined my own. In grade 10, my performance in all subjects was similar, nothing stands out, so I don't know what group of subjects I should follow. I worry because I don't know how I will perform in grades 11 and 12. I review my scores and search on the internet to see if there is any vocational training compatible with my score level. I have searched websites for a long time, I read newspapers to look for career guides. There are several newspapers that often give career guides'* (IDI, F, 15, HCMC).

Thus in rural areas, it was largely boys who spoke about limited opportunities in terms of employment and infrastructure, whilst for girls (and parents) the limited availability of services – ranging from contraception, to having someone to teach about these services and from whom they could seek advice (it seems the Women's Union was not active in these areas, otherwise they could have been an option), to support for drug users' detoxification and rehabilitation) – seemed to pose more of a threat to their wellbeing. For instance, one young man shares that that it is costly to find a job: '*We*
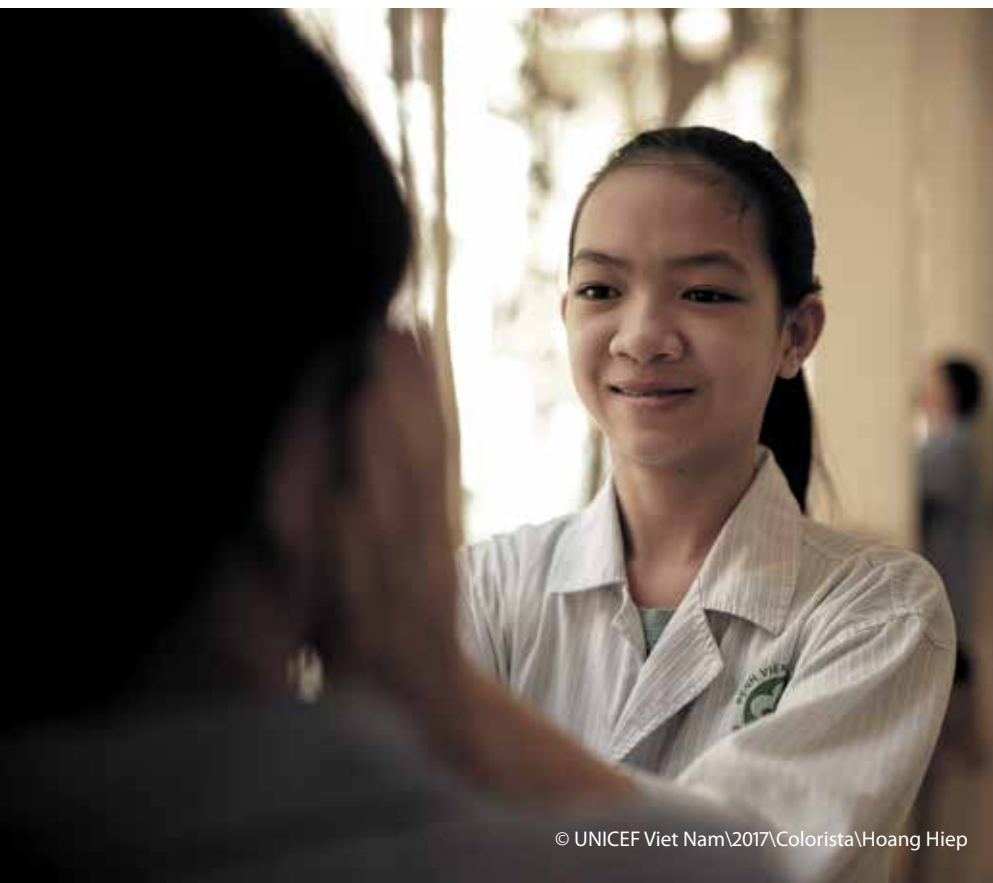
want stable, long-term employment that can give us income. Working for the state is preferable, light-duty work is better than farming' (FGD, M, 16, Keo Lom commune, Dien Bien). Concerns around employment are validated by KIIs: *'Many children cannot get a job after school; some children even say frankly that they don't need to go to school, because it would be pointless, because they won't get a job anyway. It's a stress in their lives. Vocational training and employment are difficult in Dien Bien at the present. Jobs are very limited in this small province, especially in mountainous areas'* (KII, DOH, Dien Bien Phu city). Another young boy discusses the challenges in reaching the school due to failing roads: *'What concerns us is the road. The school is far from our houses, the road is bad and difficult. If you don't know the road, you can fall'* (FGD, M, 16, Keo Lom commune, Dien Bien). Similarly one young man shares that employment is difficult because of lack of transportation: *'We do a lot of work, but earn little. It's not efficient. And we don't have means of transportation either, so it's difficult for us to travel'* (IDI, M, 28, Keo Lom commune, Dien Bien).

There was also a sense that there were limited leisure opportunities in all areas, and even when they were available, infrastructure to support the activities was lacking, as noted in the interview of a 15-year-old girl in HCMC, who stated that even though boys and a small number of girls play sports, *'The playground here is not sufficient enough to play'.* This lack of leisure opportunities was shown to result in children and young people spending a lot of time on the internet (see individual risk factors section above), which was also seen particularly by girls as being dangerous and a risk factor also for suicide, as this narrative from girls in Hanoi shows:

Q: What is the risk factor for committing suicide among young people?

A: Being humiliated on the internet, or your photo is edited for wrong purposes.

A: Your video clip is posted.

A: Your photo is edited to prove the wrong doing that you didn't do. (FGD, F, 13, Hanoi)

Harmful norms appear to be perceived differently according to whether respondents were based in rural and more urban/semi-urban areas. Some of these views were also echoed in the discussions with key informants. Thus in rural areas and largely in the north norms and stereotypes around ethnicity are often perceived by respondents to be a major causes of mental health challenges. Thus, for instance, according to one respondent from Dien Bien, excessive alcohol drinking can be a result of ethnic rituals and customs, including receiving guests: *'We ethnic people often have ritual ceremonies. Hmong people often do it when someone is sick. We drink alcohol and we also kill animals, for example chickens or pigs, and then invite our relatives to come'* (IDI, M, 28, Keo Lom commune, Dien Bien). Ethnic norms were also given as an explanation as to why people *'smoke black opium'.* Thus parents in an FGD in Dien Bien explained that when someone is not well, a shaman is called upon who makes the 'sick person smoke first' before healing them. They further explained this ritual, also distancing themselves somewhat by saying that: *'There are two types of Hmong; we're white Hmong; we also smoke [drugs], but less. The red Hmong smoke the most. There are 25 villages in the commune, but the majority of drug smokers are red Hmong'* (FGD, Parents, Keo Lom commune, Dien Bien). They also noted that this phenomenon is likely to continue since the *'young generations learn from their grandparents',* often by observing. Similarly, stereotypes around ethnic groups are a reason stated for high numbers of suicides – one

respondent was asked whether his area is mostly occupied by Hmong people, and he replied, *'Yes, they lack knowledge. Those with better awareness [in other areas] are less likely to commit suicide'* (FGD, M, 15, Dien Bien Phu city).

Perhaps even more striking are the norms around gender, which largely affect girls in a negative way and are particularly prevalent in rural areas and in the north (Dien Bien), though there is evidence of such in An Giang as well. These include norms around early marriage – usually also resulting in a girl leaving school at an early age – what a girl should do with her life, how she should behave and look/dress, and the domestic roles that she needs to take on. It should be noted, as already mentioned above, that despite the legal age of marriage being 18 for girl and 20 for boy in Viet Nam, the reality is that in places such as Dien Bien girls are still getting married at very young ages. All of these can affect the mental health and psychosocial wellbeing of girls. Thus one respondent spoke about girls getting married as young as six years old. She continued, *'There's one girl who didn't get married until age 17, but are considered "on the shelf" when they are 20'* (IDI, F, 19, Keo Lom commune, Dien Bien). Another respondent also spoke about how she had chosen to marry early and the neighbours had disapproved, asking: *'Why are you getting married so early? You're still young, why don't you wait? If you do that, you'll have to drop out." That was what they said, but I had already married him, so I couldn't do anything'* (IDI, F, 18, Keo Lom commune, Dien Bien). This same girl went on to say that despite being in an unhappy marriage, she had very few options now because of the norms around custody of her children. If she asked for a divorce she would lose the rights to her children, and her own family would not allow her to return to live with them permanently out of fear of the

societal backlash that would result from a divorced woman:

'The children would be in my husband's custody; it's his right. Some people split [the children]; they may say the son belongs to their family line, so they let the father take him away. Meanwhile, as for the daughter, some people may say she's a girl; she is staying here now but she will grow up and then get married, and she then won't belong to the family anymore. Therefore, the mother can take her away because later on she will get married anyway. Some people choose that solution. Meanwhile, some people say that the first person to mention divorce doesn't get the right to raise their children… According to our ethnic tradition, once I'm married, it's like I will not be included in their (my family's) worship rituals anymore. If I walk away [from my marriage] alone, I can stay with them (my parents) for 1-2 years, [but not] longer. And then they will build a small house for me to live in separately; I won't be allowed to live with my parents anymore. And when I'm too seriously sick, they will not perform my funeral in their house; that's not allowed. It's said that my family's ancestors don't recognize me anymore, so they will build a separate house for me' (IDI, F, 18, Keo Lom commune, Dien Bien).

Other girls also in Dien Bien spoke about how their teachers had dissuaded them from having certain career aspirations, suggesting that they focus on what was more acceptable for a girl. Other girls also mentioned the need to take on domestic tasks: *'When I was little, my older brothers cooked. When I grew up, in 7th-8th grade, I had to cook because here boys don't usually cook'* (IDI, F, 22, Keo Lom commune, Dien Bien). Finally, comparisons were made between the Kinh and the Hmong women, with respondents noting that Hmong wives were more restricted: *'We Hmong people are not like Kinh people. When Kinh people go somewhere, both the husband and the*

wife go together. But to Hmong people, the wife stays at home to look after the house for the husband to go' (IDI, F 18, Keo Lom commune, Dien Bien).

In An Giang, an FGD with KIs describes norms that constrain girls' participation in leisure activities – something that is already limited to begin with: *'Girls are under pressure if they do what they want. For example they are not allowed to play football or something requiring strength. Parents say that's men's business, "if you play football, you will be sneered at"'* (FGD, Provincial officers, Long Xuyen city, An Giang).

Respondents in semi-urban areas also perceived people in rural areas, and in particular girls, to be more at risk of harmful norms. Thus, for instance, in a focus group discussion with girls in Dien Bien Phu city, they note that norms around gender, including those around son preferences, in rural areas may put girls at a higher risk for suicide: *'In the commune, girls face more difficulties, because in ethnic [minority] groups, people often value men over women. The society is progressing, but some parents are not knowledgeable, so they often prefer having sons. They may treat daughters a bit differently'* (FGD, F, 15, Dien Bien Phu city).

Boys also perceive girls to be more discriminated against than themselves, as this following quote shows: *'Girls are forced to drop out to work, marry men they don't love, [are subject to] wife kidnapping, though that is not as commonly practiced anymore'* (FGD, M, 15, Dien Bien Phu city). Norms around males as protectors are also prevalent in boys' minds as noted in the following quote: *'Boys are scared too, for example, when I come home late from class, that road section is very dark, and in that case, if I'm robbed, I won't know how to cope; or when I go home with two girls, I'll hold the heavy responsibility of protecting them. In that case, I don't know whether I*

should walk ahead of them or behind them to be able to protect them' (FGD, M, 16, Hanoi). Similarly, boys believe that they want to show girls *'strength, power, being manly, being a lady-killer, worker, fame'* and they expect girls to be *'beautiful and have a nice body'* (FGD, M, 16, Hanoi). One introspective boy stated that *'(he) likes girls who have "Cong – Dung –* **La ngon** *– Hanh'* (industriousness, good appearance, being well-spoken, virtue – four qualities of an ideal woman according to Confucian concepts). *'They don't have to be pretty; an average and good-looking appearance is enough'* (FGD, M, 16, Hanoi).

Generally there is a sense (which was voiced predominantly by 15-17-year-olds) that urbanisation is viewed as *'the society is getting worse'* since people care about *'economic issues (money) and social status'* without paying attention to *'human emotions'* (FGD, F, 15, Dien Bien Phu city). This is highlighted, according to respondents, by the fact that the increasing social status often associated with urban residence drives parents to have different career expectations from children than the ones children have for themselves, leading also to clashing values, which, with lack of communication between parents and children, merely worsens things. Similarly, and different from other studies, people in town are believed to be more knowledgeable than those in villages and as such it is believed that they are less likely to commit suicide (as mentioned in section 3). Moreover, urbanisation is driving parents to be away from their children due to changing employment structures, as noted in the KII with a teacher in Hanoi: *'Co Loa [a commune of a suburb in Hanoi] is mainly based on agriculture, but farmland is being narrowed because of population growth and urbanization speed. Parents are hired workers in Da Hoi. They go to work early in the morning and leave their children*

almost to grandparents' care. Some might go to work at 2-3 AM. They buy vegetables in Van Noi, Van Tri which is about 10 km away from Co Loa and sell in Hanoi. Several parents have day labourer jobs (iron foundry) in Da Hoi. A number of people work for industrial zones which are 7-8 km away from Co Loa (footwear factories) and Bac Thang Long industrial zone. Workers of industrial zones finish work very late so they have little time for their children'.

4.4.2 Community level protective factors, coping, responses

In terms of factors at community level which can be seen as protective, many of them are the mirror images of what is discussed above. Thus, where and when there are **opportunities or services**, these can be seen as being protective for children and young people's mental health and psychosocial wellbeing. In terms of services, children and young people, particularly in urban areas knew about the existence of the MOLISA psychological hotline that *'provides us with psychological counselling'* (FGD, M, 13, Hanoi). They are also aware of a *'sharing radio channel'* that comes on from *'8 to 11 PM'* and *'shares about everything, psychological [issues], sexual health, anything'* (FGD, M, 16, Hanoi). Despite the shortcomings of the rural health centres, children and young people also mentioned that they were important sources of information about *'sanitation during menstruation, contraception, child marriage, reproductive health, and student psychology, which helps girls know more life skills and understand better about gender'* (FGD, F, 17, An Giang).

The commune health station also saved the life of a young man who had taken poisonous leaves in Keo Lom. Similarly, a married mother in Dien Bien discussed how she was able to get a health check at the commune health station when she *'had pains in her belly'* and that her

baby gets free health checks, despite not having a health insurance card. There are also *'delegations from Phu My Health Station who give information about health'* (FGD, M, 17, An Giang). All these reasons may be why *'Traditional medicine is not popular anymore. People rarely use it. It's not available here. I heard it's available in Muong Cha, which is 100 km away; some people go there to get it'* (FGD, Parents, Keo Lom commune, Dien Bien) (see also section 4). Finally, in terms of infrastructure development, a FGD with parents indicated that children now have better access to school due to 'big roads', and *'for those in remote villages, there is a boarding school, and [children from] poor families are supported with [free] meals in the boarding school'* (FGD, Parents, Keo Lom commune, Dien Bien).

Children and young people also note that the importance of holding **positive attitudes and beliefs,** all which has a positive effect on mental health and psychosocial wellbeing, a perception coming largely from children and young people in the urban areas, as seen in the FGD with 17-year-old girls in Hanoi: *'The positive thing for young people is that we are open and objective, so we can find many people with the same ideology like ours. We are also supported by parents, so we have positive looks at the life.'* According to an FGD with boys in Hanoi, avoiding harmful practices is taught in schools: *'Boys are taught about harmful effects of early marriage in school: They say that if marrying early, your body has not fully developed, and you will give birth to a baby with deformity'* (FGD, M, 16, Keo Lom commune, Dien Bien).

In conversation with girls, however, despite the relatively high frequency of early marriage for girls in Dien Bien, their perceptions appear to be more flexible and subject to their own choice. Thus, older girls say that they largely can choose their marriage partner (and even that

parents allow a girl to keep a child out of wedlock). This was framed, however, as a comparison to other ethnic groups: *'We ethnic people, when we like each other, we don't do like Kinh people. If we [want to] get married, we just do it ourselves, just go to the husband's home, and the parents won't know until then .. In my ethnic group, we get married when we want; if one is 30 or 40 years old, she will get married if she likes; otherwise she just stays that way'* (IDI, F, 22, Keo Lom commune, Dien Bien).

As well as being taught about the harmful practice of early marriage, it was noted by boys the importance of being taught broader, everyday skills: *'Just some everyday life skills, I think. Soft skills that are very important to us, which are necessary both in school time and later on when we become adults. For example, how to dine properly, what to observe and what to do during a meal. Or how to choose food, which food is good and which is not. Or how to treat other people, what behaviours and actions are right and appropriate, in terms of society and social ethics, and human dignity'* (FGD, M, 16, Hanoi). These same boys also pointed out how they wanted to learn about the world: *'The culture of communication, to improve general understanding. Viet Nam is increasingly integrating itself in the world, such as WTO, and OPEC, and joining some large economic markets, so we should learn from [the world's] experiences'* (FGD, M, 16, Hanoi).

Mental health and Psychosocial Care service delivery systems

The provision of mental health services falls within the remit of a number of ministries, including the Ministry of Health (MOH), the Ministry of Labour, Invalids and Social Affairs (MOLISA), and the Ministry of Education and Training (MOET). Each ministry has a different paradigm of administration, with different areas of responsibility, roles and functions, and has their own programmes, proposals and models for dealing with mental health and psychosocial issues. For example, MOH is in charge of health-related matters, hospitals and health centres. Health centres and hospitals diagnose and provide treatment primarily for serious and persistent mental illness stemming from neurological conditions and developmental disabilities. While MOLISA, through its system of community and social protection centres, deals with social support policies for social protection beneficiaries and provides services for cases in need of urgent protection (according to the Government's Decree No. 136/2013/ND-CP of October 21, 2013, providing for social support policies for social protection beneficiaries; Decree No. 103/2017/ND-CP of September 12, 2017 stipulating the establishment, organization, operation, dissolution and management of social protection facilities; Decree No. 28/2012/ND-CP of April 10, 2012, detailing and guiding a number of articles of the Law on Persons with Disabilities; the Prime Minister's Decision No. 1215/2011/QD-TTg of July 22, 2011, approving the Progrgamme for community – based social protection and rehabilitation for people with mental illnesses and mental disorders in the period of 2011 – 2020; Decision No. 32/QD-TTg on March 25, 2010 of the Prime Minister, approving the Programme on the development of the social work profession.

'Health centres check and provide treatment. Labour affairs sector is the second agency which will provide allowance afterthe cases

are checked and included in the list … The labour affairs sector reviews all the cases and manages the cases. The serious cases will be requested to get an allowance. The less serious cases will be cared for by the health sector. For these cases, we pay for home visits and regards, give gifts and provide checks-up or help' (KII, DOLISA staff, Dien Bien Phu city).

The ways these different ministries approach and provide services of mental illness and psychosocial distress vary depending on the functions and responsibilities of the ministry. The ministries develop and implement complementary policies for people with mental illness and people in difficult circumstances. The health stations, psychiatric hospitals and paediatric hospitals largely provide medication and use a set of internationally recognised tools to diagnose problems of serious and chronic mental illness, neurological disorders and developmental or cognitive delays. Some of the cadres of MOLISA have proper qualifications in health and social work. Annually, MOLISA holds senior and master's degree courses on social work.

MOLISA staff will also refer people to their social protection and social work centres, where they exit. According to study respondents from DOLISA in An Giang, they see themselves as playing a 'connector role': 'We mainly serve as connector, because we are a state management agency, not a service provider… For example, the provincial child protection fund belongs to DOLISA, we connect sponsors for health care services, such as screening, treatment and surgery' (KII, DOLISA, Phu Tan District, An Giang). Finally, in schools, aside from diagnosis of illness, approaches used are geared to psychosocial distress and are largely those of counselling of students. In this section we explore mental health and psychosocial service provision

through the different ministries (MOH, MOLISA, MoET).

Before exploring services through these largely public institutions, it is important to note that in Viet Nam, both the private and NGO sector pays inadequate attention to the provision of services, particularly social services to people with mental illnesses in some special difficult provinces. In addition to the government's mental health-related service provision programmes and schemes which the MOLISA has implemented, there is a limited number of NGOs providing mental health related services to children and young people in Vietnam as follows: i) RTCCD which has set up a clinic, TUNA, in Hanoi, which focuses primarily on mental health problems, starting from pregnancy of the mother; ii) BasicNeeds (funded by BasicNeeds UK) also based in Hanoi, which opened in 2009, has three fulltime employees and works with Women's unions. Their activities include: designing tools to screen for common mental health problems, building capacity of community level health staff to screen for and treat mental health problems, organising activities for patients (peer support groups, support to find employment), and training other NGOs and government departments in mental health related issues (KII, BasicNeeds, Hanoi); and iii) PHAD (under the Viet Nam Union of Scientific and Technical Associations (VUSTA)), which is implementing a three-year project, 'Taking care of mental health for adults and children–a cost saving initiative', a model for depression control in community which has been carried out in 8 provinces/cities in Vietnam, sponsored by the Grand Challenges Canada-GCC and MOLISA. The project consists of two components: one for adults with depression and one for children with behavioural difficulties. Hanoi and Danang have been selected as the pilot sites (KII, PHAD (Institute of Population, Health

and Development), Hanoi); and iv) WeLink which, established in 2013 in HCMC, provides both training particularly to teachers working as counsellors in schools in HCMC and counselling for mental health challenges.

According to key informants, there were no NGOs focusing specifically on mental health in Dien Bien, though some (e.g. World Vision) were integrating it into their existing programmes. Additionally, it was noted that when the social protection centre in Dien Bien could not house any more children they would refer them to the SOS village: 'But in addition to this Centre, there is also an NGO-funded SOS village which has better infrastructure; it has different houses, each of which has its own "mothers" (caregivers), so they can take in a larger number of children' (KII, Social Protection Centre, Dien Bien Phu city). In An Giang it was noted that UNICEF and JICA supported the Social Work Centre for Child Protection in the past, but their support has ceased (KII, Social Work Centre for Child Protection, Long Xuyen city, An Giang).

5.1 Service provision through Ministry of Health infrastructure

The health system in Viet Nam is decentralized into four levels: central, province, district and commune/ward. The Ministry of Health (MOH) is in charge of technical aspects, including both prevention and treatment activities. The MOH currently plays the most prominent role in delivery mental health services and, as stipulated in Decree No. 36/2012 / ND-CP, is dedicated to the management and operation of: preventive medicine; medical examination and treatment, rehabilitation; medical examiners, forensics, forensic psychiatric; traditional medicine; reproductive health; medical equipment; pharmacy; cosmetics;

Box 4: Mental health services through the government hospitals in Hanoi

The **National Hospital of Paediatrics** has a department of mental health where around 80 out-patients are examined, tested (through the use of a number of psychology tests), and diagnosed every day. These patients are often referred from other departments (e.g. neurology or rehabilitation) within the hospital. Once the diagnosis is made, treatment programmes are developed, which can include behavioural therapy or family therapy, usually requiring the patients to visit at regular intervals. According to study respondents, around 25% of the cases are diagnosed as autism, 20 to 30% as hyperactivity, and the rest are a range of disorders. In terms of ages of patients, around 20-30% are adolescents (KII, health worker and psychologist, National Hospital of Paediatrics, Hanoi). There are a total of five doctors specialized in mental health, seven nurses, and two teachers specialized in providing therapeutic treatment for autistic children and those with special needs. It seems all staff come together as a group every day to discuss cases; when there are emergency or difficult cases, they can call the more specialised staff.

The **National Institute of Mental Health** is an affiliated institute of Bach Mai Hospital. It has a total of 187 beds, and receives annually about 3,000 patients for inpatient treatment for mental disorders, and carries out maintenance tracking for more than 50,000 outpatients[i].

Additionally, Hanoi has been implementing the national program on mental health care for community and children in the whole city. All the district medical centers have psychiatric clinics, and each district mental health clinic has from two to eight clinic nurses and doctors. Currently, 100% of communes, wards and towns have consolidated the network of mental health care. Each ward/commune has a specialized staff for the management of mental patient records, and is dispensing medicines for patients monthly[ii].

[i]*http://bachmai.gov.vn*

[ii]*http://www.soyte.hanoi.gov.vn*

food safety; health insurance; and family planning (UNICEF & MOLISA, 2015, p. 22). While the various departments and agencies within the Ministry of Health all have some functions and tasks related to child healthcare, the key unit in charge of healthcare for children is the Department of Maternal and Child Health. The national hospitals, including the National Hospital of Paediatrics, National Hospital of Obstetrics and Gynaecology, HCMC Children's Hospital No. 1 and Tu Du Hospital (HCMC) are assigned the responsibilities of providing guidance to the lower levels, supporting the development and dissemination of plans, monitoring

and supervising mother and child health care activities throughout the country. The National Hospital of Paediatrics is given charge of the northern provinces, while the HCMC Children's Hospital No. 1 is in charge of the southern provinces. Implementers of nutrition and prevention activities for children also include the National Institute of Nutrition, National Institute of Hygiene and Epidemiology, the Hospital of Tuberculosis and Lung Diseases, and National Institute of Malariology (MOH, 2006).

Drawing on findings from our study, the next sections explore mental health services at the city level; this

Box 5: Mental health services through the government hospitals in HCMC

Mental health services are provided in the **Paediatric Hospital** through the psychiatry ward. The staff in the psychiatry ward is comprised of three doctors, including two trained in psychology, two psychologists, two teachers specialized in teaching children with mental diseases, one social worker, a reception nurse, a nurse's aide and volunteers. The volunteers support patients and relatives by, for instance, carrying out administrative tasks and acting as a go-between with the hospital staff: *'When patients are admitted to the hospital, the volunteers help them with administrative procedures. Or the patient's relatives have some complaints, but can't get feedback to the staff, so the volunteers serve as a bridge. Or they help the school-age patients continue studying. Or if the children feel sad, the volunteers help entertain them or organize annual events such as the full moon festival or the Children's Day on June first for the children to participate in, with the aim to make the hospital friendly and children feel almost at home. In addition to that, the volunteers guide those who need psychological consultation to see the psychological specialist'* (KII, Paediatrics Hospital No 1, HCMC). The services provided at this hospital primarily include examining, evaluating and classifying children, referring them onwards for the correct service. They also provide education to the patients, and hold training courses in clinical psychology for doctors, nurses and social workers. A KII with the psychologist reveals that in addition to providing counselling for cognitive problems, behavioural problems, and somatic complaints mentioned in section 3, the psychiatry department also provides mental health support for families with children who exhibit homosexual tendencies, children who have faced child abuse, and counselling for parents whose children have had to undergo serious surgery.

In terms of awareness-raising about the psychiatry ward's services, the hospital uses a range of approaches: *'First, we rely on mass media – for example, television, newspapers and radio. I rely heavily on them to let people know about us and they come. Then we also communicate to schools. Several schools organize the sessions of health education where specialists are invited to talk with parents and teachers. At some schools, teachers recommend parents to take the children with problems for examination'* (KII, Paediatrics Hospital No 1, HCMC). Other approaches include distributing brochures in the districts on a regular basis that is organised and coordinated by a 'Department of Healthcare Network' in the mental health hospital.

The **Psychiatric Hospital** of HCMC is the leading hospital specialized in mental health in the south of Viet Nam, providing services to both adults and children. There are nearly 400 employees to undertake the prevention, detection, and treatment of all mental disorders and mental illnesses. The hospital has three agencies. The main agency, with 100 beds for acute patients, is located in Cho Quan, and the second agency, with 250 beds for subacute, chronic and rehabilitation patients, is in Le Minh Xuan. The last one, specialized in children, is located in Phan Dang Luu.

'Every day, we [at Cho Quan] receive 500-600 outpatients; […]there is another location in Le Minh Xuan, also about 500 outpatients. The one in Phan Dang Luu receives 120-150 patients per day' (KII, Psychiatric Hospital of HCMC).

Additionally, HCMC has a network of district psychiatric clinics in all 24 districts (usually located in the medical centre of the district), which are responsible for the treatment and case management of outpatient psychiatric patients and coordinating activities of the network of health stations at ward level. Currently, HCMC has implemented the national program on mental health care and protection for community and children in 49 wards/communes.[i]

i http://www.bvtt-tphcm.org.vn

is then followed by a description of mental health related services at provincial, district and commune level.

5.1.1 City level mental health service provision

In **Hanoi,** mental health services are provided through a number of hospitals, including the National Institute of Mental Health, the National Psychiatric Hospital No. 1, Hanoi Psychiatric Hospital and the Mai Huong Daytime Psychiatric Hospital. Box 4 provides some details of two of these hospitals.

In **HCMC,** mental health services are provided primarily through a number of hospitals including the **Paediatrics Hospital No 1** and the **Psychiatric Hospital**. Box 5 provides some details of these hospitals in HCMC.

5.1.2 Provincial Level mental health service provision

In **Dien Bien Province** mental health services are essentially provided through the government and through two hospitals in Dien Bien Phu city: the provincial (general hospital), which has a mental ward and the **Psychiatric Hospital**, which was established in June 2012. While there are a large number of private clinics and health care providers in Dien Bien Phu city, according to study respondents, none provide mental health services.

The **Psychiatric Hospital** is housed, and has been since it opened, in the TB hospital. Currently there are two floors and about 20 offices and treatment rooms. There are a total of 30 staff, up from an initial 17; out of these staff, there are five doctors and seven nurses, but currently no counsellors or psychologists. All the medical staff have received some form of mental health training – for nurses it is three months, for physicians and doctors it is six-seven

months continuously at the National Mental Hospital; they also get refresher training every three-four years. Currently, there are 20 beds, up from four when it opened, and they are in the process of trying to 'borrow' more rooms from the TB hospital to be able to increase their beds to 50, though they still face challenges in infrastructure, equipment and human resources. According to study respondents, the number of inpatients has been growing over the last few years, largely as a result of better communication and education on mental health. Thus, in 2014 there were 270 inpatients, in 2015 there were 398, and estimates for 2016 were around 500 (in the first quarter there were 130 people). In 2015, there were a total of 2,800 outpatients and, according to key informants, they are currently managing 760 patients in the community, covering the whole district.

According to study respondents, inpatients present the following disorders/complaints: schizophrenia, affective disorders, dissociative disorders, depression, anxiety disorders, headaches, sleep loss, old age dementia, and mental

disorders due to substance abuse, including alcohol. Additionally, a disorder reportedly on the rise was computer game addiction. In terms of treatment of common mental disorders (vs the severe ones that were mentioned) or where patients could go to receive just counselling in Dien Bien, the response was that there was nowhere else to go (KII, Psychiatric Hospital of Dien Bien, Dien Bien).

According to the DOLISA key informant from Dien Bien, he noted that staff at this hospital work with health centres all over the province to identify people facing disabilities /mental health problems. He also said that the hospital provides counselling services, and staff from this centre/hospital hold training courses for health workers in the districts and communes every year.

In terms of awareness-raising about their services, they use a range of approaches: '*First of all, people have learnt about this hospital because many newspapers have mentioned us. Before this hospital was opened, people had to suffer a lot; they had to go all the way to the National [Mental] Hospital No. 1. Now they know about*

this hospital, so they bring the patients here; they don't have to go to the national hospital anymore. Secondly, the quality of the treatment has been improved; and another thing is that the scope of treatment has been broadened. Before, headaches and sleep loss used to be treated by internal medicine only, but now they've been considered mental [problems]. Affective disorders and anxiety disorders too; they weren't considered illnesses before, but now people have realized that they are, so they come here' (KII, Psychiatric Hospital of Dien Bien, Dien Bien).

Although there is no psychiatric hospital in **An Giang**, according to key informants, the DOLISA staff support the hospital wards and health centres by providing them with financial support to accept referrals of serious mental health patients; they also have formed a social work centre: '*Although we [DOLISA] haven't got a centre, we still have the responsibility to support hospital wards and health centres, providing them financial support to send serious patients off for treatment. Secondly, we formed the Centre for Social Work and Child Protection and Care - which mainly provides*

The exterior of the TB hospital which houses the Dien Bien Psychiatric Hospital. © Fiona Samuels, 2016

counselling to children who haven't got mental disorders (at risk), I mean providing counselling to children who suffer from shocks or stresses'.

An Giang also has been implementing the national programme on mental health care for community and children within the whole province. While the DOH has been in charge of medicine distribution for mental patients with schizophrenia, epilepsy and depression, DOLISA has been responsible for providing support in the form of cash to beneficiaries from the national program of mental health care, and supporting health centres for mental health care.

There is also a Women's Union that provides support to those with mental health needs. For instance, the Women's Union facilitates the process of getting admitted into a hospital, though it seems that this only takes place for someone who is severely mentally ill: *'If any woman member has a child having mental problems, I will recommend her to the receiving council in the township or write a recommendation to a hospital for examination and treatment. If it is a seriously ill mental patient, he/ she will get social protection from the local authority. Generally, there are fewer mentally ill children than adults. In my neighbourhood, there are several mentally ill adults. They wander the streets and make a fuss'* (KII, Chairwomen of the Women's Union of Phu My town, An Giang). This KI notes that awareness raising about the presence of the Women's Union is lacking.

5.1.3 Commune level mental health service provision

As mentioned above, the commune is the lowest level through which health services are provided. In addition to having commune health centres, remote areas also have hamlet health workers. These centres and individuals are the first

port of call for people living in rural areas when mental health related challenges arise. In addition, in some areas a community mental health programme was in operation.

Keo Lom in Dien Bien District, Dien Bien Province

The **commune health centre** in Keo Lom has a total of six staff members, including one head of the centre, three physicians, one midwife, and one nurse. The commune health centre sees around 450-500 people per month. Additionally, there are 21 **hamlet health workers** (HHWs) in Keo Lom (there are 25 hamlets, four without a health worker) who are selected at commune level, with a minimum requirement of lower secondary school and completion of a nine-month training course. These HHWs focus largely on providing check-ups, reporting the number of births and deaths every month and undertaking some communication and education activities. They meet with the health workers at the commune station once a month, though if there is an urgent case they will meet straightaway. During these monthly meetings, they report on numbers of births, deaths, challenges and successes, and in general share their experiences. It appears that a sub-group (10) of the Keo Lom HHWs attended a training class in which they were taught how to identify mental health problems and access drugs for the patients at the psychiatric hospital in Dien Bien. It was also noted by other HHWs in Keo Lom who have not dealt directly with mental health issues that they do informally raise issues of mental health:

Q: *Have you talked about mental health issues in your communication and education activities?*

A: *Not yet. I just focus on the issues guided by the health station. Besides, sometimes I talk about*

mental health issues out of the framework of my communication and education. I told them to take more rest and don't think too much. (KII, hamlet health worker, Keo Lom commune, Dien Bien).

The **community mental health programme** (see also Section 7) appears to have been running for around ten years in Dien Bien province, whereby the psychiatric hospital distributed medicines to the districts and the responsible officers (generally the head or deputy head of the health centre) at district level, who then distributed them to patients in their coverage areas. Thus, through this decentralised programme, health workers based in the community treat and follow mental health patients, also providing them with appropriate medications. According to a Keo Lom commune health worker, the service has expanded over time: *'It has been carried out for 7 or 8 years. I was promoted to be deputy head of the centre for several months. The medicine has been supplied this way for 5 or 6 years only. Before that, they [patients] had to go to the provincial capital to get it, as the district authorities didn't supply it",* (KII, Commune Health Centre, Keo Lom commune, Dien Bien).

As part of this community mental health programme, there is also a system at commune level whereby people with disabilities are identified by the commune officers in terms of their eligibility for an allowance through DOLISA. Since mental illness is also considered a disability, DOLISA can also identify people with mental health issues. However, according to study respondents, identifying people with mental health problems is more difficult: *'If a person has an epileptic seizure or threatens other people, it is easier to know, but it is difficult for our communal staff to identify the cases of ordinary depression. In this case, we will recommend that these people*

get appraised by the provincial medical panel. Based on the result, the commune will decide whether to provide disability allowance' (KII, DOLISA, Dien Bien Phu city).

According to study respondents, only 'serious' and 'very serious cases' are eligible to receive an allowance, of which there are several levels. *'The standard level is 180,000 dong. For the poor, it is 270,000 dong. In the future, the level of support will be the same for everyone at 270,000 dong. Those with mental health problems receive support worth about 540,000 dong. The rate for elderly and children is higher. Amongst people with disabilities, there are rates for the serious disability and less serious disability; the poor and non-poor. The mental patients are the people with disabilities'* (KII, DOLISA, Dien Bien Phu city)

It also appears that at commune level, community meetings are held in which communication on mental health is integrated: *'Yes. There are general community meetings, in which communication on mental health is integrated. Besides, there are communication posters in public spaces. This is organized by the mental program because it has a fund for it. As for slogan banners, they are available in some places, not everywhere, usually only in the communes'* (KII, DOH, Dien Bien Phu city, Dien Bien).

Phu My town in An Giang province

In terms of awareness-raising on mental health and existence of services, one hamlet leader received a seven-day training course on child development a couple of years ago that included child psychology issues. Upon returning to the village he shared what he learnt, which included information on mental health and wellbeing: *'[I shared] not only with the adults in the hamlet, but also with the children. I gathered children in a group and explained to them what they should and shouldn't*

do. I also encouraged them to share their feelings with me.. I integrated it with the knowledge on gender equality, child legislation and others. They were interested in it very much. They told me that it's difficult to speak about child psychological issues. They didn't know how to explain it* (KII, hamlet leader, Phu My town, An Giang).

Officers of the Women's Union and Youth Union feel that awareness raising is an important step, one that is currently missing from their services: *'here is no material on mental health. My organisation, like the Women's Union needs communication materials to disseminate in our activities so that both parents and children can learn. The prevention of mental problems is rooted in the family, so we should do our communication activities for families on the prevention and treatment of mental problems. [...]Through communication activities, people will be aware of mental problems so that they can discover the patients to send to hospital'* (FGD, officers of Phu My town, An Giang).

5.2 Service provision through MOLISA

According to Decree No.36/2012/ND-CP issued by the Government of Viet Nam, MOLISA is *'responsible for managing the following sectors: employment, vocational training, wages and salary, social insurance, occupational safety, veterans and their families, social protection, child care and protection, gender equality, control and prevention of "social vices", i.e., illicit drug use and the sex trade'* (UNICEF & MOLISA, 2015, p. 26). The departments working on mental health related issues under MOLISA include the Department of Labour, Invalids and Social Affairs (DOLISA), the Department of Child Protection and Care (DCPC), which is responsible for ensuring the comprehensive

development of children, and the Department of Social Protection which is responsible for addressing the needs of social beneficiaries with mental disorders. Among its tasks, collaborating with the Ministry of Health in implementing health care and nutrition activities for children is included (MOH, 2006). Annually, MOLISA coordinates with the Ministry of Finance to allocate budgets to provinces and cities to provide cash assistance to social policy beneficiaries, including the families of individuals with severe, serious and mild mental disorders. Institutions under MOLISA through which mental health and psychosocial wellbeing-related social work services are provided include the social protection centres, the social work centres and the hotlines. Annually, cadres, staff and collaborators have been trained in mental health related issues. Thus, according to the DOLISA staff in Dien Bien, for the past few years, in liaison with the psychiatric hospital in Dien Bien, they have been organising mental health related training, including refresher training, for their officers at district and commune level, teaching them about mental health problems as well as ways to identify them. Additionally, between 2013 and 2015 they also trained family members (approximately 120) so that *'they can help the mental health patients in the family'*.

In 2011, the Vietnamese Government has approved a programme for social support and community-based rehabilitation for people with mental illnesses and disorders, for the period 2011-2020 (Decision 1215 for short). Through social mobilisation, the programme aims to both prevent the triggers of mental ill-health and also support families and communities by providing spiritual, material support and rehabilitation for people with mental illnesses and support them to integrate into the community, contributing to improved general social security.

The network of social protection institutions has been established and developed throughout the country, with 418 social protection units throughout the country, including 195 public units and 223 non-public units, (including 33 social protection institutions taking care of the elderly people; 144 social protection institutions taking care of children in special circumstances; 74 social protection institutions taking care of people with disabilities; 31 social protection institutions providing care and rehabilitation for people with mental illnesses and disorders; 102 general social protection institutions taking care of beneficiaries of social protection or those in need of social protection; 34 social work centres providing counselling services, urgent care or other necessary support for those in need of social protection) (MOLISA, 2016). Social protection institutions have the following responsibilities: (i) Provide urgent services (receive those in need of urgent protection; assess beneficiaries' needs, screen and categorize beneficiaries. When needed, refer beneficiaries to health, educational, police, judicial or other relevant institutions or organizations; ensure safety and address urgent needs of beneficiaries such as: temporary accommodation, food, clothes and transport); (ii) Consult and treat mental disorders, psycho crisis, and physical rehabilitation for beneficiaries; (iii) Advise and assist beneficiaries to access social support policies; coordinate with other relevant units and organizations to protect and assist beneficiaries; search and arrange types of care services; (iv) Develop intervention and assistance plans for beneficiaries; monitor and review intervention and assistance activities, and adjust plans if needed; (v) Receive, manage, and care for social protection beneficiaries who are in seriously difficult situation, unable to take care of themselves and cannot live in a family and community; (vi) Provide primary medical treatment

services; (vii) Organize rehabilitation and occupational activities; assist beneficiaries in self-management, cultural, sport activities and other activities suitable for the age and health conditions of each group of beneficiaries; (viii) Take the lead and coordinate with relevant institutions and organizations to provide academic and vocational training and career guidance to promote comprehensive development of beneficiaries, physically, intellectually as well as in terms of personality. (ix) Provide social education and capacity building services (Provide social education services to help beneficiaries develop problem-solving capacity, including parenting skills for those in need; teach life skills to children and adolescents; Collaborate with training institutions to organize education and social work training for staff, collaborators or those working for social work service providers; Organize training and workshops to provide knowledge and skills to beneficiaries who have demand. (x) Manage beneficiaries who receive social work services… to all beneficiaries of social protection and those in need of urgent protection.

This network of social protection centres currently care for approximately 42,000 social protection beneficiaries, provide social protection services to tens of thousands of people in difficult situations and social protection beneficiaries, of which children, people with disabilities and mental illnesses make up a large proportion, 46.5%. On average, 01 social protection institution cares for about 100 beneficiaries. The total number of workers and staff in the social protection network is around 15,000 individuals. The social protection institutions receive, manage, care and feed social protection beneficiaries, organize activities such as rehabilitation, education, vocational training and career guidance and provide social

work services, thus meeting the need for social support of 30% of people in difficult situation.

While there have been a number of telephone hotlines operating in Viet Nam, the most prominent, longest-operating one (since 2004) that deals with young people and mental health issues is 'the Magic Buttons –18001567". Housed in MOLISA headquarters in Ha Noi under the Department of Child Care and Protection, it operates 24 hours a day, 7 days a week and has 20 staff and 10 collaborators /adjunct staff with backgrounds in psychology and special education. There is an advisory council of doctors and academics specializing in psychology and law to provide support in difficult cases. Between 2014-2015, the hotline received more than 2 million calls from children and adults throughout the country.

5.2.1 Social protection centres

As described above, the social protection institutions are established in 63 provinces and cities to receive, assess, provide care and support and other necessary services to various groups of social protection beneficiaries, vulnerable groups, specially disadvantaged children, people with mental illnesses, and women suffering postpartum depression. The social protection institutions also organize activities such as rehabilitation, education, vocational training and career guidance and provide social work services, thus meeting the need for social support of 30% of people in difficult situation. Up to date, there are 45 Centres for social protection and rehabilitation for people with mental illnesses providing care, rehabilitation, basic education, vocational training, livelihood support (such as mushroom growing, pond garden farming, votive paper making).

While original function of some centres was to look after orphans, elderly people, people with disabilities, and homeless people, according to study respondents, they are now also dealing with people with mental health problems, though the beneficiaries appear to be disproportionately adult males. Thus in An Giang province, according to a KII at DOLISA there are now two social protection centres, one of which takes care of mental health patients: '*In the past, the Social Protection Centre only took care of social welfare beneficiaries, such as lonely and elderly people, people with disabilities, and orphans. But now they also have to take care of mental patients, including both children and adults … But it only admits a very limited number, because the infrastructure is not sufficient. Now we have two centres in the province; the one in Long Xuyen is taking care of about 40 mental patients, and many other beneficiaries. The second centre is the Chau Doc Social Protection Centre of Chau Doc city, which mainly takes care of homeless people*' (KII, DOLISA, An Giang).

The social protection centre in Long Xuyen city, An Giang, is staffed by six nurses, caring for a total of 40 people, of which 27 are children. There are a total of 33 staff at the second social protection centre, including 10 people in charge of administrative work, caring for a total of 150 people. Out of these 150 people, 38 are mentally ill, of which 5 are under 14 years of age.

In Dien Bien, according to study respondents there was one social protection centre in operation that targets orphans (single and double) and vulnerable children in the province. In operation since 1990, there are currently 77 beneficiaries (they have a maximum capacity of 80), 65 of whom receive direct care (on site) and 12 of whom are attending universities, secondary technical schools and vocational schools. There 32 girls and 45 boys;

the age of the children ranges from 4 to 22 years.

There are a total of 24 staff and three departments in the centre: the Nutrition and Health Division takes care of the children's health and daily diet and is staffed by two physicians — if there are difficult cases, they can be referred to the ward health station, city health station, or provincial or national hospital. The Beneficiary Management Division provides extra-curricular activities to children, including teaching cultural knowledge and life skills, music, sports, vegetable gardening and pig and chicken rearing. Staff on this division were mostly former teachers and while some have been given additional (one-week) training on social work, none have received training on psychological counselling for children. Despite this '*All the staff here has a lot of compassion and love for them. Because it comes from our own hearts, we always try to provide the best conditions for them. Although the salary is low, we always stay close, pay attention and take care of the children*' (KII, Social Protection Centre, Dien Bien Phu city).

The social protection centres receive an allowance per child from MOLISA, though they stress this was not sufficient and had to seek support from other sources, though this was not consistent: '*The meal allowance, according to state policy, is 80% of the minimum wage, which means 920,000 VND/month. The living allowance, which includes electricity, shampoo, toothpaste and such, is 30% of the minimum wage, which means 345,000 VND/month. For those who are attending universities/ colleges, their meal allowance is 80% of the minimum wage, which means 920,000 VND/month, and their living allowance is 50% of the minimum wage, which means 575,000 VND/ month […] Our centre has to call for support from other organizations and donors to increase the amount of money for dinner for these 25 children*'

(KII, Social Protection Centre, Dien Bien Phu city).

5.2.2 Social work centres

The category of social work centres (SWCs) was also mentioned by various respondents. According to UNICEF & MOLISA (2015, p.31), "the SWCs are envisioned to provide services and supports to people in disadvantaged circumstances and individuals with mental disorders and to assist with other social service needs that are identified in communities and at the SWCs throughout the country". In 2016, there were 30 social work centres and plans for 33 more (Kidd et al., 2016). According to a key informant in An Giang, the social work centre there focuses on child protection and care: '*There's a Centre for Social Work and Child Protection and Care, directly under the administration of the provincial DOLISA. Currently, this centre has the functions of providing counselling and guidance to abused children, and psychological counselling to children. The staff here received training on mental health in Hanoi*' (KII, DOLISA, An Giang). This is validated by the findings from UNICEF and MOLISA's (2015) report that states that the social work services that are being provided in these centres include counselling, psychological treatment, case management, community re-integration, referral, resource mobilization, prevention, communication, training, and capacity building.

According to Decision No. 32, every year, MOLISA is responsible for supporting Social Work Centres to develop their networks of social work collaborators, provide social work services to disadvantaged and vulnerable groups in the community, provide capacity building for social work cadres, staff and collaborators through technical training courses on operating social work centre models, case management

procedures, community-based rehabilitation procedures for people with mental illnesses and disorders, case management for people with disabilities, caring and foster care for children in difficult situations; sharing experience of operating social work centre models; organize training on case management for people with disabilities for Labour, Invalids And Social Affairs cadres and staff throughout the country.

Similarly, according to a member of staff at the Centre for Social Work in An Giang, they support on average about 40 children a year who were abused and suffering from violence, including sexual violence. Staff at the centre have been trained to provide psychological support and counselling to these children: *'My team has received training on identifying children with depression and providing psychological support for children suffering from psychological disorders'* (KII, Social Work Centre for Child Protection, Long Xuyen city). They have also improved their resources as noted in a KI with the head of the Child Protection Division of DOLISA in An Giang: *'Previously only one social worker was in charge of child protection at commune level, now the child protection program has established a network of collaborators in hamlets and also set up the social work centre for child protection, making the address better known to many people to come or call there.'* More generally, the social work centre focuses on three main areas: *'educational communication; referral service (e.g. if a child is HIV-positive, they will connect to the relevant service) and case management; and community development. Educational communication is divided into two sub-areas, one is educational communication and propaganda, depending on each annual topic, the second one is treatment, receiving cases and providing consulting treatment'.* In 2014, the centre also set up a 24-hour hotline focusing on

children and trafficking (KII, Social Work Centre for Child Protection, Long Xuyen city, An Giang).

However, even though the social work centre is supposed to provide counselling to children, it is unclear the extent to which people know about this; an FGD with provincial officers in An Giang thought that there was no counselling service nor specialised ward for dealing with mental health in the province. This was echoed by a KI in An Giang:

Q: Is there any examination and treatment service for the children with mental health issues or psychological difficulties?

A: There is no such kind of service. If you are ill, just go to the hospital. There is no psychological consultation or mental health clinic. There is no mental hospital in the province. People with mental diseases often go to Dong Thap and Tien Giang for examination and treatment. (KII, DOLISA, Phu Tan district, An Giang)

To raise awareness of a Social Work Centre for Child Protection, one respondent described the following approaches:

A: First, we inform local authorities at communal level; we send to 164 communes information about the functions and responsibilities of our centre. The second way is to communicate through newspapers and television; they will do propaganda for us. The third way is to display in each of 11 groups of districts a billboard to propagandize about our centre.

Q: Where are these billboards located?

A: At district or communal people's committees, or areas with a high density of population, such as train or bus stations. (KII, Social Work Centre for Child Protection, Long Xuyen city, province).

5.2.3 Hotlines

While there have been a number of hotlines operating in Viet Nam dealing with a range of topics, the most prominent, longest-operating one that deals with children and young people and also includes mental health issues and psychosocial support is the one set up by MOLISA, also referred to as 'the Magic Buttons – 18001567' which has been changed to number 111 since December 2017. This nationwide hotline is housed in the MOLISA headquarters in Hanoi under the Department of Child Care and Protection. Since 2004, it has been supported by Plan International. It operates 24 hours a day, 7 days a week. There are 20 staff and 10 collaborators /adjunct staff with backgrounds in psychology and special education; additionally, there is an advisory council, consisting of doctors and associate professors with psychological and law specializations to support in difficult cases. The telephone counselling staff have specialisations in psychology, social work, social studies, and law; upon being recruited they all receive an additional two- month training course focused on dealing with children.

Children from all 63 provinces can make free phone calls to share information, look for psychological and spiritual assistance, receive recommendations and get connected to the appropriate organizations or emergency service if needed. Adults can also call to look for information related to child care and protection. The hotline gives priority to counselling, answering questions and providing intervention and support in five areas: (1) child protection against mental violence, physical violence, sexual abuse, neglect, abandonment, exploitative labour, and smuggling; (2) providing information and services related to child protection; (3) Psychological assistance; (4) Counselling on

treatment, policies, laws on children protection; and (5) linking services for the children in need. Since 2011, the hotline has strengthened its operation of evaluating and directly applying psychotherapy for children. It also provides skill training for children and parents in life skills; motor and sensory development for kindergarten children; open classes for creative mind development for preschool and primary-school children; and parenting skills.

Between 2014-2015, the hotline received over two million calls from children and adults throughout the country, 20% of which asked for advice. More than 3,000 children who had been abused, suffered from violence, been smuggled, been lost or abandoned, or in been in need of financial assistance benefited from the hotline intervention and assistance. MOLISA keeps track of all calls, noting the locality, sex, age, and problem type of the caller. Counsellors, upon receiving a call, give an initial diagnosis and/or provide callers with information about a particular mental disorder (e.g. ADHD, autism, depressions) and then refer them to relevant services for further treatment, if necessary. *'In the North, we can refer them to our therapy centre* (an "*in-person Psychological and Therapy Centre' that has existed for three years*"). *To children who are abused and suffer from psychological traumas or crises, we provide them with direct treatment for free. We also collaborate with different projects to raise funds to support them during their travelling and stay'* (KII, Hotline, MOLISA).

Both adults and children use the hotline, and so both receive treatment. *'When they (parents) bring them (children) here, we have to work with the parents as well. In some cases, when the child was abused, the parents were in an even greater crisis than the child. Therefore, we have to work with them; only when their psychological state is stable can they support their*

children.' The respondent went on to note that there are usually more mothers than fathers who bring their children since *'their perception is that taking care of children is the responsibility of women and that women are better at passing on the skills they learn to their children. It's easier for mothers to show their love (to their children) than it is for fathers, so usually more mothers than fathers (come here)'* (KII, Hotline, MOLISA).

Recently, according to study respondents, more calls are being received from rural areas, a phenomenon that can be explained by the fact that the hotline has been operating recently on the VOV (radio channel). People in urban areas, however, are less likely to listen to radio: *'Because urban people are used to using the internet, they rarely watch TV or listen to radio. But rural people listen to radio very often; recently, we thought that radio broadcasting wouldn't work, but in fact, it has come back to life again recently. Farmers bring radios with them to the fields. That's why the calls have to do with people in rural areas. We received calls related to mental disorders related to parent-child attachment. Most of the calls were made by adults, not children. When we described the symptoms of children with mental disorders, a lot, 80-90% of the calls were made from grandparents, or caretakers, telling us that their grandchildren had the same symptoms as described on the radio. Nearly 100% of these cases are due to the parents leaving rural areas for urban areas to make a living over a long period of time, not returning to take care of their children. Children at an early stage, if separated from their parents, they will be troubled, leading to behavioural disorders'* (KII, Hotline, MOLISA).

On 6 December 2017, upgraded from the children consultancy and support hotline, the **National Child Protection Switchboard with the telephone number of 111** was lauched with the responsibility to

provide children with psychological protection and consultancy.

5.3 Mental health and psychosocial service provision through schools

On 18 December 2017, the Ministry of Education and Training issued a circular guiding the implementation of psychological counseling for students in general schools with the purposes to: (i) Prevent, support and intervene (when necessary) for students who are experiencing psychological difficulties in their studies and life so that they can find approriate resolution and mitigate negative impacts which may possibly occur, contributing to the establishment of a safe, healthy, friendly and violence-free school environment; (ii) Support students to practice life skills, strengthen their will, trust, courage and appropriate behaviors in social relations; exercise physical and mental health, contributing to the forming and improvement of their personality.

There are two main ways in which mental health and psychosocial wellbeing of children and young people are potentially addressed through schools. On the one hand, and as also mentioned by children, life skills training, which includes *'teaching the kids about social skills, life values, self-management and working ability; about all the different fields, understanding about themselves, about society, about relationships, about their working capacity, and [guiding the children to] practice all these skills'* (KII, Psychologist, Olympia School, Hanoi), can have an impact on their broader psychosocial wellbeing. This training is carried out by teachers who themselves have usually been trained specifically on this. The number of hours spent on this subject varies by school, with private schools generally paying more attention to it than government schools: *'This school pays a lot of*

"

'The boys are in 6th and 7th grades. Almost no boys in 8th and 9th grades come because they have their own passions. For example, they like playing shuttlecock kicking on the playground, which is more interesting'

(KII, school psychologist, LSS District 3, HCMC).

attention to life skills. I proposed that all the school teachers spend one hour/day on teaching life skills to primary pupils, and two-three hours/week to secondary and high school students, not like other schools which only allow one period per week for life skills education' (KII, Psychologist, Olympia school, Hanoi).

The second main way of providing support to mental health and psychosocial wellbeing in schools is through school-based counselling services (see Annex 2 for further details on the background of school counselling in Viet Nam). Thus in An Giang, for instance, six schools are currently providing counselling. However, this service tends to be provided mostly in upper secondary schools (USS) and in urban areas

(which often go together, i.e. many USS are located in urban areas). Similarly, the large cities of Hanoi and HCMC appear to have a more widespread programme offering psychological services, particularly private schools:

Q: Do the private schools in Hanoi have psychological counselling rooms?

A: Some schools do; and we also launched a school mental health care program at Doan Thi Diem School and some other schools. The schools implement it themselves and pay the salaries with their own money, because they're not limited in terms of number of official staff. (KII, National University, Hanoi)

Box 6: Systemic counselling in schools (a case of Olympia School in Hanoi)

'In general, [the children's situations] are varied, but of course the majority of them don't have good connections, at least to their family. Because when I ask them who they often talk to, the children often answer that they usually don't talk to anyone. Not because there's something wrong with their parents, but in general they don't feel connected. In this school, my counselling approach is a systematic one.'

'For example, people often think of counselling as directly influencing (working on) a child when he or she is under distress or bullied, or worried or miserable about something. But here I will not only do that, but also influence the amount of homework assigned to him/her. Homework can be reduced for him/her for a while. I will intervene in things such as [making sure] at least one teacher will talk to him/her once a day, or make a certain number of calls to him/her outside class hours, or talk to him/her before or after class. Or there must be some kind of activity in his/her class to create a more favourable environment for his/her presence in that community. And I'll influence the education system around him/her, or his/her family, for example, the family culture must be changed. For example, in the afternoon, he/she should not have to wait for too long for her parents to pick him/her up. Their parents need to pick him/her up on time. Because I work in a school, my advantage is [my ability of] influencing the system. And I find this approach very effective for children, because we can't demand that a child is an agent of change; instead, the entire system has to support him or her.'

'We support each family throughout an entire process of change, from very little things; it's a long process; changing habits of not only one individual. In all the cases that I provided counselling for a year or 3 months or so, the change has been quite steady. I mean they change from the smallest things. Some people, when they got home and saw their children throwing things around, they shouted at the kids right away, and so suddenly everyone in the family became tense. And my counselling is very simple; I ask them for example, "When you go home, you just say hi to your child and then go take a shower; after the shower, you'll already have a different feeling when you see your child; you won't feel annoyed and tired anymore." I aim for such changes to change the state of the whole family, from the smallest habits of that system. If meals are the only time when the family meet, I'll follow up with them, to see what percentage of time is spent by parents and children on talking to one another, I'll take notes about the parents and the children; every change needs to be followed up with for quite a while before it becomes the new norm. In principle, once I've talked to them, they may stop shouting at their children for the next three-four days, but because it's a habit, of course they tend to revert to their old habit very quickly. In some cases, if they're highly motivated to change, they will stay with the counselling process for a long time; they will come once a week and say, "Oh dear, I hit my child again yesterday," and I'll listen and give them advice. Or, "Everyone in my family has been very happy the last few weeks!" and then I'll acknowledge their [efforts]. Such a procedure brings more sustainable changes.'

KII, psychologist, Olympia School, Hanoi

The quality of the counselling service as well as the level of training and commitment of the counsellors provided in schools appears to vary considerably, with those outside of Hanoi and HCMC being of generally lower quality and, consequently, rarely accessed. In the large cities, the quality is quite high. For example, the psychologist in the lower secondary school (LSS) in HCMC has a degree in educational psychology from the HCMC University of Pedagogy. She holds sessions in the school five times a week, and in some cases her job requires her to go to students' homes (often on Saturdays and Sundays), providing consultation through emails and also through Facebook (KII, school psychologist, LSS District 3, HCMC). The psychologist at Olympia School in Hanoi holds a degree from France and prior to starting at the school was a lecturer in psychology at the national university. While recognising that teachers can do counselling and some have been sent for training, she feels that there is need for professional psychologists in schools.[6] Similarly, while she recognises that different approaches are necessary according to different cases and can take varying lengths of time, she generally works within a systemic approach that deals with the child in context over a relatively long period of time. As a result, she also talks to parents, and teachers and takes into account the general environment around the child (see Box 6). School psychologists also refer the children to the national hotline and to a new website (ask14. vn), where it is relatively easy for children to share their problems anonymously and receive answers (KII, school psychologist, LSS, Dong Anh district, Hanoi).

According to the school psychologists, there are many ways in which students are made aware

of and can access the counselling units. The counselling service can be advertised during school activities; in one school, a Facebook page was created for students. Teachers can also identify students who they think may be facing difficulties, and in other cases, the psychologists themselves may identify students by walking around the school area.

'For example, when I walk around, I see some students who do not play or talk with anyone. They just sit and look at nowhere. That is the first case. The second case is someone who is too naughty, or someone whom teachers complain about too much, so then I invite them to my office to talk to. It is because there are some students with special family conditions. Their parents are divorced or separated. The common thing about most of the cases I invite here is that there are some problems in their families' (KII, school psychologist, LSS, District 3, HCMC).

The number of students that the psychologists see varies. One says she sees, on average, 10-15 students a month (KII, school psychologist, LSS District 3, HCMC) while another says she sees only 4-6 cases each quarter (KII, school psychologist, LLS Dong Anh District, Hanoi). While one psychologist says there are equal numbers of girls and boys in her patient base, another said that for every 10-15 students there are only 3-4 boys and those who come tend to be younger: *'The boys are in 6th and 7th grades. Almost no boys in 8th and 9th grades come because they have their own passions. For example, they like playing shuttlecock kicking on the playground, which is more interesting'* (KII, school psychologist, LSS District 3, HCMC).

Some teachers in An Giang were sent for training to HCMC. One school psychologist in HCMC mentioned getting refresher training from Welink (the courses cost around VND 200,000 to 300,000), and she in turn

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'Patients living in mountainous and ethnic minority areas use it (traditional/ herbal medicine), but people in the nearby areas don't'

(KII, Health Worker, National Hospital of Paediatrics, Hanoi)

sometimes trains others (KII, school psychologist, LSS District 3, HCMC).

5.4 Service provision through informal providers

Traditional medicines and shamanism

The use of herbal medicines and shamanism persists in some areas. According to some study respondents, due to a range of interrelated factors, including remoteness, allegiance to ethnically rooted practices, and lack of awareness, people will take herbal remedies and perform certain rituals before taking people to formal health providers – this is as much

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Box 7: Shamanism and the Hmong according to Hmong Shaman

'In general, yes [there are shamans in my community]. Also in Hmong communities. I am a shaman myself. They ask me to help them; I don't like to do it, but it's our people's traditional custom. Rituals only [help] in part; they have to go to hospital to get over illnesses. Going to hospital and performing rituals, the former makes up two parts, while the latter makes up only one part (of treatment). If a person doesn't get better after going to hospital, or even gets worse, when they get home and perform the rituals, they will get better. […]

We say we go to see the ghost; it's the ghost that causes the headaches, so we'll perform the rituals. It does help to perform the rituals. Yes, the ghost causes belly aches or headaches, or harms and gradually weakens people. There, so I'll see that it's due to this ghost, and ask it whether it wants to eat something, a chicken. And then I kill a chicken and call for the ghost to eat it, then [the patient] will get better. But it won't make diseases (more serious than belly aches or headaches) better; they can only be treated by hospitals.' (KII, Village Patriarch, Keo Lom commune, Dien Bien)

He goes on to say that while he thinks most people believe in this, in general he thinks children do not. He also thinks that people now compared to the past are healthier since *'In the past, old people kept believing that belly aches, appendix pain… they kept saying that it was caused by a ghost, so they just performed rituals, and after 1-2 days, the patient died. They didn't know it was the appendix. Now people don't believe in it anymore; people have studied medicine, and they examine, if it's the appendix, [the patient] will have to go [to hospital] quickly, within 24 hours, to have the appendix removed. Now it's much better.'*

KII, Village Patriarch, Keo Lom Commune, Dien Bien

the case (or more) for mental health problems as other medical issues (see Box 7).

'Patients living in mountainous and ethnic minority areas use it (traditional/ herbal medicine), but people in the nearby areas don't' (KII, Health Worker, National Hospital of Paediatrics, Hanoi)

'The traditional customs of mountainous people are still very backward. Usually they must perform rituals before going to hospital. In some cases, after hospitalisation, they still asked to go home to perform rituals in the middle [of the hospital treatment]' (KII, Psychiatric Hospital of Dien Bien, Dien Bien).

'They [people in the community] buy traditional medicines and use it together with Western medicine. I know that many families go to hospital and they use traditional medicines as the supplement' (FGD, officers of Phu My town, Phu Tan district, An Giang).

The family … parents as supporters

There is a sense that the family already plays an important role in the provision of care for mental health patients and could provide more if they were trained. *'Serious cases should be sent to treatment centres and for those who are living in the family, family members should be trained to provide proper care. It's impossible to train the patients, we are*

just able to train their caregivers' (KII, DOLISA, Dien Bien Phu city).

In the cities there is a move to both train and involve family members in issues relating to both better parenting and how to deal with children facing mental health challenges. Thus, one school in Hanoi provides sessions for parents on parenting skills, though uptake could be better: *'Each parent has the chance to attend at least one half-day training course on parenting skills each year. But among the primary pupils' parents, the attendance rate is about 60% of*

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the parents, while that of secondary and high school students' parents is perhaps 50%' (KII, Psychologist, Olympia School, Hanoi).

Similarly, a psychologist working in a school in HCMC stresses the importance of both working with families as well as the critical role of parents in supporting the general wellbeing of their children: *'There should also be programs for parents to learn that it is essential to care for their children. In the city, there is a large number of students not receiving enough spiritual care. Having money, a*

family just hires a maid or private tutor for children, then how can there be sharing between parents and children? In general, if parents are close to their children, children will have stable psychological development' (KII, school psychologist, LSS, District 3, HCMC).

Parents are also a focus in some of the hospitals in the cities. Thus a health worker in the National Hospital of Paediatrics in Hanoi talks about the training classes held for parents with autistic and hyperactive children: *'We are holding training*

classes for the group of parents of autistic and hyperactive children. The highest number of participants is 20 parents in a time. It is held once a week for the parents who bring the children for consultation in the mental health department on Thursday afternoons and for the parents whose children come for intervention in the hospital every Tuesday. […] It costs [the parents] 200,000 VND a session' (KII, Health Worker, National Hospital of Paediatrics, Hanoi).

Challenges in service provision

6.1 Supply side challenges

In this section we explore challenges in the delivery of mental health services including the failure to differentiate between treatment of serious and persistent mental illness, neurological difficulties and severe learning disabilities with the psychosocial distress associated with the risk factors listed in the earlier part of this report.

Generally, and drawing also on the previous chapter, the realities in Vietnam show that service delivery is mainly concerned with a group of people with serious or severe mental disorders and pays relatively little attention to the provision of services for children and young people facing common mental health disorders and psychosocial distress.

6.1.1 Limitations in coordination between government departments

Our findings suggested that there is a mixed level of coordination between government departments, and although there are some good practices, there is still further room for improvement. Similarly, while the role of the DOH was seen to be critical in terms of coordination between different ministries and departments, it was also seen to be lacking and in need of revision: *'Even the roles of the DOH need to be revised, to include provision of guidance and advice to the provincial People's Committee, and especially concerned departments. There should be guidance from the DOH to the commune health stations and related departments, such as DOLISA and DOET to develop activities to implement. The DOH has the roles of leadership and orientation; and then we can review our target groups for management and treatment'* (KII, DOH, Dien Bien Phu city).

According to study respondents, in order to have effective programme and policy implementation, improved coordination between government departments is critical: *'I think the most important is the inter-agency coordination between MOLISA, MOET, and MOH. Department of Child Care and Protection is implementing community-based consultation on an experimental basis. Because it's a state project, it is located in communities to make it widely effective. In these consultation spots, there will be social workers. It's like a social work centre for children, but staff of the consultation spots have their own duty. For instance, the psychologists will give a test to assess the personality or disorder level of children. Social workers will manage cases and work with community'* (KII, Hanoi National University of Education, Hanoi).

6.1.2 Lack of qualified, sufficient and gender appropriate human resources needed for the care and treatment of severe psychosocial distress …

'Another group that we're totally lacking is psychotherapists. In Viet Nam, there are only about 50 clinical psychotherapists. There are many [people specialized] in general psychology, but that's different. Psychotherapy requires specialized training. For children, psychological therapy has a more emphasized role; if only medication is used, it will be difficult to cure [the problems]; it can even worsen the condition. But in Viet Nam, people don't pay much attention to psychotherapy. For example, the problem of depression is very common among children or adolescents, but most of the cases of children having at-risk and suicidal behaviours are not detected until too late. Or when the facilities provide treatment to patients of depression, they mostly focus more on medication, while medication can't cure these cases. In such cases, they should start with psychotherapy; only when psychotherapy fails should medication be used. On the contrary, they use medication first' (KII, Officer, Agency of Medical Services Administration (Medical Technical Division), MOH, Hanoi).

The limited number of **qualified staff** was a challenge mentioned by all respondents, and particularly at district and provincial level. The limited number of staff from a social work background who are able to deal with less severe mental disorders and psychosocial distress, was particularly challenging. Additionally, there was considerably less capacity to deal with children and adolescents presenting with mental health and psychosocial distress issues: *'In terms of doctors, the human resources specialized in child psychiatry are very limited in Viet Nam. This aspect is largely not being focused on; therefore, in-depth diagnosis and treatment for children with mental disorders are currently very limited'* (KII, Officer, Agency of Medical Services Administration (Medical Technical Division) MOH, Hanoi). Thus, for instance, in An Giang while they have the space/land to build/upgrade the social protection centre (to start to take care of mental health patients), the main challenge is to find permanent qualified staff, i.e. those with a social work background. Similarly, they stressed the need for more qualified staff particularly at community level as currently in An Giang they are almost 'non-existent'.

Even in a city like HCMC, the KIs reported being *'stretched too thin'* in terms of staff, with one KI making a stark comparison between HCMC and Paris to explain his point: *'Paris is a city with nearly the same population as HCMC, but it has more than 3,000 psychiatrists, whereas this city has only 90 psychiatrists in total, from here and the 24 districts. The entire population of France is 60 million people, while ours is 90 million. There, that's the difference between the human resources [of the two countries]'* (KI, Director, mental health hospital, Hanoi).

In HCMC in particular, doctors and psychologists feel unprepared

for dealing with issues around culturally- sensitive issues, including homosexuality, as mentioned by a KI in the Paediatrics Hospital in HCMC: *'And another thing which is quite common at the present, which we are also being confused about and sometimes fail to help – it's the issue of homosexuality. Children nowadays show these tendencies too early. Many children came here just to tell us "I'm here to prove to my parents that that's what I am." I mean they're expressing themselves more strongly. They're also adolescents. More girls'* (KI, Paediatrics Hospital, HCMC).

Self-learning and **on-the-job learning** in relation to mental health appears to be a coping mechanism given the lack of training provided**.** Thus a nurse in Hanoi says: *'I haven't taken any systematic training in the mental health speciality. We are nurses who were trained in general nursing care of children... Regarding paediatric mental health, we have to teach ourselves, read books and learn from more experienced colleagues. Self-teaching poses certain challenges. The workload is heavy and the number of patients is high, we have little time left for self- teaching'* (KII, Health Worker, National Hospital of Paediatrics, Hanoi). Similarly, a health worker in the social protection centre in An Giang says: *'We have to learn by ourselves and provide care accordingly. I know the characteristics of each child, hence, I don't find it difficult'* (KII, health worker, Social Protection Centre, Long Xuyen city, An Giang). In another social protection centre in An Giang, a KI indicates that when mentally ill patients are unwilling to take medicines, the [workers at the centre] mix it with tea to trick them, a technique they learnt on their own: *'There should be training courses on caring for people with mental disorders. We are not professionally trained to care for them. We teach ourselves. Mixing medicine with tea is our own idea. It is not what we are trained. I am not sure if it is the right way or not'* (KII, Vice Director Social

Protection Centre, Long Xuyen city, An Giang).

Even where there were qualified staff, as in the case for the major cities, many are away on further training and short courses. Furthermore, once they are qualified and trained, many of them leave (KII, psychologist, Hospital of Paediatrics, Hanoi). It was also noted that currently in Viet Nam there are limited numbers of students in the specialisations that are needed – according to the hotline manager, they need experts in clinical psychology and special education and *'There are not many students in these two specialisations yet, and it's another story whether they can [find] work after graduating. When we take them in, we do provide training, but funding and training experts are still our limitations'* (KII, Hotline, MOLISA).

Lack of **sufficient (and qualified) staff** also came out in relation to the provisions of counselling/ psychological support in schools. In particular, when comparing public schools with private schools, it was noted that teachers were less willing to take on and provide counselling service to their students (where there was not a dedicated school counsellor or psychologist, which is often the case, as mentioned in several KIIs) because of their workloads and the fact that class sizes in public schools were so large (50-55 pupils vs. 25-30 in private schools). This reluctance existed despite the fact that the school principal (of a public school) was keen to start a counselling programme in her school and was willing to provide some incentives for the teachers (KII, National University, Hanoi). Additionally, it was felt that there should be a dedicated and appropriately qualified psychologist or counsellor in schools, as opposed to teachers taking on additional workloads and being unqualified for it. Because of salary-related constraints in public schools where there are psychologists, it was

> **'There should be training courses on caring for people with mental disorders. We are not professionally trained to care for them. We teach ourselves. Mixing medicine with tea is our own idea. It is not what we are trained. I am not sure if it is the right way or not'**
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> **(KII, Vice Director Social Protection Centre, Long Xuyen city, An Giang).**

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'Only some schools do it (school counselling) substantively. In some cases, the sign of "school counselling corner" was hung on the door, but no one comes in. It means that they haven't won the trust of the students'

(KII, Principal Teacher, USS Phu My town, Phu Tan district, An Giang).

noted that they are often unable to carry out the necessary number of sessions with the students or have the continuity critical for dealing with issues related to mental health and wellbeing. Finally, it was noted that byworking in the private sector, someone can earn three times the salary as in the government sector (KII, school psychologist, LSS District 3, HCMC).

Even where there are school psychologists, often **their gender** is not appropriate, i.e. girls are reluctant to speak to male counsellors and vice versa (see also sections 4 and 5). Thus possibly because of gender issues, but also because of sufficient/ qualified staff and lack of awareness, some schools may have a counselling service only in name: *'Only some schools do it (school counselling) substantively. In some cases, the sign of "school counselling corner" was hung on the door, but no one comes in. It means that they haven't won the trust of the students'* (KII, Principal Teacher, USS Phu My town, Phu Tan district, An Giang).

6.1.3 Stress on existing mental health providers…

Arguably mental health providers face a double stress burden. First, they are stressed because the scarcity of mental health providers increases the workloads for existing ones. For instance, in HCMC, the head of the psychiatry department explains that as a result of limited staff, they are unable to meet demand for services. Second, providers speak about the high levels of stress because of the subject matter: *'Most of us are under pressure, we have to be self-confident to endure the pressure. Usually the pressure is very high' (*KII, Health Worker, National Hospital of Paediatrics, Hanoi). Similarly, the director of the psychiatric hospital in Dien Bien says: *'A psychiatrist is always at a disadvantage, because taking care of normal people is already hard work, let alone taking care of this type*

of patients; we have to care for them day and night, even when they have a fit. When they have a fit, we have to work extremely hard, because they have disordered behaviours, and we can even be beaten. Caring for and serving them are very strenuous and difficult; and for difficult cases, they will run away immediately if we fail to watch them. If we lock them up in a room, they'll defecate all over the place. Regarding our compensation policy, we are included in the group of hazardous and dangerous occupations and get our occupational allowance which is 70% of our salary. And plus 0.4% for the hazardous nature of the job. Nothing else. It's similar to those working in TB, forensics, and HIV. In some provinces with better conditions, they get an additional 30% of their salary' (KII, Psychiatric Hospital of Dien Bien, Dien Bien).

In terms of remuneration, when asking about the salary of psychologists, in the one hand the response that the salary was fine, but on the other hand it was felt that it was not sufficient when compared with other staff since psychologists have to devote much more time to a single patient: *'We think that it (the salary) is reasonable. It is not high, it is not low, and it depends on what people think. It is low in comparison to staff members of other departments, because we spend nearly one hour to handle a case, while other specialists have done a lot of things in the one hour'* (KII, psychologist, Hospital of paediatrics, Hanoi).

Similarly, in HCMC, a psychologist in the hospital of paediatrics reports that, *'Frankly, we work for the State, so we must accept its pay policy. But often times I feel it's not worth our efforts. Because it doesn't match what we have to do and invest in. For example, in the hospital, we charge 70,000 VND or 150,000 VND per case (30-60 minutes), while our colleges in the private sector can charge 500,000 VND-700,000 VND for a similar therapy session. The difference is quite big for that same*

work position' (KI, Psychologist in Department of Psychiatry, HCMC).

6.1.4 Undervaluing /stigmatizing of mental health services

Not only do people refrain from accessing mental health services because of the stigma associated with mental illness, but there is also a sense coming from providers that mental health is not seen on a par or is undervalued when compared to other health areas. Thus, for instance, as a KII from the national hospital of paediatrics in Hanoi reports, given that mental health challenges are not as visible as physical injuries, people do not treat them as seriously. Similarly, mental health issues cannot be treated quickly in comparison with physical injuries, which usually have visible treatments and improvement quickly manifests itself.

'Many people think that patients in this department (mental health) are not in as serious conditions as those in the intensive care department, or other departments where the seriousness is visible. It takes much more time for patients in this department to improve and the improvement is not as visible as for the patients with physical injuries. For example, patients with high fever are treated with fever reducer, patients with pneumonia are treated with injections for several days, and then they recover. It is unlike treating the patients with high fever who recover after several days of intervention. It is so difficult' (KII, Health Worker, National Hospital of Paediatrics, Hanoi).

There is also the perception amongst the mental health doctors themselves that delivering mental health services does not have as much status as doctors working in the General Hospital, as the quote from a mental health doctor in Dien Bien shows: *'Even among us, we say that working in the mental hospital or TB hospital doesn't sound as impressive as those doctors who work in the General Hospital over there. It's even the same at the central level; those working in* mental health are at a disadvantage' *(KII, Psychiatric Hospital of Dien Bien, Dien Bien)*. Similarly, a respondent from the paediatrics hospital in HCMC says that for some, being a mental health doctor is a last resort: *'.. very few people choose to follow this career. Those who choose it can be divided into two groups. Some follow their family tradition. And others are employed by no one else, so they are driven to this position. In general, in the doctor's circle, the mental health doctors receive less respect than others. But the situation is different if I am a podiatrist associated with psychology, the approach is different, the word 'psychology' is preferable. People prefer visiting a psychological ward to a mental ward. Because mental disease means something terrible to them* (KII, Paediatrics Hospital No 1, HCMC). Another KI discloses that 'psychiatrists suffer from inferiority complexes' and being a psychiatrist himself, he does not specify that he works for a mental health hospital in social gatherings, choosing instead only to mention the name of the area he works in.

6.1.5 Infrastructure

Infrastructure-related challenges appear to be more frequently mentioned in the locations outside of Hanoi and HCMC. The challenges in locations beyond Hanoi and HCMC range from having no provincial mental hospital, as is the case for An Giang, to having poor infrastructure and equipment. In An Giang, there is only a small psychiatric ward in the general hospital, so patients have to be sent to Tien Giang, Dong Thap and HCMC for treatment. Since the number of people, particularly young people, facing mental health challenges is increasing, this lack of a specialised centre raises severe challenges (KII, Social Protection Division, DOLISA, Long Xuyen city, An Giang).

Even where there is a mental health hospital, as in the case of Dien Bien Phu City, it continues to be housed in the TB hospital, and the focus on providing treatment to children is largely absent. This hospital also lacks space and equipment, yet people travel up to 300 km to go there because there are no services whatsoever in outlying areas. Likewise, Social Protection Centres, despite increasing caseloads, often lack the space to expand to accommodate more beneficiaries (Dien Bien) and/or accommodate the addition of mental health patients (An Giang).

In terms of challenges in infrastructure relating to school counselling services, as also mentioned by students, often the office or room is inadequate; thus, students will refrain from seeking out the service: *'..many schools do not have good facility, students will not come if the room is not relaxing, or for example, if the consulting office is near the principal's office, students won't dare to come"* (KII, Social Work Centre for Child Protection, Long Xuyen city, An Giang).

6.2 Demand side challenges

In this section we explore challenges relating to access and uptake of services. According to study respondents (see also Section 3), either people: i) **do not recognise mental health challenges**; ii) even if they do see that their child might be facing difficulties, they **do not think it is important enough when compared to physical health to warrant attention,** including sending them to an appropriate service provider; iii) **do not know where to go for an examination**; and iv) **will only access a service provider, rather than caring for them at home, if someone is seen to have a 'serious mental health problem'**. This is particularly the case in areas where there are limited service options and availability. But even in areas where there are appropriate services, people are reluctant to access them – often because of the associated stigma – and even if they do access these services, either they do not see their importance or get disheartened when the individual does not appear to be improving:

'Several patients don't understand why they come here. They say that they come here at the doctor's request, so they don't cooperate. They only listen and do what they are told to do, they don't understand this stuff. In their mind, medicine should be used to cure diseases … According to psychology, the most common response to diagnosis of such diseases is that at first they reject the diagnosis. They can't accept that the diagnosis is right. They will argue or look for another doctor to have the diagnosis which they like. It is a normal response. Before the diagnosis, they don't tell anyone. After the diagnosis, they hide it (KII, Paediatrics Hospital No 1, HCMC).

'Mental illnesses are extremely difficult to cure; they can only be stabilised. Whether it takes a short or long time depends on whether they

take medication regularly or not. Their families get disheartened. They (people) are poor, and once broke, they don't have any more money for treatment'* (KII, Psychiatric Hospital of Dien Bien, Dien Bien).

The **lack of importance placed on mental health** issues was also brought out by a mental health doctor in the psychiatric hospital in Dien Bien when comparing differences between Viet Nam and 'developed countries': *'In developed countries, they really pay a lot of attention to mental problems, such as headaches, sleep loss, anxiety and stress; when they have these problems, they will see a doctor for counselling, treatment and care. We're only a developing country, so for now we only pay attention to physical health. Secondly, people underestimate [mental problems]; they only seek treatment once it's already become serious"* (KII, Psychiatric Hospital of Dien Bien, Dien Bien).

In remote areas, people will **resort first to herbal medicines and perform rituals**, for both mental health and other related problems, resulting often in coming too late for treatment: *'The majority of people are not well aware, so people in remote hamlets usually hold worshipping rituals before going to health centres … Three years ago a baby was brought to the centre; I told them that the baby had a very serious case of pneumonia and gave them permission to transfer to a higher hospital, because I didn't have enough medicine or the oxygen concentrator… They brought the baby (home) to perform worshipping rituals and intended to bring the baby to hospital the following morning, but he died. After performing the ritual, they picked leaves to hang around the house* (KII, Commune Health Center, Keo Lom commune, Dien Bien).

The general lack of knowledge about mental health issues among medical professionals is also an obstacle; patients often have to go from one

doctor to another before being finally referred to see a psychiatrist/psychologist: '*When patients come, we often ask them if they've been somewhere else for examination before coming to us. Many people said that when they had such symptoms, they went to the local health station at first. For example, when a patient felt he had a problem, he went to the health station, but they (health staff) said there was no problem and just gave him some supplements. And then they (patients) would go to the district, and then provincial hospital. Most of them went to the General Hospital. Some even came here with a pile of medical files; I mean they've done all these tests without finding out anything. And I don't know how much money they've had to spend all those years. They only came to our ward in the end. When asked why they didn't come from the beginning, they said that they didn't know, that other doctors didn't tell them*' (KII, psychologist in Paediatrics Hospital, HCMC).

The **gender of providers** also creates challenges for uptake of services. As also outlined in sections 4 and 5, according to children and young people, the gender of the school counsellor will influence whether their services are used. Thus, for instance, girls are reluctant to talk to a male counsellor. Similarly, a female school psychologist mentions that boys do not share freely with her compared to girls*: "Some boys come for consultation, but don't feel comfortable so they do not share all the details about their problems. And their friends tease them so I cannot complete my consultation with them. Girls even send messages to me whenever they are sad* (KII, school psychologist, LSS, District 3, HCMC).

Stigma also remains a barrier to accessing services as noted in several key informant interviews, for instance with the director of a mental health hospital in HCMC: '*People's attitude is a big problem. It's called "stigma" (using the English word).*

People think that mental illnesses are abnormal illnesses that these illnesses twist a person's personality, and are incurable. Whenever they talk about "mental", people tend to be sarcastic, contemptuous, or want to deny. Any family that has a mental patient feel haunted by it. If they have another type of illness, they can talk about it with people outside the family, such as "I have a stomach ache", but if someone in the family has depression, anxiety or psychosis, they will hide it. Sometimes they go for health examinations, but they mostly will hide it from other people.' There were even discussions about changing the name of the mental hospital in Dien Bien to encourage more people to access the services.

Others also share that they refrain from using the term mental health when they work with families and instead use child health: '*First and foremost, it's necessary to control the so-called stigma which influences families. Families are afraid that their children have mental problems, they will hide it. You think, "if a girl of grade 7 or 8 is a mental patent, her future will be influenced". It also relates to her prospect of marriage. But if you say it's the health of the mind, it's fine. We did research to find out what people think about mental health, the health of minds, mental disorders. If you say it's mental disorder, [people will think] it relates to the situation that children learn too much and the situation can be worked out by letting them rest, changing their schedule and reducing shouting at children. But if it's mental problem, you have to take medicines and hospitalise. The symptoms are known as looking half-witted and wandering aimlessly. No one wants their children to be considered having mental problems*' (KII, Officer, RTTCD NGO, Hanoi).

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"Some boys come for consultation, but don't feel comfortable so they do not share all the details about their problems. And their friends tease them so I cannot complete my consultation with them. Girls even send messages to me whenever they are sad

(KII, school psychologist, LSS, District 3, HCMC).

Political economy of mental health and psychosocial support in Viet Nam

Viet Nam's rapid economic growth over the past two decades has brought many financial resources for increasing state expenditure on healthcare and contributed to improving the health of children. The Vietnamese Government has also introduced various strategies and solutions to reform the policy of health financing, including rapidly increasing the proportion of public finance resources; reducing step-by-step the out-of-pocket payment method; and upgrading health facilities, with priority given to strengthening the grassroots healthcare system, the preventive medicine system, the provincial and district-level general hospitals, and the regional health centres.

The policies related to socialisation of the healthcare system - which include policies related to public finance resource allocation, universal healthcare coverage, health insurance for the poor, and healthcare services for disadvantaged groups such as ethnic minority children and poor children - which the Vietnamese Government has been implementing over the past years have produced favourable results, contributing to better healthcare for children in Viet Nam, despite continued inequality of access across social class and geographical area (Dang, 2015 a, b).

7.1 National level legislation and policy on mental healthcare and psychosocial support for children

Currently Viet Nam does not have an explicit mental health law, or any specific legislation on mental healthcare for children in particular. No policy dealing with children's mental healthcare explicitly has been in place. Nevertheless, general healthcare for children has been well noted in the Vietnamese legal system, which shows the Vietnamese Government's efforts

and commitment to ensuring every child enjoys the best healthcare possible, as clearly stated in the UN Convention on the Rights of the Child, of which Viet Nam was the first country in Asia and second in the world to ratify. Moreover, Viet Nam has also developed and put into effect multiple policies and programs related to healthcare for children. The Law on Child Protection, Care and Education, first passed in 1991, was revised and renamed the "Law on Children" in 2016. The law, which provides for children's right to comprehensive childcare, will go into effect on 1 June 2017. It. Healthcare for children is also mentioned in several other laws, such as the 1989 Law on Protection of People's Health, the 2008 Law on Health Insurance, the 2006 Law on Gender Equality, and the 2007 Law on Domestic Violence Prevention and Control (see Annex 4 for further details). In addition, there are a number of other laws that do not deal with the topic directly, but have regulations related to protection of children's right to healthcare in the event of legal conflicts or violations, namely the 1999 Penal Code (amended in 2003 and 2016), the 2000 amended Law on Marriage and Family, and the 2006 Law on HIV/AIDS Prevention and Control. Moreover, the Law of People with Disability (Law No. 51/2010/QH12 addresses people with disabilities more generally. Individuals living with mental, psychiatric and intellectual disabilities are identified as a subgroup under Article 3 whereas Article 4 of the disability law prescribes the rights of people with disabilities.

In parallel with revising and improving the laws, the Vietnamese Government has promulgated and led the implementation of various policies, strategies and programs that directly or indirectly address healthcare for children in general and mental healthcare for children in particular. Examples include the

National Program of Action for Children, the Extended Program on Immunization, the National Strategy on Nutrition, the National Strategy on Protection, Care, and Improvement of the People's Health, the National Action Plan on Safe Motherhood, and other policies on financing healthcare, strengthening and developing the grassroots healthcare system, regulating Social Protection Centres, and improving the quality of healthcare services.

Specifically, some policies are more aligned with addressing the needs of mental health issues than others. For instance, Decree No. 136/2013/ND-CP states that individuals must have *severe* disabilities in order to accesses social assistance benefits (UNICEF & MOLISA, 2015). Decree 68/2008/NĐ-CP delineates policies that regulate Social Protection Centres such as ensuring the admission of individuals who are living with exceptionally serious (mental) disabilities, pending the absence of family support or ability for self-care. This decree also grants beneficiaries at Social Protection Centres the rights to: health care, education, information, vocational training, leisure activities, opportunities for production, autonomy and community interaction (ibid.). The Government Decree No. 103/2017/ND-CP dated 12 September 2017 regulates the establishment, organization, operation, dissolution and management of social assistance facilities. The Decree No. 28/2012/ND-CP dated 10 April 2012 details and guides the implementation of a number of articles of the Law on Persons with Disabilities. Similarly, in 2011, the Vietnamese Government approved the decision No. 1215/QD-TTg approving the scheme of social support and community-based rehabilitation for people with mental health illnesses and people with mental disorders for the period of 2011-2020. The scheme aims to mobilise families and communities to provide spiritual and material

support to the rehabilitation of people with mental illnesses to help them stabilise their life, integrate into the community and prevent people from acquiring mental disorders, thus ensuring social security (MOLISA, 2014). A number of agencies and departments are responsible for implementing the scheme. Among them, MOLISA plays a key role as the hosting organisation, followed by the MOH and MOET. These ministries also coordinate with organisations and agencies at various levels to carry out the scheme's activities at these local levels. To date, four projects have been rolled out: (1) Constructing infrastructure and equipment for the social protection facilities which provide care and rehabilitation services for people with mental illnesses; (2) developing human resources for community-based social support and rehabilitation for people with mental illnesses; (3) developing facilities for mental disorder prevention and treatment; and (4) communicating and raising awareness on the responsibilities of families, communities and the wider society in caring for and rehabilitating people with mental illnesses.

As a result of the Programme 1215, by 2014, there have been 45 social protection units (which include social protection centres) which provide care and rehabilitation for people with mental illnesses, of which 26 units provide specialised care and 19 units provide combined care (MOLISA, 2014). Some provinces and cities have built successful models of occupational therapy and rotating rehabilitation for people with serious mental illnesses, for example the Provincial Centers for Social Protection in Son La or Thua Thien Hue and the Center for nursing and rehabilitation for people with mental illnesses in Viet Tri. The centres have taken initial steps in combining counselling, psychological therapy and social work services with

medical treatment to prevent and treat mental disorders. Moreover, 34 provinces and cities have built social work centers some of which have been evaluated by MOLISA to be effective (e.g., the Provincial Social Work Centers in Quang Ninh, Da Nang, Ben Tre, Long an, Thanh Hoa and Ho Chi Minh city).

In 2010, the Prime Minister of Viet Nam approved the National Project on Social Work Profession Development (2010-2020) to be implemented by MOLISA with the aim of training 60,000 social work staff, including both social workers and managers, by 2020. Based on that, on 24 October 2013, the MOLISA issued the Circular No. 07/2013/TT-BLDTBXH regulating professional standards of social work collaborators at commune/ward/town level. It tasks the social work collaborators with helping people with mental illnesses and people with mental disorders including: collecting and receiving information or requests for help from beneficiaries; monitoring and assessing their health situation, family and social relationships and what kind of support they need ranging from counselling, consultancy, therapy, education, prevention to separation; participating in the implementation of policies and programs supporting the beneficiaries; and participating in communication efforts to raise awareness for families and communities on mental health. So far, 50 provinces and cities have approved the plan for establishing the network of about 10,000 social work collaborators. Some provinces or cities like Quang Ninh, Long An, Ben Tre, Da Nang, Thua Thien Hue, An Giang, Khanh Hoa and Phu Yen have taken initial steps in forming the network of collaborators and social workers. MOLISA has also collaborated with universities those provide training on social work in development of training programmes and curricula in the

field of mental health. As a result, six training modules on mental health care have been developed, including general knowledge on mental health care, case management, clinical psychology, counselling, social work in mental health care, and procedures for caring and rehabilitation for people with mental illnesses (MOLISA, 2014). Additionally, MOLISA has collaborated with UNICEF and the University of Social Labour to develop curricula and technical instructions on social work professional skills in supporting people with mental illnesses and to organise training courses for social welfare cardes and staff of employees who work at social protection centres for people with mental illnesses in the provinces which implement a pilot project (ibid.).

In 2006, the Ministry of Health issued the 'National comprehensive plan for protecting, caring for and enhancing Vietnamese teenagers' and young people's health for the period 2006-2010 with vision to 2020'. Among other things, 'mental trauma and other issues related to mental health' are seen as one of main dangers to Vietnamese teenagers' and young people's health.

Presently, the government of Viet Nam is creating a National Mental Health Strategy on prevention and control of mental disorders for the period 2015 – 2020, with a vision to 2030 (UNICEF & MOLISA, 2015).

Additionally, the first ever National Programme on Child Protection in Viet Nam (2011-2015) promoted the establishment and functioning of the community-based child protection system (CBCPS). Specific aims for this programme were that community-based social assistance would be provided to 80% of children in special circumstances to rehabilitate and reintegrate themselves into the community and 70% of children at risk of falling

into special circumstances would be identified for early intervention so as to mitigate and eliminate that risk. There were five priority projects under this programme: a) communication, education and social mobilisation, b) building the capacity of child care and protection staffs, collaborators and volunteers, c) building and developing child protection service systems, d) building and expanding models of community-based support for children in special circumstances, and e) improving the effectiveness of state management of child protection and care. Although the improvement of the mental health of children is not explicitly stated in the objectives, the nature of the projects and target beneficiaries (e.g., vulnerable groups, such as children, who are victims of trafficking, kidnapping, abuse, and violence; children with injuries; and children from poor families) suggests that they will reach children who are in need of mental health services. See also Annex 4 for further details of these policies, strategies and programmes.

In summary, from reviewing the system of laws and policies related to healthcare for children, it can be argued that this system has created a basic legislative and policy framework for the improvement of children's healthcare. However, within this framework, there is still a need for specific regulations that explicitly address the issue of mental health care for children. According to the Ministry of Health (2009), limitations of the strategies and policies on healthcare for children lie in the lack of science- and evidence-based content and targets. Policy-making is too slow to keep up with the country's speed of economic and social development. Collaboration between different sectors has not been vigorous enough, and the monitoring and supervision of policy implementation are still limited.

7.2 Existing programmes and plans on mental health and psychosocial wellbeing

The National Target Program on mental health started in 1998 when the Prime Minister signed the inclusion of the Project for Community Mental Health Protection into the National target program on prevention and control of some social illnesses, dangerous epidemics and HIV and AIDS (now it is a part of the National program on healthcare). In 2001, the Government approved the Project for Community Mental Health Protection, which was implemented in three phases, each with a distinct focus: (1) 2001-2005 with a focus on mental healthcare and protection in communities'; (2) 2006-2010 with a focus on the integration of epilepsy and depression into the first phase of the project as part of the initiative 'Prevention and Control of Some Non-communicable Diseases'; and (3) 2011- 2015 with a focus on mental health protection for communities and children.

According to the report on implementation of the component project of '*Mental health protection for communities and children*' (Ministry of Health, 2015) during the period 2011-2015, treating mental illness patients in communities helps them stabilize their illness quickly, integrate more easily with their families and society and reduce the cost of treatment. The network of mental healthcare has developed evenly and widely from central to local levels; mental health expertise has also been improved among district and commune level officers. The project is implemented in all 63 provinces and between 2011 and 2015 it treated an estimated 72% of all patients nationwide diagnosed with schizophrenia, 65% of all patients nationwide diagnosed with epilepsy and it also treated a total of 19,900 suffering depression. Unfortunately,

the report does not disaggregate the data related to children and teenagers.

However, there are many challenges to the effectiveness of the project, including financial and human resource issues, as well the community's attitude toward mental illnesses. Funds allocated to the project in its first year, 2011, were only 47% of the planned amount, and the discrepancy between the budgeted and allocated amounts grew over time. In 2012, the project only received 42% of the budgeted amount, in 2013, 37%, and in 2014, a paltry 11%. The report also indicates factors that constrain effectiveness of the project (they are also difficulties facing the project), including: specialised doctors and medical personnel serving the psychiatry sector are lacking; the education work on mass media is limited, especially in remote, mountainous and island areas; the system of mental healthcare services is inadequate; some localities do not have inpatient care facilities; people's awareness about mental illnesses is still limited; many mental illness patients are not in treatment; and transportation for implementation and checking are not available.

The Joint Annual Health Review of 2014 (ibid) evaluates difficulties in implementing the projects and indicates that the implementation of policies on mental health care in Viet Nam is not comprehensive and lacks a long-term vision. Not only has the law on mental health has not been formulated, but existing policies are not based on a comprehensive, long-term strategy with vision, target and concrete solutions on mental health. The project that only focuses on schizophrenia, epilepsy, depression, has not dealt with other common mental disorders, has not focused on special target beneficiaries, such as children, teenagers, pregnant women, mothers, people in detention centres, and people with mental

disorders after natural disasters. Management of depression patients is only implemented in some pilot models and hasn't been included in a regular management program. There is no intervention to reduce the risk of mental illnesses in communities, schools, families and workplaces (MOH and Health Partnership Group, 2015).

7.3 Limitations in policies

When people were asked their views on policies around mental healthcare, particularly for children and young people, it was generally thought that these were lacking and more attention needed to be paid to them, both within the health sector more broadly and also with school related health care. This lack of services results in, amongst other things, people not being able to access services or going to inappropriate places. There was also a sense that while there is policy on mental health, though not necessarily for children, little or nothing exists concerning psychological counselling, and if there is some psychological service being provided, often through the private sector, it is not regulated in any way (see Box 8).

Even where there are policies, as already seen in section 4, there is a lack of staff and other resources to implement them.

'*In terms of effectiveness, the policies introduced by the state, no matter what is said, always bring a certain impact on the beneficiaries, helping them to be more stable, and solving part of their family difficulties. But the most challenging thing at the present is that, although the policies are there, the current human resources to support these target groups at the grassroots level are insufficient, even mostly non-existent. I mean in addition to the money, we need a team to provide psychological counselling*

Box 8: Limitations in policies

On mental health care and children

'*The healthcare sector only takes care of children's general health and nutrition. There is no program for mental healthcare for the children … school healthcare deals only with dentistry and ophthalmology. With regard to mental health, the school medical workers are unable to detect any issue. It is not their specialty. Most of the workers are accountants and take charge of the school medical units; they were not trained in medicine*' (FGD, provincial officers, Long Xuyen city, An Giang).

'*Regarding the policy on mental health, I think that the public healthcare network should pay more attention than it does today, because most patients look for help at the national paediatric hospital. There is no public mental healthcare service, according to my own point of view, there is no such thing*' (KII, Health Worker, National Hospital of Paediatrics, Hanoi).

'*This field (children and young people's mental health) hasn't received much interest in the community. Currently, within the mental healthcare system in particular, and for children in Dien Bien in general, it's largely still absent. Guidance from the Ministry and province for this field has been very limited. The issue of mental healthcare for children really needs more attention from the Government and Ministry. Only after that can we have orientation for its programmes; the province also needs to provide training on this type of work… We need to strengthen the network of mental healthcare, at least at the district level first, and then the commune level. At the commune level, healthcare for the elderly and people with disabilities is receiving more attention*' (KII, DOH, Dien Bien Phu city).

'*There has been no policy for mental health support, especially in terms of prevention. For example, when children suffering from mental disorders go to hospital, they enjoy [benefits under] the Ministry of Health's policies, but these are general policies; there's no special support policy for children… in Viet Nam, there has been almost no policy for mental health support in schools. Neither the MOH nor the MOET has produced any policy. Currently, the MOET has issued a circular on school healthcare and paid attention to the issue of physical health, for example physical education in schools, and there was a circular in 2006 which requires psychological counselling to be provided in schools. They are all there, but there have been no guidelines for implementing these circulars… Therefore, at present, parents and teachers just do what they like*' (KII, National University, Hanoi).

On the psychological dimension

'*Private services are booming. From what I see, in big cities, many types of counselling centres have sprung up; you see psychological counselling centres everywhere you go. But whether such centres are licensed, who manages them and how [good] their quality is are still unclear. Because psychological counselling is an area that has a lot to do with the practitioner's ethics and license. Take depression for example. We often say jokingly that if you don't do a good job, maybe the child will even kill himself, not that he will feel better. And there has been no policy (regulation) either for these psychological counselling centres, for example in terms of requirements of practicing license or professional certificates. Of course those centres must have worked with Science and Technology Department or so, so they're legal, but there is no regulation on professional quality and expertise requirements*' (KII, National University, Hanoi).

'There are policies on mental healthcare. But no policy on psychology is in effect. No professional license is issued or managed. There is no official administrator, making it difficult for both practitioners as well as patients, because people don't know the practitioner's qualification as well as their supervisors. There should be clear regulations about such things. Besides, the developmental and behavioural speciality is very new, I don't know who to ask for help' (KII, Paediatrics Hospital No 1, HCMC).

'There has been no [compensation] policy for psychologists. At the present, the hospitals pay their psychologists independently. The hospitals sign separate contracts with them… There has been no policy either (for).. training or further training' (KII, National University, Hanoi)

'Vocational allowance is needed (for psychologists). For example, the mental health staff working six or seven hours a day can enjoy it. The psychological staff deal with the same cases, but they are not eligible for it. Secondly, they have to work administrative office hours, there is no regulation allowing them to work fewer hours' (KII, Paediatrics Hospital No 1, HCMC).

'The current National Program only focuses on three groups, which are schizophrenia, epilepsy and depression. The rate of children with epilepsy is 0.05%. But in fact, the rate of children with epilepsy currently being managed at commune and ward health stations is lower than 0.05%. That means most of the children [patients] have not been included in treatment management. But that's not everything, because in some cases, the family can afford to send their child to higher-level facilities for treatment, without going through the commune health station. The children's epilepsy treatment gap is about 70-80%; I mean only 20-30% of the children patients are being managed. Although the policy is there – which states that patients of epilepsy or schizophrenia or depression are entitled to treatment management and free medication – in fact, they can't access these services, perhaps partly because they get treatment from other facilities. Besides, maybe during the treatment process, some drugs in the National Program are from the old generation, which have many side effects and can cause other disorders, such as mental disorders, if used for a prolonged period. Only when a child has serious fits of convulsions will he/she be taken to a mental health hospital and given new-generation drugs. At that point they won't want to go back to the commune anymore, because if they do, they will get the same old generation drugs which have a lot of side effects. There are such policy barriers' (KII, Officer, Agency of Medical Services Administration, Medical Technical Division of MOH, Hanoi).

and support to them; even within the labour (DOLISA) or education or health sectors, I find it's lacking. As long as this gap persists, the effectiveness of these programs is not high' (KII, Social Protection Division, DOLISA, Long Xuyen city, An Giang).

Generally, it should be noted that current mental health-related policies are scattered in various legal documents in which mental health is mentioned to varying degrees. Additionally, mental health is generally not considered a major issue in the provisions of these documents. Even in the People's Health Care Law, a very important legal document in the field of health, mental health issues are only mentioned in a cursory manner.

7.4 Future plans regarding policy development and implementation

The Government of Viet Nam is developing the *National Strategy on Mental Health, 2016-2015, with a View to 2030*. The draft document expresses the view of providing healthcare coverage to all people, giving priority to poor regions, those in difficult situations, and ethnic minorities and other vulnerable groups. The attention to children's mental health is also expressed using a lifecycle approach, in which policies, plans and mental healthcare services should be adapted to the healthcare and social needs in all life phases (new-born, childhood, teenage, adulthood and elderly period). Notably, the Draft Strategy has a target for the prevention or early dection of up to 50% of mental disorders in children and teenagers by 2025 *(Draft Decision on the National Strategy on mental health in the period 2016-2025)[7]*.

According to study respondents, several policy recommendations

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have been put forth to improve the national mental health program, but are currently in draft phase: *'Firstly, with such a budget, you should only focus on issues such as training of human resources and communication activities; that money shouldn't be used to buy medicines. Because those drugs, if not provided by the National Target Program, can still be obtained under the health insurance policy if the child has a health insurance card. They will be given drugs included in the MOH list of essential medicines, which are covered by the health insurance. And so instead of buying medicines – and that budget is not enough to do it anyway, they'd better focus on training of human resources to make sure everything is done properly. Currently, children under 6 years of age can enjoy the free medical services policy; as for other groups, from 6 to 15 years old, the rate of having health insurance is very high. For children with mental disorders, usually the local authorities have other policies, for example, if they're from near-poor households, they are all entitled to free health insurance. According to surveys of other mental hospitals, they also said that nearly 70-80% of the patients with mental disorders have health insurance. Therefore, instead of buying drugs for them, you should use the health insurance policy, and there are more drugs in the list of medicines that are covered by health insurance'* (KII, Officer, Agency of Medical Services Administration (Medical Technical Division), MOH, Hanoi).

At the local level, our findings suggested that there are also some specific plans for future implementation of programming and service provision around mental health, including more places to care for people facing mental health challenges. In other places, it appears that the polices and programme have been agreed and they are just waiting for the investments, including staff:

'Two (social protection) centres have got approval in Chau Doc, I mean it's about upgrading the Social Protection Centres, and add the task of caring for mental patients into their existing responsibilities. The Provincial People's Committee (PPC) has agreed and approved everything, but now we're just waiting for investments… Now the hardest part is the permanent staff quota' (KII, Social Protection Division, DOLISA, Long Xuyen city, An Giang).

In An Giang provincial officers also spoke about wanting to establish counselling points in the community and to link child protection workers with Women's Union members who could provide additional support: *' In the period 2016-2020, we intend to publicise the hotline (see above) and upgrade the centres. Secondly, in the child protection program 2016-2020, we plan to connect and establish counselling points in the community to help the children protect their mental health and avoid serious illnesses. We advise the provincial people's committee to link child protection workers with trustworthy addresses of the Women's Unions, which have been established in 156 communes and wards. As we can see, the addresses have been established but very few children and parents come, because they don't understand that child abuse can affect their mental health'* (FGD, Provincial officers, Long Xuyen city, An Giang). In An Giang as well, though also aware of the human resource constraints, they spoke about expanding the school counselling model (currently provided in six schools) as well as establishing further social work offices in 11 districts and towns *'under the government's scheme No 32'* (FGD, Provincial officers, Long Xuyen city, An Giang).

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'In terms of effectiveness, the policies introduced by the state, no matter what is said, always bring a certain impact on the beneficiaries, helping them to be more stable, and solving part of their family difficulties. But the most challenging thing at the present is that, although the policies are there, the current human resources to support these target groups at the grassroots level are insufficient, even mostly non-existent. I mean in addition to the money, we need a team to provide psychological counselling and support to them; even within the labour (DOLISA) or education or health sectors, I find it's lacking. As long as this gap persists, the effectiveness of these programs is not high'

(KII, Social Protection Division, DOLISA, Long Xuyen city, An Giang).

Recommendations

Our findings highlight that while Viet Nam has made huge strides economically and in tackling poverty, the social sectors have often been left lagging, and now with rapid globalisation and exposure, there is an urgent need to tackle the resulting cultural and inter-generational conflicts. Without a firm foundation of support and care for mental and psychosocial ill-being, it will be difficult for Viet Nam to ensure that its young people have the coping skills and set of services to overcome these challenges going forward. Viet Nam needs to find a uniquely Vietnamese path through these challenges, which would involve, at a minimum, drawing on traditional cultural values (e.g. collective solidarity, tight family bonds etc.) whilst also recognising the need in the current age for flexibility and adaptation facilitated through improved communication skills across generations.

Based on the study findings, the report proposes following recommendations:

GENERAL RECOMMENDATIONS

In terms of policy framework, there is a need to complete the national level legislation and policy on mental healthcare and psychosocial support for children. Although the system of laws and policies related to healthcare for children has created a basic legislative and policy framework for the improvement of children's healthcare, there are still many gaps in the mental health care and psychosocial support for children. In the future, Vietnam needs to develop more specific regulations that explicitly address the issue of mental health care and psychosocial support for children and young people.

Develop more and better policies on enhancing responsibilities and coordination between relevant agencies and sectors in the field of mental health care for children and young people. There is a need for additional and improved policies that strengthen the roles and responsibilities of key agencies, including providing clear guidance and mandates to all relevant agencies (MoET, MoH, Commission on Ethnic Minority Affairs and Women's Union) on mental health care for children and young people, as well as specific mechanisms to ensure effective coordination between these agencies.

Based on the study's findings, this report also recommends **increasing the quantity and quality of human resources,** including the development of a training plan for more and better social workers, counsellors, psychiatrists, and psychologists to deal with less severe / common mental disorders, tailoring their training to the needs of children and young people.

Raise and improve awareness around young people's psychosocial and mental health care needs, as well as existing support services, including providing supports to parents, largely through or linked to school environments, in parenting, caring and communication skills training and support, including regular follow- ups to promote positive behavioral changes in mental health care for children and young people.

Increase the number and quality of specific support services for children and young people's mental health care throughout the country. Develop clinical diagnostics standards and activities for children and young people thus allowing for the early detection and treatment of mental health challenges as well as psychosocial distress among children and young people.

SPECIFIC RECOMMENDATIONS

1. Better and more coordinated policies on mental health psychological counselling, for children and young people

Although various policies related to mental health are in place, they are scattered across many different legislation documents; and generally, in such documents, mental health is not a main focus. Even within the Law on Protection of People's Health, a critical document in the field of health, the issue of mental health is modestly addressed. The Government of Vietnam needs to pay attention to improving the policy system related to mental health care and psychosocial support for children and young people, especially in the National Programme on mental health care and healthcare programmes for children. The National Programme on mental health care needs to cover less serious/common mental disorders as well, not only focusing on serious illnesses such as schizophrenia, epilepsy and depression.

Consider **improving the laws and policies** related to mental health care in the social assistance and social security system in Viet Nam, because they serve as the legal basis for increasing human resources and enhancing networks of mental health care services for children and young people, including policies on social work practices. This would allow for: 1) the strengthening of human resources and 2) improving the quality of mental health care services in social assistance establishments and in the community, and 3) development of specific policies explicitly targeting children and young people. This process would need to be led by MOLISA and MOH in collaboration with other key ministries.

School healthcare programmes also need to address more specific issues related to mental health care and psychosocial support for school children; this includes setting specific objectives for the prevention and treatment of mental health problems for school children. Currently, the existing school healthcare policies still focus mainly on physical health, such as prevention and treatment of children's spinal problems, eye diseases, infectious diseases, dental care etc., while mental health care for children, including psychosocial counseling and support, is still being neglected.

Going forward, it will be important for the Government of Viet Nam to approve the **National Strategy on Mental Health in the period 2018-2025**, with its emphasis on providing healthcare coverage to all people, giving priority to poor regions, those in difficult situations, and ethnic minorities and other vulnerable groups. Adequate budget allocations from the Ministries of Health, Education and Labour and Social Affairs will require not only increasing the number of social workers, specialised medical professionals, and community- and school- based counsellors, but also setting standards and guidance for tailored training and periodic retraining to ensure professionals in the field at all levels (national, provincial, district and commune) are adequately equipped to deal with the evolving psychosocial and mental health vulnerabilities that young people face in a fast-paced developing country like Viet Nam. Additionally, synergies should be promoted through the development of an Action Plan and implementation of the **Master Plan for Social Assistance Reform and Development for 2017-2025 with vision towards 2030 (MPSARD),** which includes attention to social assistance for particularly vulnerable groups, including those with mental health problems. In this regard,

MOLISA will have a critical role to play in ensuring integrated policy and programme implementation.

Policy implementation will also necessitate providing **clear guidance and mandates to all relevant agencies** – Ministries of Health, Education and Labour and Social Affairs – to ensure that these goals are reflected in their respective policies and programmes. Additional linkages to ensure a holistic approach to supporting children and young people's mental health and psychosocial wellbeing would include the MOET's Department of Student Affairs), the Commission on Ethnic Minority Affairs, and the Women's Union.

Given the high level of unmet demand for support services and treatment among children and young people, capitalising on existing NGO and private service providers by providing referrals as well as clear guidance on practice standards will be an important short-term step. Of course, any such approach should be embedded within an integrated model that includes attention to addressing broader determinants of mental ill-health and psychological stress, including poverty and inequity.

2. Increase quantity and quality of human resources

There is an urgent need to **enhance training to develop a cadre of health workers**, from nurses to doctors, as well as specialist training. Because the current system is highly medicalised and there is a lack of attention to broader psychosocial wellbeing dimensions, there is a **strong need to pay attention to developing training for more and better counsellors, social workers, psychiatrists, and psychologists** who could deal with less severe types of mental health problems and disorders. Moreover, **tailored**

training programmes in each of these fields related to the needs of children and young people is essential. Embedding such training within an integrated model would be especially helpful, including for the purposes of early detection, prevention, and early intervention.

The role of the education sector and schools in particular is critical here as well. **Thus more training is needed to establish a cadre of dedicated and professional schools psychologists and counsellors**, who are not teachers working as part-time counsellors without professional and formal training, which is now often the case. It is also necessary to develop school psychology graduate programmes, especially given the present context of Viet Nam where huge needs for psychological counselling among children and young people are being met with a very limited system of psychological counselling services are still very limited. Therefore, it will be critical to provide adequate resources for **dedicated counsellors in school settings, along with the appropriate infrastructure (counselling units /centres).** Different models of providing such kind of support in a school environment (e.g. using different kinds of counselors / psychologists) could also be piloting, drawing on existing models currently being used in schools in Viet Nam but also from other countries.

It is also essential to develop a cadre of professional of social workers. While policy documents refer to a **cadre of professional social workers,** our findings highlighted that they are not yet in place, at least in our four research sites. This presents an urgent need for more and better training and capacity building to establish a cadre of social workers in the field of mental health care, clinical psychology and psychotherapy. In particular, there appear to be insufficient incentives

to motivate relocation to rural areas. With the implementation of the scheme to develop social work, there is a possibility of improving caseload burden. However, the scheme only puts forth administrative policies to develop the field of social work and does not lay out ways in which quality of social workers will be maintained. In addition, there is an urgent need to strengthen the knowledge and capacities of the staff at Social Protection Centres. Finally, because existing social workers have such high case loads, there could be important dividends in developing a cadre of para-social workers (commune collaborators) who could play an important role in case collaboration.

The **community health level model** appears to have been very successful in general, although not yet at scale, indicating that there is a need to revisit and support retraining for a cadre of community level health workers. These health workers could in turn be trained in psychosocial and mental health support, and provided with clear guidance and resourcing from district, provincial and central levels.

The **content of the training programmes** need to be developed jointly with mental health and psychosocial experts, drawing on international best practice, but also ensuring that the particular realities of the Viet Nam context are taken into consideration. Modules should include an exploration of different drivers or risk factors of mental health and psychosocial wellbeing amongst children and young people and would include discussion around norms as well as issues around violence and changing contexts all of which can precipitate mental ill health and psychosocial distress amongst this age cohort.

For all cadres of staff, it is important that on the one hand they **are incentivized** to work in this sector,

and in particular that they are incentivized to work in areas beyond large cities. This is particular the case for those dealing with the less severe mental health disorders (the social workers, counselors etc.) who are still few in number. On the other hand, it is also critical that all these cadres are provided with sufficient and good quality **supervision and guidance**.

3. More and improved awareness around young people's psychosocial and mental health care needs, as well as existing support services

Currently, MOLISA provides support for social protection beneficiaries, including people with severe, serious and mild mental illnesses living in social protection institutions and in the community. Every year, MOLISA organizes training to raise awareness among social work staff, collaborators and families about mental health care. There is, however, need to increase these awareness raising activities in order to raise **public awareness around less severe mental health and psychosocial needs of children and young people.** In particular, it would be important to raise awareness about the linkages between discriminatory social norms – e.g. pressures for child marriage, limited options for girls in rural areas given traditional gender roles – and mental ill-health and the social isolation that many girls often feel in such situations.

This awareness-raising can be done through a range of activities including: **developing training curricula** for different carders of workers and relevant to their sector (e.g. health, education); developing **communications activities** targeting communities; and through providing information (leaflets, etc.) at service points (e.g. health centres/ commune clinics, schools, etc.)

This awareness-raising could be done at various levels, but in particular starting at the commune level, providing communities with more information about symptoms, manifestations and available support services, including the role of the social workers (where they exist) as well as hotlines. At commune level, the role of the village health worker could include awareness-raising about mental health, the need to train them to be able to identify symptoms of mental illness, in counselling and referrals. In this regard, the Women's Union as well as other grassroots political and social organizations at ward or commune level, could also potentially play a role in raising awareness among its members and the community more broadly, as well as detecting and referring early symptoms of mental ill-health.

Related to this, it would be beneficial to **support parents with parenting, caring and communication skills training and support**, including regular follow-ups in order to promote behavioural norm changes. Some of this is happening through private schools but could usefully be expanded to public schools, and/or be organised beyond the school environment, e.g. through community health workers following appropriate training.

It is also vital to ensure that the approach is **inter-sectoral**, and so at the commune level for example, must include working with teachers, and training them – given their proximity to children and general awareness about community dynamics – to detect early warning signs and to refer students to school counsellors and relevant healthcare professionals, commune office staff, and social workers.

It is also important that the prevention of potential risks to children's mental health and psychosocial wellbeing is included in the communication

programmes on mental health in the community which are being carried out by MOLISA under the Scheme 1215, Scheme 32, Scheme 647 and Scheme 529. Given that MOLISA has an existing cadre of child protection workers at various levels, more training and knowledge should be provided to them about the prevention of potential risks to the children's mental health, enabling them to carry out this communication work. At the community level, especially in rural areas, there needs to be improved coordination between child protection workers and medical workers, women's unions and youth unions in disseminating knowledge both about potential risks to children and young people's mental health as well as possible ways to prevent this mental ill-health. Communication efforts around children's mental health could also be integrated into existing programmes, such as women's union's programmes, in order to be cost effective.

Moreover, it is also essential to organize activities to raise public awareness and provide knowledge of caring for children with mental and psychosocial problems at the community level. At the same time, effective mechanisms should be developed to link families of children with mental health and psychosocial challenges to social protection services in a professional manner, to support these families in taking care of their children's mental and psychosocial wellbeing.

4. More and better coordinated services throughout the country

Through the health and social protection facility systems, MOH and MOLISA should:

(i) Increase the number and quality of mental health and psychosocial-related services throughout the country, while at the same time ensuring that **appropriate and dedicated infrastructure** is in place for provision of specialized support related to mental health and psychosocial wellbeing.

(ii) In the near future, develop clinical diagnostics standards and activities for children and young people thus allowing for the early detection and treatment of mental health challenges as well as psychosocial distress. This requires active support and budget from MoH, MoET, and MOLISA.

(iii) At the same time, set up collaborations and partnerships between line ministries for the provision of services to ensure complementarity and best use of resources. A cross-ministerial working group and collaboration mechanism could be set up in order to facilitate this at national level, which could also be mirrored at provincial and commune level. At present, MoET has joined the collaboration in organizing regular health check-ups for school children at the beginning of each school year. However, these regular check-ups have been focusing only on height, weight, eye diseases and spinal problems, while neglecting the screening and early detection of students' mental health problems. Therefore, MoET needs to consider including screening and early detection services of mental health problems and psychosocial distress for school children, based on national standardized criteria and tools for diagnosis.

(iv) Besides physical infrastructure, capitalise more on the connectivity of many young people, and ensure that there are **strong online sources of information and support** that can be accessed by mobile phones or computers. At the same time, it is obviously critical that there are adequate safeguards in place to protect children from the negative dimensions of social media and addictive behaviours.

(v) Facilitate **support groups for parents** who are caring for children with specific and diagnosed mental health disorders – e.g. autism or epilepsy. These parent support group models exist in multiple international contexts, so it would be advisable to learn from this good practice and, drawing lessons also from where such groups already exist in Viet Nam, adapt these models to local needs.

In addition, given the inter-linked nature of many psychosocial and mental health problems, there is a need to invest in **systemic counselling,** i.e. working closely with families to help them provide adequate attention and care to their children. This is already happening in some schools but the model needs to be expanded to other schools and beyond the education sector.

In order for these changes to happen, a prerequisite is clearly raising the profile of the specificity of children's mental health needs at national level and across sectors, led by a **clear governmental champion** who can move this agenda forward – in both its mental and psychosocial dimensions.

5. Ministry of Education should take on role for championing children's needs for better mental health and psychosocial wellbeing

Our research shows that a significant set of risks to children's mental health and psychosocial wellbeing are related to study pressures, and to relationships with teachers and friends; meanwhile, risk prevention and control services are still limited, and there is a lack of mental health care and psychological counselling services in schools. As such, MOET has a key role to play and should be encouraged to further champion the mental health and psychosocial well-being of children and young

people. Amongst other things MOET, through both primary and secondary schools, could: i) support a focus on **prevention** by teaching children the skills needed to respond to emotional and psychological difficulties faced in relationships with parents, teachers, friends and people around them - this could be done by increasing the number of class hours devoted to life-skills education in the official curriculum in both primary and secondary schools; ii) **relieve** study pressure by evaluating the volume of knowledge children are expected to learn; iii) invest in developing psychological counselling in all schools, especially for children of ethnic minorities; and iv) **equip parents with skills** that can help ease the problems that children face at school and at home, by teaching them better communication skills and providing knowledge about emotional and psychological difficulties corresponding to the biological and psychological characteristics of children and young people. But also to support parents to understand the importance of having a balanced development of children, of which academic achievement is just one dimension.

MoET could consider developing and piloting a number of models of mental ill-health prevention and psychosocial support in schools for children with mental problems. Currently, a dedicated full-time staff or a part-time staff who is also the school health worker has been available in most of the schools in Viet Nam. This serves as a convenient basis for the provision of checking, screening, managing, counselling services to students and parents in a timely manner in the process of supporting school children with mental problems, at the same time enabling them to access social activities suitable for their health conditions. However, this also requires the Government to invest in training and capacity building for

school health workers in the field of mental health and psychosocial wellbeing.

Moreover, MoET also needs to strengthen the coordination between families and schools related to mental health care and psychosocial support. This could be done through regular communication between families and schools to foster sharing about the psychosocial problems and difficulties that children face at school or at home, and prompt coordination between teachers and parents in supporting children to improve their psychosocial issues. On the other hand, MoET should also develop appropriate communication approaches to support both teachers and parents to understand the importance of having a balanced development of children, of which academic achievement is just one dimension.

6. Further research and better data

Given that the focus of this study was on limited number of areas, broadening the geographical scope in subsequent studies to cover a wider range of regions and ethnicities would be important. More specifically, we would recommend that a number of steps be taken to address the data gaps on children's mental ill-health and psychosocial ill-being in Viet Nam. These knowledge gaps include the following:

- Local level service mapping in order to inform local communities about what services are available. Prior to local service mapping, it is necessary to carry out research and survey to assess the quantity, quality, variety and density of service providers, such as basic social services or social work services.

- National data collection on manifestations and prevalence of different mental ill-health and psychosocial problems

- Improved monitoring and evaluation reporting at all levels, from commune through to central levels vis-à-vis service provision for children and young people

- Improved data collection and databases on referrals and follow-ups

- Support further analysis of the strong linkages with underlying gendered social norms that impinge on adolescents' mental wellbeing

- In the future, carry out studies on larger scales on issues related to mental health and psychosocial wellbeing of children and adolescents in Viet Nam. At the same time, conduct research on mental health and psychosocial wellbeing among particular groups, such as children and young people in special situations, or ethnic minority groups.

References

Abeyasekera, S. (2005) Quantitative analysis approaches to qualitative data: why, when and how? In: Holland, J.D. and Campbell, J. (eds.) Methods in Development Research; Combining Qualitative and Quantitative Approaches. ITDG Publishing, Warwickshire, pp. 97-106.

Amstadter, Ananda B., Lisa Richardson, Alicia Meyer, Genelle Sawyer, Dean G. Kilpatrick, Trinh Luong Tran, Lam Tu Trung, et al. (2011). "Prevalence and Correlates of Probable Adolescent Mental Health Problems Reported by Parents in Viet Nam." *Social Psychiatry and Psychiatric Epidemiology* 46 (2): 95–100. doi:10.1007/s00127-009-0172-8.

Anh, H., Minh, H., & Phuong, D. (2006). Social and behavioral problems among high school students in Ho Chi Minh City. In L. B. Dang & B. Weiss (Eds.), Research findings from the Viet Nam Children's Mental Health Research Training Program (pp. 111–196). Hanoi, Viet Nam: Educational Publishing House.

Bazley, P. (2004) Issues in Mixing Qualitative and Quantitative Approaches to Research. Published in: R. Buber, J. Gadner, & L. Richards (eds). Applying qualitative methods to marketing management research. UK: Palgrave Macmillan, pp141-156

Bloom, D.E., Cafiero, E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., Feigl, A.B., Gaziano, T., Mowafi, M., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A.Z. and Weinstein, C. (2011) The Global Economic Burden of Non-communicable Diseases. Geneva: World Economic Forum.

Blum, Robert, May Sudhinaraset, and Mark R. Emerson. (2012). "Youth at Risk: Suicidal Thoughts and Attempts in Viet Nam, China, and Taiwan." Journal of Adolescent Health 50 (3 SUPPL.). Elsevier Inc.: S37–44. doi:10.1016/j.jadohealth.2011.12.006. Bronfenbrenner, 1979

Bragin, M. (2014). Clinical social work with survivors of disaster and terriorsm: A social ecological approach. In Brandell, J. R. (Ed.). Essentials of clinical social work (366-401). SAGE Publications.

Chan B and Parker G. (2004). "Some recommendations to assess depression in Chinese people in Australia". Aust N Z J Psychiatry, 38(3):141–147.

Dang, B.T., 2010. A report summarising the ministry-level research theme "The relationship between parents – teenage children in Viet Nam: situation and issue to concern". IFGS. Hanoi

Dang, Hoang-Minh, Bahr Weiss, and Lam T. Trung. (2015). "Functional Impairment and Mental Health Functioning among Vietnamese Children." *Social Psychiatry and Psychiatric Epidemiology* 51 (1). Springer Berlin Heidelberg: 39–47. doi:10.1007/s00127-015-1114-2.

Diep, Pham Bich, Ronald A. Knibbe, Kim Bao Giang, and Nanne De Vries. (2013). "Alcohol-Related Harm among University Students in Hanoi, Viet Nam." *Global Health Action* 6: 1–10. doi:10.3402/gha.v6i0.18857.

Do, Mai, Nhu Ngoc K Pham, Stacy Wallick, and Bonnie Kaul Nastasi. (2014). "Perceptions of Mental Illness and Related Stigma Among Vietnamese Populations: Findings from a Mixed Method Study." *Journal of Immigrant and Minority Health* 16 (6): 1294–98. doi:10.1007/s10903-014-0018-7.

Dzator J (2013) Hard Times and Common Mental Health Disorders in Developing Countries: Insights from Urban Ghana. The Journal of Behavioral Health Services & Research 40(1), 71–87.

Erikson, E. (1968). Youth: Identity and crisis. New York, NY: WW.

General Statistical Office (GSO) (2011), Viet Nam Multiple Indicator Cluster Survey 2011, Final Report, Ha Noi, Viet Nam.

Giang TL (2010) Social Protection in Viet Nam: Current State and Challenges. In: Asher M, Oum S, Parulian F (eds) Social Protection in East Asia—Current State and Challenges. pp. 292–315. Economic Research Institute for ASEAN and East Asia, Jakarta.

Giang, K. B. (2006). Assessing health problems: Self reported illness, mental distress and alcohol problems in a rural district in Viet Nam. Dissertations from Karolinska Intitutet.

GSO, 2010. Survey on Vietnamese Adolescents and Youth, round 2. Ha Noi

Huong, T.N. (2009) "Child Maltreatment in Viet Nam: Prevalence and associated mental and physical health problems". Unpublished thesis, Queensland University of Technology.

Huy, N V, M P Dunne, and J Debattista. (2015). "Factors Associated with Depression Among Male Casual Laborers in Urban Viet Nam." *Community Mental Health Journal* 51 (5): 575–84. doi:10.1007/s10597- 015-9835-y.

Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

International Organization for Migration (n.d.) Welcome to IOM Viet Nam,http://www.iom.int.vn/joomla/index.php.

Jones et al., (2014) "Falling between the cracks: How poverty and migration are resulting in inadequate care for children living in Viet Nam's Mekong Delta". Final report, Overseas Development Institute, London UK.

Jordan, Lucy P., Elspeth Graham, and Nguyen Duc Vinh. (2013). "Alcohol Use among Very Early Adolescents in Viet Nam: What Difference Does Parental Migration Make." *Asian and Pacific Migration Journal* 22 (3): 401–19.

Kaljee LM, Genberg BL, Minh TT, Tho LH, Thoa LTK, Stanton B. (2005) "Alcohol use and HIV risk behaviors among rural adolescents in Khanh Hoa Province Viet Nam". Health Educ Res, 20: 71_89.

Kaljee, L.M. et al. (2011) "Gender, Alcohol Consumption Patterns, and Engagement in Sexually Intimate Behaviors among Adolescents and Young Adults in Nha Trang, Viet Nam," Youth &Society, 43(1):118- 141.

Kidd, S., Abu-el-Haj, T., Khondker, B., Watson, C., Ramikisson, S. (2016) 'Social Assistance in Viet Nam: A Review And Proposals For Reform. MOLISA & UNDP.

Kieling, C., & Rohde, L. A. (2012). Going global: Epidemiology of child and adolescent psychopathology. *Journal of the American Academy of Child and Adolescent Psychiatry*, 51, 1236–1237. doi:10.1016/j.jaac.2012.09.011

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodum, O., Rohde, L.A., Srinath, S., Ulkuer, N. and Rahman, A. (2011) 'Child and adolescent mental health worldwide: evidence for action', Lancet 378 (9801): 1515-1525.

Ko, I,, and Xing, J. (2009). 'Extra Classes and Subjective Well-being: Empirical Evidence from Vietnamese Children', Working paper no. 49. Accessed from: http://www.younglives.org.uk/sites/www.younglives.org.uk/files/YL-WP49-Ko-ClassesAndWellbeing.pdf

Lê T.N.D, 2009. Status of mental health of children in Ho Chi Minh City – a case study of adolescents in upper secondary schools. A summary research's report.)

Le, Minh Thi Hong, Huong Thanh Nguyen, Thach Duc Tran, and Jane R W Fisher. (2012). "Experience of Low Mood and Suicidal Behaviors among Adolescents in Viet Nam: Findings from Two National Population- Based Surveys." *Journal of Adolescent Health* 51 (4): 339–48. doi:10.1016/j.jadohealth.2011.12.027.

Levinson, D., Lakoma, M.D., Petukhova, M., Schoenbaum, M., Zaslavsky, A.M., Angermeyer, M., Borges, G., Bruffaerts, R., de Girolamo, G., de Graaf, R., Gureje, O., Haro, J.M., Hu, C., Karam, A.N., Kawakami, N., Lee, S., Lepine, J.–P., Browne, M.O., Okoliyski, M., Posada-Villa, J., Sagar, R., Viana, M.C., Williams, D.R. and Kessler, R.C. (2010) 'Associations of serious mental illness with earnings: results from the WHO World Mental Health surveys', British Journal of Psychiatry 197: 114-121.

Marcus, R. with Harper, C. 2014. Gender Justice and Social norms – processes of changes for adolescent girls.Towards a conceptual framework. ODI publication.

McKelvey RS, Davies LC, Sang DL, Pickering KR, Tu HC (1999) Problems and competencies reported by parents of Vietnamese children in Hanoi. Journal of American Academy Child Adolescent Psychiatry 38:731–737

Ministry of Health, General Statistics Office, World Health Organization and the United Nations Children's Fund, (2010a). Survey Assessment of Vietnamese Youth Round 2. (SAVY 2) Hanoi, Viet Nam.

Ministry of Planning and Investment (General statistics Office), 2015, *The 1/4/2014 Viet Nam Intercensal Population and Housing Survey: Major Findings*. Hanoi

MOH, Hanoi Medical University, GSO, CDC, and WHO (2010b). Global Adult Tobacco Survey (GATS), Viet Nam, 2010. Hanoi, Viet Nam.

MOH. (2005).Survey Assessment of Vietnamese Youth. Viet Nam Ministry of Health, Hanoi.

MOH, 2006. Healthcare Report 2006: Equality, effectiveness, development in new situation. Hanoi.

MOH and Health Partnership Group, 2015. Joint Annual Health Review (JAHR)- Strengthening Prevention and Control of Non- communicable Disease. Medical Publishing House. Hanoi

MOLISA, 2014. Report evaluating the outcomes of the implementation of the scheme on social support and rehabilitation for people with mental illnesses and people with mental disorders for the period 2011-2015 and orientation for the period 2016-2020

MOLISA, 2015. Synthesis report on planning of the social assistant network 2016-2025. Hanoi.

Nguyen H.M., 2006. Family – Support Source for Youth and Adolescents. Journal of Sociology, No 3/2006.

Nguyen, D. T., Dedding, C., Pham, T. T., & Bunders, J. (2013). Perspectives of pupils, parents, and teachers on mental health problems among Vietnamese secondary school pupils. *BMC Public Health*, *13*(1), 1046.http://doi.org/10.1186/1471-2458-13-1046

Nguyen, D. T., Dedding, C., Pham, T. T., Wright, P., & Bunders, J. (2013). Depression, anxiety, and suicidal ideation among Vietnamese secondary school students and proposed solutions: a cross-sectional study. *BMC Public Health*, *13*(1), 1195. http://doi.org/10.1186/1471-2458-13-1195

Nguyen, Huong Thanh, Michael P Dunne, and Anh Vu Le. (2009). "Multiple Types of Child Maltreatment and Adolescent Mental Health in Viet Nam." *Bull .orld Health Organization* 88 (October 2008): 22–30. doi:10.2471/BLT.08.060061.

Patel, V., Flisher, A.J., Hetrick, S. and McGorry, P. (2007) 'Mental health of young people: a global public- health challenge', Lancet 369(9569): 1302-1313.

Pham, Diep B. et al. 2010 "Alcohol Consumption and Alcohol-related Problems among Vietnamese Medical Students," Drug and Alcohol Review, 29(2):219-226.

Pham, H. N., Protsiv, M., Larsson, M., Ho, H. T., de Vries, D. H., & Thorson, A. (2012). Stigma, an important source of dissatisfaction of health workers in HIV response in Viet Nam: a qualitative study. *BMC Health Services Research*, *12*, 474. http://doi.org/10.1186/1472-6963-12-474

Phan, T., & Silove, D. (1999). An overview of indigenous descriptions of mental phenomena and the range of traditional healing practices amongst the Vietnamese. Transcultural psychiatry, 36(1), 79–94.

Phuong, T B, N T Huong, T Q Tien, H K Chi, and M P Dunne. (2013). "Factors Associated with Health Risk Behavior among School Children in Urban Viet Nam." *Global Health Action* 6: 78–86. doi:10.3402/gha.v6i0.18876.

Samman, E. and Rodriguez-Takeuchi, L.K. (2013) Old age, disability and mental health: data issues for a post- 2015 framework, ODI Background Note. London: Overseas Development Institute.

Samuels, F. Gupta, T. and T. Dang Bich. (2018) Mental health of children and young people in Viet Nam. Draft Literature review. ODI.

Stern, L. M. (1998). The Vietnamese Communist Party's agenda for reform: A study of the eighth national party congress. Jefferson, NC: McFarlane.

Stratton et al. (2014) "Caretaker mental health and family environment factors are associated with adolescent psychiatric problems in a Vietnamese sample". *Psychiatry Res*. 2014 December 15; 220(0): 453–460. doi:10.1016/j.psychres.2014.08.033.

Thanh, H T T, G X Jiang, T N Van, D P T Minh, H Rosling, and D Wasserman. (2005). "Attempted Suicide in Hanoi, Viet Nam." *Social Psychiatry and Psychiatric Epidemiology* 40 (1): 64–71. doi:10.1007/s00127- 005-0849-6.

Thanh, H. T. T., Tran, T. N., Jiang, G. X., Leenaars, A., & Wasserman, D. (2006). Life time suicidal thoughts in an urban community in Hanoi, Viet Nam. *BMC public health*, *6*(1), 1.

Tho LH, Singhasivanon P, Kaewkungwal J, Kaljee LM, Charoenkul C. Sexual behaviors of alcohol drinkers and non-drinkers among adolescents and young adults in NhaTrang, Viet Nam. Southeast Asian J Trop Med Public Health 2007; 38:152_60.

Trang, Minh, and Chau Duc. (2014). "Violent Disciplinary Practices towards Children among Caregivers in Viet Nam : A Cross-Sectional Survey" 5 (1).

UNICEF (1997). Capetown Principles. Accessed from: http://www.unicef.org/emerg/files/Cape_Town_Principles(1).pdf

UNICEF & MOLISA (2015) 'Assessment of the mental health service system of the Social Welfare and Labour Sector'. Hanoi.

Vuong, D.A., et al., (2011) 'Mental health in Viet Nam: Burden of disease and availability of services'. Asian Journal of Psychiatry doi:10.1016/j.ajp.2011.01.005

Wasserman, D., Cheng, Q., & Jiang, G.X. (2005). Global suicide rates among young people aged 15-19. *World Psychiatry*, *4*(2), 114–120

Weiss, Bahr, Minh Dang, Trung Lam, Minh Cao Nguyen, Tam Hong Thuy Nguyen, and Amie Pollack. (2014). "A Nationally Representative Epidemiological and Risk Factor Assessment of Child Mental Health in Viet Nam." *International Perspectives in Psychology: Research, Practice, Consultation* 3 (3): 139–53. doi:10.1037/ipp0000016.

Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J. Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J.L. and Vos, T. (2013) 'Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010', Lancet 382(9904): 1575-1586.

WHO (2001a) Burden of mental and behavioral disorders. Available viahttp://www.who.int/whr/2001/chapter2/en/.

WHO (2001b) The World Health Report 2001, Mental Health: New Understanding, New Hope. Geneva: World Health Organization.

WHO (2005) Maternal mortality in Viet Nam, 2000: an in-depth analysis of causes and determinants (Report No.: ISBN 92 9061 191 X). Manila: World Health Organization, Regional Office for the Western Pacific; 2005.

WHO (2007) Helping youth overcome mental health problems. Geneva: World Health Organization.

WHO (2008) The global burden of disease: 2004 update. Geneva: World Health Organization.

WHO (2010). 'Mental health and development: targeting people with mental health conditions as a vulnerable group'. Geneva, World Health Organization.

WHO (2011) Mental Health Atlas 2011. Geneva: World Health Organization.

WHO (2011). Alcohol. Fact sheet. Available from: http://www.who.int/mediacentre/factsheets/fs349/en/ [cited 3 March 2016].

WHO (2015a) 'Mental Disorders: Fact Sheet'. Retrieved from http://www.who.int/mediacentre/factsheets/fs396/en/ [cited Jan 25, 2016]

WHO (2015b) 'Suicide: Fact Sheet'. Retrieved from http://www.who.int/mediacentre/factsheets/fs398/en/ [cited Jan 25, 2016]

WHO (2015c) 'Mental Health Action Plan 2013-2020'. Geneva, World Health Organization.

World Bank (2013) Gini Index Viet Nam, Retrieved from http://www.unicef.org/Viet Nam/protection.html#2. [cited March 3, 2016]

World Economic Forum and the Harvard School of Public Health (2011) 'The global economic burden of non- communicable diseases'. Geneva, World Economic Forum.Annex 1: Data on suicide in Dien Bien province

Table 1: Dien Bien Province, 2015

(Source: Dien Bien DOH)

Total	Attempted suicide	Cases resulting in death (from total attempted suicide cases)	Female among total cases	
			Attempted	**Cases resulting in death**
Total	333	73	159	35
Age 0-4	1			
Age 5-14	63	3	36	
Age 15-19	76	13	41	11
Age 20-60	191	57	82	24
Over 60	2			

Table 2: Dien Bien Dong District Suicide data by "la ngon", January-June 2015[8]

(Source: DOLISA Dien Bien Dong)

Total	Attempted suicide	Cases resulting in death	Female among total cases	
			Attempted	**Cases resulting in death**
Total	62	12	43	7
0-9	-	-	-	-
10-14	16	-	15	-
15-19	25	7	17	5
20-24	7	3	4	2
Over 24	14	2	7	-

Table 3: Dien Bien Dong District Suicide data by "la ngon", January-June 2016

(Source: DOLISA Dien Bien Dong)

Total	Attempted suicide	Cases resulting in death	Female among total cases	
			Attempted	**Cases resulting in death**
Total	53	25	39	15
0-9	3	2	3	2
10-14	10	3	9	2
15-19	12	5	9	4
20-24	11	5	8	3
Over 24	17	10	12	4

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8.   There was no data on suicide cases from July-December 2015.

Table 4: Keo Lom Commune suicide cases, 2007-2015

(Source: commune health station)

		Suicide cases by gender	
		Male	**Female**
Total	40	16	24
0-9	3	-	3
10-14	4	1	3
15-19	14	5	9
20-24	6	3	2
Over 24	13	7	7

Table 5: Keo Lom Commune suicide cases by year[9]

(Source: commune health station)

Years	2007	2008	2009	2010	2011	2012	2013	2014	2015
Cases	4	3	3	3	6	5	7	6	3

Note: There were 35 Hmong, 3 Thai and 1 Kho Mu from the total of 40 cases. 36/40 cases took poisonous "heartbreak grass" leaves.

9.   There was no data on gender and age by year.

Annex 2: Background on School Psychological Consulting/ Counselling in Viet Nam

Terminology

The English term "*School Psychological Counselling*" is translated differently in the Vietnamese language, most commonly as "*tham van tam ly hoc duong*" (school psychological counselling) or "*tu van tam ly hoc duong*" (school psychological consulting). These two terms bear different notions, but both denote the English term "*School Psychological Counselling*" or "*Psychological Counselling in Schools*". MOET's Directive No. 9971/BGD&ĐT-HSSV on 28 October 2005 on implementing student counselling services clearly states: "*Career and socio-psychological consulting services*" ("*counselling*" in some places), generally referred to as "*tu van hoc duong*" (school consulting), are focused mainly on secondary and high school students.

In this field study at secondary and high schools where a counselling/ consulting office was available found that the use of these terms seemed to differ between HCMC and Hanoi. Schools in HCMC tend to use the term "*School consulting office*", while those in Hanoi (within PLAN project) prefer the term "*School psychological counselling office*". However, the goals and implementation methods of these offices are similar, and lean closer towards the "*psychological counselling*" meaning.

In her research into school counselling services in HCMC schools, Nguyen (2014) developed a working definition of "*school counselling*" as follows: *School consulting is an interactive process between a consultant and a student who is facing difficulties in school and*

daily life and in need of assistance to solve his problems, and any other concerned individuals, in an educational setting. However, the author herself also noticed the differences between "*counselling*" and "*consulting*" in other studies. The author cited Tran Tuan Lo (2006): "*consulting is a process of seeking and providing advice, between party A – either an individual or an organisation that is seeking an answer for a question or a solution for a problem, and party B – an individual or organisation that has the appropriate expertise and experience to help party A answer its question or deal with its problem.*" Nguyen Thi Tram Anh (2014), argued that "*counselling*" did not stop at helping the subject find a way out; it also aimed towards improving the subject's capacity to understand and solve his own problems.

According to Tran Thi Minh Duc (2003), counselling is an interactive process between a counsellor – a person with counselling expertise and skills and professional ethics, who is recognised by the law – and a client, a person in need of help for psychological issues. With skills in effective communication, rapport building and sharing of inner feelings, a counsellor helps the client understand and accept his situation, and find strength within himself to solve his own problem (as cited by Nguyen Thi Tram Anh).

Number of secondary and high schools that have a counselling office

Currently, no official data on the total number of schools in the country with a psychological consulting/counselling office is available. However, within this study,

discussions with the psychologists and teachers-counsellors in schools that provide counselling services suggest that this model seems to be quite common in HCMC only. Most secondary and high schools in HCMC have their own "*School consulting offices*". Meanwhile, this model has not gained such popularity in Hanoi. In An Giang, there are 4 schools that have psychological counselling offices, but still in the form of pilots. No presence of the school counselling model was observed in Dien Bien. In Hanoi, the psychological counselling model is applied by several schools, in which counselling services are directly provided by psychology specialists; however, the majority of these schools are private or international ones.[10] Recently, PLAN International in Viet Nam has been funding and supporting pilots of the "*Safe, Friendly and Fair School*" model in 20 secondary and high schools in Hanoi. Within this project, each school established a "*School counselling office*" to provide assistance to students to deal with difficulties related to school violence, socio-psychological and studying issues (The project is ending on 30 November 2016).

HCMC appears to be the only locality where the "*School counselling office*" model is being applied on a large scale. According to HCMC DOET's data, (as cited by Nguyen Thi Tram Anh, 2014), school counselling services have been implemented throughout the vast majority of the secondary and high schools of the city: 89% of public secondary schools and 86% of public high schools; 57%

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10.   Different numbers are obtained from different sources (varying from 5-10 schools)

Human resources for school counselling activities

Currently, in charge of counselling offices are mainly school teachers, who are already burdened with their own responsibilities in the schools. They are mostly Civics teachers or teachers in charge of the school's Young Pioneers' Organization or Youth Union, and lack professional and in-depth training (they only attended short-term courses). This has been noted by many psychology specialists as a challenge and limitation to the present school counselling services in Viet Nam (Cao Xuan Loc, 2014; Ngo Thi Thu Dung & Nguyen Thi Van Anh, 2014; Nguyen Thi Tram Anh, 2014).

For instance, in HCMC, data from the city DOET (2013) pointed out that of the total 480 school counsellors (305 from secondary schools and 175 from high schools); only 21% were full-time, while 79% were part-time.[11] The number of counsellors with appropriate qualifications (degrees in Psychology, Education or Social Sciences) made up only a modest proportion (18%) (as cited by Nguyen, 2014).

A study conducted in 2013 with 16 schools (comprising of 10 secondary and 6 high schools) across the 13 urban and rural districts of HCMC revealed that the majority of the school counsellors in the study sample (26 in total) were part-time. Most of them were already working as school teachers (54%), supervisors (19%), teachers in charge of school Young Pioneers' Organisations (15%), members of school boards (8%), even school health workers (4%). These counsellors had qualifications in social sciences such as Political Education, Technical Education, Literature, History, Geography, Economics, even Aesthetics and Physical Education. The Study also found that these part-time counsellors faced difficulties in providing counselling services to students, such as lack of counselling and support knowledge and skills (which were rated as the top difficulties), and other issues such as low compensation and pay, lack of a private counselling office, lack of time due to large demand were also reported, though rated less significant (Nguyen Thi Thuy Dung, 2014).

A critical cause of this current situation of school teachers/staff being assigned with the role of counsellors in Vietnamese schools as proposed by Cao Xuan Loc (2014) was the fact that up to that point, MOET had not promulgated a regulation to allow School Psychology graduate programs to be included in the formal education system; as a result, most of the existing staff who work in field of school psychology lack formal and professional training required for the job.

Although no graduate program on School Psychology has been available, a number of universities have started teaching subjects or course credits that are related to school psychology. Within the Educational Psychology faculty at Hanoi University of Education[12], a School Psychology program has been incorporated into the university's syllabuses as a major specialisation since 2008 (Tran Thi Le Thu, 2011, cited by Cao Xuan Lieu, 2014). The Psychology specialization under the Psychology faculty of the University of Social Sciences and Humanities has been offering course credits related to school psychology (making up 12.5% of the total syllabus). In 2000, a Clinical Psychology team was set up, and a Counselling Psychology team was formed in 2008 (Cao Xuan Lieu, 2014).

Discussion on effectiveness of the model

Building on existing studies on students' socio-psychological problems, Nguyen Thi Tram Anh (2014) concluded that most students were faced with psychological difficulties and had high demands for counselling services. However, the nature of current counselling offices has led to a bias that counselling offices are where "*problematic*" people are treated, which makes students reluctant to approach for fear of their peers' inquisitive eyes. Meanwhile, the rest are largely unaware of the existence of counsellors and psychological support activities in schools. The quality of the human resources for school psychological counselling is still inadequate. At the present, school counsellors are usually part-time; they are only present at the counselling office when a student is taken there. There is a lack of detailed planning and programming towards comprehensive development for students and school relationships[13].

A number of studies also stressed the lack of professionalism of existing school psychological counselling offices, and problems related to qualifications as well as working conditions of the counsellors (Nguyen Thi My Loc, 2014; Nguyen Thi Thuy Dung, 2014). In addition, Dinh Thi Hong Van and Nguyen Cat Tuong (2014) believed that current counselling centres in schools still failed to come up with proactive measures and plans to effectively support students who were at risk of mental health issues or disorders.

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11. The data are consistent with the researchers' observations and information collected from interviews with teachers in Hanoi and HCMC.

12. See KII with a Lecturer from the Social Work Faculty, Hanoi University of Education.

13. This is fairly consistent with qualitative data collected from interviews with teachers and students in Hanoi and HCMC.

Students' demands for counselling services

Recently, psychologists have been paying a lot of attention to students' demands for psychological counselling, which originate from adolescents' psycho-physiological characteristics; during this period, teenagers experience various internal changes as well as influences from society. Some authors have published research providing proof of the tremendous demand of students for psychological counselling services, which have not been fulfilled.

A study in Danang city of 349 high school students and 9 teachers-counsellors in 2004 discovered that a huge proportion of the students in the sample wanted to be counselled on the problems they were facing in studying, social relationships and personal troubles. The degree to which they needed advice varied by area as follows: studying: 71%; peer relationships: 64.8%; relationships with teachers: 60.2%; relationships with parents 52.7%; and inner troubles about themselves: 51.3%. The study also pointed out that students were seeking counselling and advice mostly from friends; they found it very hard to talk with teachers and parents about their issues. The authors believed a discrepancy existed between the high demand of students for psychological counselling and the low performance of schools and educational institutions in fulfilling such needs, which posed threats to students' mental wellbeing (See Le Quang Son & Ho Thanh Thuy, 2014).

Another study in 2012 of 622 students from 3 high schools in Hue City also showed similar results for the high demand for psychological counselling among the sampled students. 57.8% of the students expressed hopes to be helped by psychology specialists in coping with their difficulties. Areas for which the students needed counselling were varied; the most

needed areas were career orientation and learning; next came relationships with teachers, peers, parents and other family members, and then love and relationships with the opposite sex (Dinh Thi Hong Van & Nguyen Phuoc Cat Tuong, 2014).

A study on the state of and demand for the Competency-Based Training model in the education sector was conducted in 2011-2013, sampling 466 teachers and school management staff, Youth Union/Young Pioneer Organization officials and student affairs officers from 466 educational and training institutions throughout 63 provinces and cities. The study provided useful information on current problems with regard to students' socio-psychological issues. Although this project did not include students in their study sample, gathering opinions and ideas from management and teaching staff is crucial to draw the attention of policy makers and state administrators in the education sector towards the urgent needs to train and establish a qualified team of counsellors to help students control and overcome socio-psychological difficulties and prevent mental health risks. According to the study's statistical results, 75.75% of the respondents believed that psychological counselling services were needed for students. The study also pointed out that at the present, the support for students in managing their problems was very limited within existing educational and training institutions (See Ngo Thi Kim Dung, 2014).

References

Cao Xuan Lieu. 2014. *Desining the School Psychology Training Bachelor Curriculum Following Credit Training Model in Viet Nam*. Papers Kit of the IV Conference on School Psychology. Hanoi 14-15/8/2014. Page 243-255.

Dinh Thi Hong Van & Nguyen Phuoc Cat Tuong. 2014. *The Relationship between the Psychological Counseling Needs of High School and some Psychosocial Factors*. Papers Kit of the IV Conference on School Psychology. Hanoi 14-15/8/2014. Page 337-346.

Le Quang Son & Ho Thanh Thuy. 2014. *The Characteristic of the Needs in Psychological Couseling of High School Students (The case of Da Nang City)*. Papers Kit of the IV Conference on School Psychology. Hanoi 14-15/8/2014. Page 453-460.

Ngo Thi Thu Dung. 2014. Forecasts of human resource needs for school counselling in educational and training institutions, period 2011- 2020. Papers Kit of the IV Conference on School Psychology. Hanoi 14-15/8/2014. Page 213-224.

Ngo Thi Thu Dung & Nguyen Thi Van Anh. 2014. *The organization of school counselling and student support networks in educational institutions*. Papers Kit of the IV Conference on School Psychology. Hanoi 14-15/8/2014. Page 59-66.

Nguyen Thi Thuy Dung. 2014. *The Situation of School Counseling at Secondary School and High School in Hochiminh city*. Papers Kit of the IV Conference on School Psychology. Hanoi 14-15/8/2014. Page 67-78.

Nguyen Thi Tram Anh. 2014. *Disscusion about Program Assistance School Psychology in the Context of Viet Nam Education Today*. Papers Kit of the IV Conference on School Psychology. Hanoi 14-15/8/2014. Page 35-44.

Nguyen Thi My Loc. 2014. Competence Standards for School Psychologists/Counselors in the World and some Suggestions for Establishing Training Program School Psychologists/Counselors in Viet Nam. Papers Kit of the IV Conference on School Psychology. Hanoi 14-15/8/2014. Page 15-32.

Annex 3: Findings of Statistical Analysis of SDQ and Self-Efficacy Scale Scores

(From a survey in 4 provinces and cities in Viet Nam)

Introduction of the SDQ

To identify mental health problems among the target groups, the research team used the Strengths and Difficulties Questionnaire (SDQ). This is a screening tool for common mental disorders among children and adolescents (3 – 16 years old) (Goodman, Ford, Simmons & Gatward, 2000 – as cited by Dang Hoang Minh et al., 2013). The SDQ is a brief behavioural screening questionnaire appropriate for young children and adolescents and children. It is a commonly used tool for the detection of mental issues in the community. The Strengths and Difficulties Questionnaire is designed to be used as a screening tool in clinical assessment, to assess interventions outcomes, and as a research tool. SDQ is one of the reliable and effective evidence-based tools, used to collect information from multiple sources such as children, parents and teachers. There are three versions of the SDQ for different informants; one self-report version for children, one parent-report version and one teacher-report version. In this Study, only the self-report version of the Questionnaire for children was used. The tool has been proved to have good psychometric attributes and has been used to screen mental health problems among children in many countries in Europe as well as in Asia, such as Bangladesh, Iran, Malaysia etc. (Dang Hoang Minh et al., 2013). The SDQ has been translated into Vietnamese (Tran Tuan, 2016; Dang Hoang Minh et al.,

2013; Vu Cong Nguyen et al.[14] etc.) and widely applied in child mental health research in Viet Nam, such as in the 2005 study by Mai Huong Psychiatric Hospital, a 2010 study by Hoang Cam Tu and Dang Hoang Minh of children in 02 high schools in Hanoi and former Hatay province, a study by Amstadter, Richarsdson et al. (2011) of children in 02 provinces in Central Viet Nam, and the 2013 study by Dang Hoang Minh et al.

The SDQ version used by the research team for the school children samples in this Project was translated into Vietnamese by the team itself, and later with reference to other translated versions by the Young Lives Project, CSAGA and Dang Hoang Minh et al., 2013; Vu Cong Nguyen et al.. The team's version is similar to the previous translations in terms of content; however, the specific wording has been slightly adjusted to better suit the Vietnamese context.

Compared to other mental health research tools, SDQ has the advantage of being concise – it asks only 25 questions (focusing on assessment of behavioural and emotional problems), as opposed to other tools such as the Child Behaviour Checklist (CBCL) which asks 118 questions, or the Youth Self-Report (YSR). However, SDQ also has its disadvantages – it cannot assess serious mental disorders (such as obsession, paranoia etc.), and it does not distinguish between physical disorders and emotional symptoms etc. (Dang Hoang Minh et al., 2013).

The SDQ version for children ages 12-16 includes 25 items, of which

10 reflect strengths, 14 reflect weaknesses, and one item may be considered neutral. Each item can be answered as: 0 – Not True; 1 – Somewhat True; and 2 – Certainly True. The Questionnaire is divided into 5 scales of 5 items each: 1) Emotional problems; 2) Conduct problems; 3) Hyperactivity/ Inattention; 4) Peer problems; and 5) Prosocial Behaviour. The Prosocial scale (the 5th scale) gives a positive score, while the other four scales (emotional problems, conduct problems, hyperactivity/inattention and peer problems) give negative scores, which are summed to generate a *Total Difficulties Score*.

The SDQ has some of the limitations such as: Issues around accuracy, specificity, sensitivity and its use as a specific diagnostic tool. Also, cultural resilience may play a role in the resulting scores and it is not suitable persons aged 18 years or older.

Based on the instructions on Interpreting Symptom Scores and Defining "Caseness" from Symptom Score[15], the cut-off point of the SDQ Total Difficulties Score (ranging from 0 to 40) in this Study is set at 15, with scores of 0-15 being considered "Normal"; scores of 16-19 being "Borderline"; and 20-40 being "Abnormal".

Similar cut-off points have been used in several studies. For example, Shojaei., et al., (2009) used the strengths and difficulties questionnaire to research the validation study in French school-aged children and cross-cultural comparisons. The authors examine the psychometric properties of the

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14. http://www.sdqinfo.com/py/sdqinfo/ b3.py?language=Vietnamese

15. http://www.copmi.net.au/images/pdf/ Research/sdq-english-uk-self-scoring.pdf

French version of the strengths and difficulties questionnaire (SDQ), compare estimates of child mental health problems and SDQ scores across France, US and UK. The French cut-off points for the scoring bands were similar to those of the UK and US, with a few exceptions (peer relationship problems, prosocial behaviour)[16].

In Viet Nam, a number of studies used the symptom score method for the children's self-report version; however, the cut-off points are different depending on the targeted population. For example, Dang Hoang Minh et al. (2013) conducted the study on both parents and children samples; the cut-off points for the "*Abnormal*" band was the same for both parents and children (from 17 to 40) (Dang Hoang Minh et al., 2013).

Meanwhile, a study by Yasong Du, Jianhua Kou, David Coghill (2008) on "*The validity, reliability and normative scores of the parent, teacher and self report versions of the Strengths and Difficulties Questionnaire in China*" set different cut-off points for the "*Abnormal*" band for parents (17-40) as opposed to the other two groups, teachers and children (18-40).

Self- Efficacy Scale

Unlike with the SDQ, during the finalization of the research tools before commencing field study, the research team did not have access to any Vietnamese version of the Self-Efficacy Scale for reference and

comparison. Perceived self-efficacy is regarded as a positive resistance resource factor. It is an operative construct; it is related to subsequent behavior therefore, is relevant for clinical practice and behaviour change. Self-efficacy refers to an individual's believes about his/her agency or capacity to successful perform various tasks; reflects person's resilience and coping. Substantial research has suggested that self-efficacy is a proxy outcome indicator as alterations in self-efficacy beliefs are closely associated with changes in actual behaviour/competence (Neil, 2011) as a result of life experiences or programmatic interventions. The scales that will be used for measuring resilience and self-efficacy as indicators of coping.

The best we could find was references to the name of the Scale in a few sources of material, which is also translated differently by different authors. During the finalization of the Vietnamese translation of the Scale, the research team consulted a number of experts in order to achieve the optimal quality and accuracy of the translation according to the original English version.

To measure and identify the self-efficacy levels of children, this Study uses the Self-Efficacy Scale. This Scale is also called Generalized Self-Efficacy Scale (GSE) in a number of English sources of material. GSE is used to assess self-efficacy in goal-setting, effort investment and persistence (Schwarzer and Jerusalem, 1995). The questions of the Scale allow for classification and assessment of an individual's adaptation, optimism and ability to deal with daily hassles or cope with adversity or difficult situations in life. This Scale consists of 10 items, for each of which there is a four choice response: 1-Not at all true; 2-Hardly true; 3-Moderately true; and 4-Exactly true. We then divided the responses to each item into two

scales: 1-True, and 0-False, and then work out the mean score on a scale of 0 to10, to measure the perceived confidence of the children from 0 (being least confident) to 10 (being most confident) (Lynne Omes and Lynda B. Ransdell, 2010)[17]. A higher score indicates higher self-efficacy. Higher scores mean the child exhibits a higher self-efficacy; the highest level means the child is confident that he or she will perform tasks in different situations.

Analysis methodology

To identify symptoms of mental health and self-efficacy of the children as well as a number of related elements, the Study uses the methods of descriptive statistics (frequency distribution), calculation of mean and total scores of scales, correlation analysis of children's mental health problems and self-efficacy by demographic characteristic such as sex, age, education level, and residence area. The Cronbach's Alpha coefficient is also used to test the reliability and intercorrelation between observed variables in the scales, the consistency of the responses, to make sure that all the participants had the same understanding of the constructs of the SDQ. Correlation analyses of the mean total SDQ and SE scores by characteristics of children were done using the method of one-way analysis of variance (one-way ANOVA), a technique used to test the null hypothesis that the sample groups are drawn from populations with the same mean values, with a probability of error of 5% (which means 95% reliability). Specifically:

- Rates of children having emotional and behavioural

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16. The French version of the parent-reported SDQ was administered to the parents of a representative sample of 1,348 French children aged 6-11 years old.The response rate was 57.6%. The author's performed three scoring methods and examined their association with socio-demographic data. French SDQ scores were compared with SDQ scores from US and UK national surveys. The French cut-off points for the scoring bands were similar to those of the UK and US, with a few exceptions (peer relationship problems, prosocial behaviour).

17. Lynne Omes và Lynda B.Ransdell (2010) A pilot study examining exercise self-efficacy as a mediator for walking behavior in college-age women in Perceptual and Motor Skills 110(3 Pt 2):1098-104 · June 2010

problems, and strengths of the children (SDQ) (see diagram/table 1 as below)

- Total Difficulties Scores (SDQ)

- Correlation analysis between the rates of children having mental health problems and Total Difficulties Scores by children's demographic characteristics (SDQ)

- Rates of children's self-efficacy (SE Scale)

- Mean scores and percentage mean for self-efficacy items (SE Scale)

- Rate of perceived self-efficacy of children (SE Scale).

- Correlation analysis between the total score of self-efficacy by children's demographic characteristics (SE Scale)

Sơ đồ 1: Phân loại điểm số SDQ cho trẻ từ 4-17 tuổi

Tự hoàn thành	Bình thường	Mức ranh giới	Bất thường
Tổng điểm khó khăn	0-15	16-19	20-40
Điểm các vấn đề cảm xúc	0-5	6	7-10
Điểm các vấn đề hành vi	0-3	4	5-10
Điểm tăng động	0-5	6	7-10
Điểm các vấn đề bạn bè	0-3	4-5	6-10
Điểm các vấn đề xã hội tích cực	6-10	5	0-4

A limitation of this Study is that the data collection was carried out among groups of children from 12 to 17 years of age, but not among parents and teachers. Moreover, the individual and demographic characteristics of the children considered in the Study did not include family living standards, parents' occupations and level of education. This somehow limits the ability to compare the study results against other studies which employed the SDQ method among samples of parents and teachers as well as children. At the same time, due to the lack of information on family and parents' characteristics, this Study does not identify related risk factors/factors influential to children's mental health and self-efficacy.

Before officially commencing the field study, the research team had tested the validity of each individual item and the whole questionnaire (which had been translated into Vietnamese), to see whether each sample/child had the same understanding despite their different responses by conducting a test survey to assess the reliability and validity of the questionnaire. Preliminary evaluation of reliability and validity of the questionnaire was done using the Cronbach alpha coefficient through the use of the SPSS 12.0 data processing software, to remove observable variables which do not qualify in terms of level

of reliability, and form the basis for next analyses and verification.

The Cronbach's Alpha (CA) of the Total Difficulties Scores is 0.62, which indicates an adequate level of reliability of the Scales, and a correlation coefficient value greater than 0.4 ($\geq$0.6) implies that comparative analysis is applicable[18].

Notes on terminology

"Having mental health problems" is a term widely used in medical research. This term is used in this Study because it implies a wide range of problems, from minor to serious, in absence of a thorough diagnosis. The term *"Having mental health problems"* in this Study implies the group of children having behavioural and emotional problems with SDQ scores within the Abnormal band, which ranges from 20 to 40.

Self-efficacy

Depending on the approach, the term "Self-efficacy" can be translated into Vietnamese in different ways, such as: " si tu

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18. Nunnally & Burnstein (1994) believe higher alpha values indicate higher levels of internal consistency; however, in general, the standard for selection of a scale is an alpha value of higher than 0.6 (as cited by Nguyen Dinh Tho & Nguyen Thi Mai Trang, 2009). As such, although the Cronchback's alpha value of this study sample is relatively low (0.62), the questionnaire's reliability is at an acceptable level.

chu" (similar to s*elf-control), "su tu tin" (self-confidence), "su tu quyet" (self-determination), "cái tôi hieu qua" (the Self's efficiency)*. Self-efficacy is one's perception of and belief in their ability to create changes, and expectation to gain outcomes through their actions. A person with high self-efficacy is one with high self-confidence, accurate self-assessment ability, willingness to take risks and a sense of accomplishment. Bandura (1977) discovered the importance of perceived self-efficacy, or in other words, personal capacity, in guiding human behaviours.

In this Study, a child's "self-efficacy" implies "*a child's ability of self-control and belief in his/her own ability to make decisions in every situation*." Bandura (1986) has defined self-efficacy as one's belief in one's ability to accomplish a task, or confidence in one's own ability. To study children's self-efficacy is to examine their perceived ability to make decisions as to how to deal with school-related and daily life tasks, relationships with peers, and social relationships in general. Children with high self-efficacy are often not put off by adversities; they don't avoid difficult tasks and

are determined to pursue and accomplish goals. When faced with challenges, these children know how to be focused and succeed in performing tasks and reaching goals, and make efforts and persist in the face of barriers.

Data collection and processing

Within the framework of the Study on Mental Wellbeing of Children and Youth in Viet Nam, in addition to in-depth interviews and focus group discussions with school children from 4 Secondary schools and 4 High schools in the 4 study sites, the research team also carried out surveys using SDQ and SE questionnaires with more than 400 school children. The data were entered using the Epidata software and double entry method, and then the data files were cross-checked to identify any errors. After that, the data were transferred to the SPSS software to be processed and analyzed.

Survey samples and characteristics of study samples

Figure 1: The mean age of children as the whole/full sample
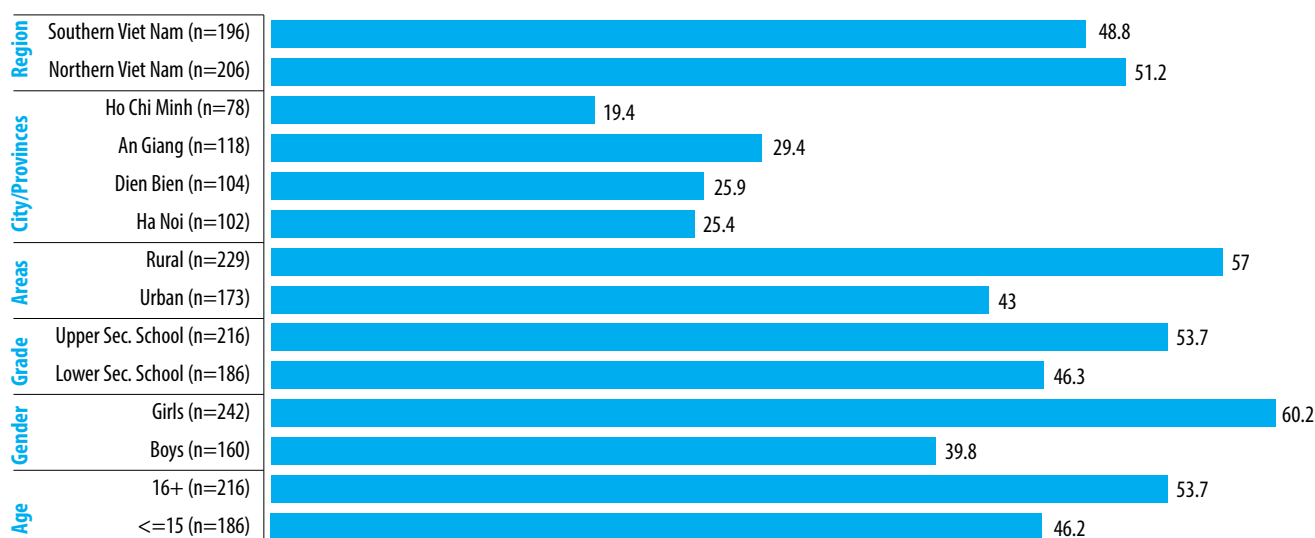
Based on the Study objectives, the selected target groups include secondary and high school aged children, who met the required criteria of sex, age and education level, and were representative for different residence areas.

The total survey sample size was 402 children (N = number of respondents). The following provinces/cities were selected by the research team to be the study sites: Hanoi City, Dien Bien province, Hochiminh City, and An Giang province. In each site, the team selected and interviewed children at two education levels – Secondary and High school, from 12 to 17 years of age. The total sample size was 402 children with a mean age of 15.07 (standard deviation 2.14), the youngest being 12 and the oldest being 17. Girls make up 60.2% and boys 39.8%. In this Study, 46.3% of the children were in Secondary school, and the rest 53.7% were in high school. By residence area, the percentages of children living in rural areas and urban areas were 43% and 57% respectively; 51.2% were from Northern Viet Nam and 48.8% from Southern Viet Nam. By study site, 25.4% of the children were from Hanoi, 25.9% from Dien Bien, 29.4% from An Giang and 19.4% from Hochiminh City (Figure 1)

Data analysis findings

Emotional Problems

Among children, symptoms of emotional problems usually include excessive fear, sadness, nervousness or upset. Anxiety disorders are also the most common problems among school-aged children, especially secondary and high school students, as they are in the period of adolescence, when they are going through a lot of psycho-physiological changes and development of social skills. In this stage, children are at risk in relation to difficulties in balancing their emotions and behaving

appropriately. The data analysis shows that a sizeable proportion of the school-aged children in the survey sample were facing emotional difficulties/problems (Table 1). The percentage of children selecting the "Certainly True" response to the relevant items ranges from 11.9% to 35.3%. Specifically, 13.7%, of the children responded "*Certainly True*" to the Item "I get a lot of headaches, stomach-aches or sickness"; 22.6% responded similarly to the Item "*I worry a lot*", 11.9% to the Item "*I am often unhappy, down-hearted or tearful*", and as many as one third (35.3%) of all the children felt they were nervous in new situations or lost confidence easily. 15.4% reported "*I have many fears, I'm easily scared*". These symptoms of nervousness, sadness, fear and worry would seriously affect their learning ability and social development.

Alongside these children, another considerable number of children were also somewhat having emotional problems. Approximately half of the children in the survey sample admitted it was "*Somewhat True*" that they were facing emotional problems (with percentages ranging from 42% to 51.7%). 51.5% of the participants responded "*Somewhat True*" to the Item related to negative physical symptoms such as headaches, stomach-aches or sickness; 51.7% reported that they worried a lot, and 46% often felt unhappy, down-hearted or tearful. 43.5% answered "*Somewhat True*" to the Item "*I am nervous in new situations. I easily lose confidence*" and 42.8% to the Item "I have many fears, I m easily scared."

The percentage of children having "*Normal*" emotional symptoms was relatively low. The number of participants choosing the "*Not True*" response to the Items of the Emotional Problem Scale makes up from only 1/5 to 1/2 (21% to 42%) of the total sample size. Specifically, 34.8% affirmed that they did not

have symptoms of headaches, stomach-aches or sickness; 25.6% did not think they worried a lot; 42% disagreed with the statement "*I often feel unhappy, down-hearted or tearful.*" 21% did not feel that they were nervous in new situations or easily lost confidence, and 41.8% said it was not true that they were easily scared or had many fears.

As such, a relatively high proportion of the children sample have somewhat abnormal emotional symptoms, one of the early signs of affective disorders whose main causes include physical and biological problems. Without timely and adequate attention from parents, family and school, these children are at risk of developing affective disorders.

Children with behavioural problems, and more seriously, conduct disorders, often show symptoms such as not caring about other people, having angry, violent or aggressive behaviours towards peers, not conforming to social norms such as playing truant from school, refusing to do homework etc., or having extreme behaviours such as opposing to or breaking rules, lying or stealing/taking other people's things etc. In this Study, the rate of children having conduct problems is quite high; the most common symptoms include getting angry and losing their temper easily, lack of self-control, or not doing as one is told. More than a fifth (21.4%) of the children answered "*Certainly True*" to the Item *"I get very angry and often lose my temper"*, and nearly a third (28.4%) to the Item *"I usually do as I am told."* Similarly, the numbers of participants selecting the "*Somewhat True*" response to these two items were relatively high, 47.3% and 63.4% in that order. What is noteworthy is that only 8.2% of the 402 children in the sample affirmed that they were not incited by other people into doing things.

The majority of the children in the sample did not think they had such behaviours as fighting, bullying (making other people do what one wants), or were accused of lying or cheating, or taking things that were not theirs. 86.8% of the children responded 'Not True' to the Item 'I fight a lot. I can make other people do what I want', 73.6% to the Item 'I am often accused of lying or cheating', and as many as 90.5% to the Item 'I take things that are not mine from home, school or elsewhere'.

Although the number of children having symptoms of conduct disorders such as fighting, bullying (making other people do what one wants), being accused of lying or taking other people's things only made up a small proportion (ranging from 0.7% to 2.5%), if we take into consideration the shares of participants who reported "Somewhat True" to items related to dishonesty and cheating such as 'lying or cheating' (23.9%) and "take things that are not mine" (8.7%), these are signs of conduct problems/disorders that need to be concerned by the family and school.

Hyperactivity/Inattention

Hyperactivity/Inattention is one of the common development disorders among children. Children having hyperactivity problems often have overactive behaviours accompanied by reduced attention; therefore, this problem often seriously affects their learning ability as well as causes difficulties to their relationships with other people.

The data from Table 1 show that about 2/3 of the children in the sample had problems or symptoms of Hyperactivity/Inattention. Specifically, 17.9% selected the 'Certainly True' response and 46.5% chose 'Somewhat True' to the Item 'I am restless, cannot stay still for long.' 18.4% answered 'Certainly True' and 32.6% "Somewhat True" to the

Item 'I am constantly fidgeting or squirming.' Finally, 20.6% responded 'Certainly True' and as many as 60.2% responded 'Somewhat True' to the Item 'I am easily distracted, find it difficult on concentrate.'

At the same time, the number of children having good attention, judgement and ability to analyse and complete tasks effectively is remarkably low. The percentages of participants deciding on the 'Certainly True' response to the Items 'I think before I do things' and 'I finish the work I'm doing. My attention is good' were only 3.2% and 8.2% respectively.

The number of children having negative symptoms such as not thinking before doing things, lack of attention and low work efficiency was fairly large. More than half (57.7%) of the respondents chose the "Not True" response to the Item 'I think before I do things', and that figure for Item 'I finish the work I'm doing. My attention is good' was 21.6%.

Besides, a significant portion of the sample chose to respond 'Somewhat True' to these Items: 39.1% to 'I think before do things', and two thirds (70.1%) to 'I finish the work I'm doing. My attention is good.' This is something to keep in mind, because these symptoms among children shall, to some extent, affect their learning ability and performance in school, especially in Viet Nam where they are often ignored by parents and schools and rarely addressed with appropriate education methods.

Peer problems

Friends are important to children, but a child's circle of friends can have positive and negative influences on his or her behaviours. In their peer relationships, if a child shows symptoms of loneliness, lack of willingness to make friends with

other peers, and withdrawal from social relationships, these can be early signs of depression.

The Study findings suggest that a significant portion of the children were rather solitary, they only had one or a few good friends; they were not liked by other children their age, preferred hanging out with adults, and some of them were even victims of bullying by their peers. Data in Table 1 point out that almost half of the respondents liked or tend to play alone and avoid making friends and communicating with other people. 9.2% of the children answered

'Certainly True' and 38.8% answered 'Somewhat True' to the Item 'I am usually on my own. I generally play alone or keep to myself.' 7.2% chose the 'Certainly True' response and 22.1% chose "Somewhat True" to the Item 'I have one good friend or more.'

The number of children who felt that they were respected and liked by peers was rather small. Only 9.5% and 65.2% of the children responded 'Certainly True' and 'Somewhat True' to the statement 'Other people my age generally like me', while over 1/4 (25,4%) of the sample thought it was 'Not True'.

Most of the participants liked or tend to like to hang out with adults more than peers. 21.6% and 44.3% of the children selected the 'Certainly True' and 'Somewhat True' responses to the Item 'I get on better with adults than with people my own age.' That means only about a third (34.1%) out of the total number of children in the sample had good relationships with peers.

Nearly half of the children were victims or at risk of being victims of bullying by peers. 6.2% of the survey participants answered 'Certainly True' and 38.6% answered 'Somewhat True' to the Item 'Other children or young people pick on me or bully me.'

Table 1: The frequency distribution of the SDQ[1912]

Item	Problems	Not True	Somewhat True	Certainly True	N
	Emotional Problem				
SD3	I get a lot of headaches, stomach-aches or sickness	34,8	51,5	13,7	402
SD8	I worry a lot	25,6	51,7	22,6	402
SD13	I am often unhappy, down-hearted or tearful	42,0	46,0	11,9	402
SD16	I am nervous in new situations. I easily lose confidence	21,0	43,5	35,3	402
SD24	I have many fears, I'm easily scared	41,8	42,8	15,4	402
	Conduct Problems				
SD5	I get very angry and often lose my temper	31,3	47,3	21,4	402
SD7*	I usually do as I am told	8.2	63,4	28,4	402
SD12	I fight a lot. I can make other people do what I want	86,8	11,7	1,5	402
SD18	I am often accused of lying or cheating	73,6	23,9	2,5	402
SD22	I take things that are not mine from home, school or elsewhere	90,5	8,7	0,7	402
	Hyperactivity				
SD2	I am restless, cannot stay still for long	35,6	46,5	17,9	402
SD10	I am constantly fidgeting or squirming	49,0	32,6	18,4	402
SD15	I am easily distracted, find it difficult on concentrate	19,2	60,2	20,6	402
SD21	I think before I do things	57,7	39,1	3,2	402
SD25	I finish the work I'm doing. My attention is good	21,6	70,1	8,2	402
	Peer problem				
SD6	I am usually on my own. I generally play alone or keep to myself	52,0	38,8	9,2	402
SD11	I have one good friend or more	70,6	22,1	7,2	402
SD14	Other people my age generally like me	25,4	65,2	9,5	402
SD19	Other children or young people pick on me or bully me	55,2	38,6	6,2	402
SD23	I get on better with adults than with people my own age	34,1	44,3	21,6	402
	Prosocial behaviours (Illustrated in Figure 2)				
SD1	I try to be nice to other people. I care about their feelings	1,2	63,9	34,8	402
SD4	I usually share with others (food, games, pens etc.)	4,2	59,2	36,6	402
SD9	I am helpful if someone is hurt, upset or feeling ill	1,7	48,0	50,2	402
SD17	I am kind to younger children	4,0	35,6	60,4	402
SD20	I often volunteer to help others (parents, teachers, children)	6,7	60,9	32,3	402

19.   SD7, SD21, SD25, SD11, SD14 have been reversed scored: Not True 0= 2; Somewhat True=1; Certainly True 2=

Prosocial behaviours

Most of the children in the survey sample demonstrated prosocial behaviours. The vast majority of the sample chose to respond '*Certainly True*' and '*Somewhat True*' to all the Items of this Scale. The percentage of children answering '*Not True*' to these Items is very low, ranging from 1.2% to 6.7% only. It can be seen from Figure 2 that 34.8% and 63.9% of the children responded '*Certainly True*' and '*Somewhat True*' respectively to the Item '*I try to be nice to other people. I care about their feelings.*' Similarly, 36.6% and 59.2% thought it was "Certainly True" and '*Somewhat True*' that they '*usually share with others (food, games, pens etc.).*' 50.2% and 48% chose the '*Certainly True*' and '*Somewhat True*' responses to the Item '*I am helpful if someone is hurt, upset or feeling ill.*' 60.4% answered "Certainly True" and 35.6% answered '*Somewhat True*' to the Item '*I am kind to younger children.*' Finally, to the last Item of the Scale, '*I often volunteer to help others (parents, teachers, children)*', 32.3% and 60.9% of the children thought it was '*Certainly True*' and '*Somewhat True*', respectively.

The rates of children having mental health problems based on the SDQ scores

The children's emotional, conduct problems and difficulties

Figure 3 illustrates the distribution of the total difficulties scores as calculated from the children's self-report SDQ survey. The results show that the mean Total Difficulties Score of the children in the sample is 13.99, with a standard deviation of 4.76 (N = 402), and a kurtosis of -0.058. The highest score is 29 and the lowest is 4.

This figure is higher than the mean Total Difficulties Scores produced by the Study of Dang Hoang Minh et

al. (2013)[20], which were 9.56 among adolescents ages 12-16 for the self-report SDQ version (SD = 4.84, N = 591), and 8.41 among children ages 6-16 for the parent-report SDQ version (SD = 4.73, N = 1320).

Table 2 presents the mean Total Difficulties Score and separate Scores for the individual Scales of Emotional Problems, Conduct Problems, Hyperactivity, Peer Problems and Prosocial Behaviours. Based on the instructions on '*Interpreting Symptom Scores and Defining "Caseness" from Symptom Scores*', the Study results

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20. The Study by Dang Hoang Minh was an epidemiologic study on mental health of children in Viet Nam over a sample 591 children ages 12-16 and 1314 parents of children ages 6-16. It was carried out in 60 selected sites of 10 provinces representing the different regions of Viet Nam, including Hanoi, Hoa Binh, Thai Nguyen, Hai Phong, Ha Tinh, Danang, Binh Thuan, Hau Giang and Hochiminh City. The Study used the Children Behaviour Checklist (CBCL) for parent-report, Strengths and Difficulties Questionnaire (SDQ) for parent-report and child self-report, the Brief Impairment Scale (BIS) (a tool to assess a child's functional impairment) for parent-report, and the Youth Self Report (YSR) – a tool to assess children's behaviours and emotions. It should be noted that the comparison of our Study's results with those of Dang Hoang Minh is for the mere purpose of reference, because these two studies have different scales and representativeness.

Figure 2: The frequency distribution of prosocial behaviour items (%)
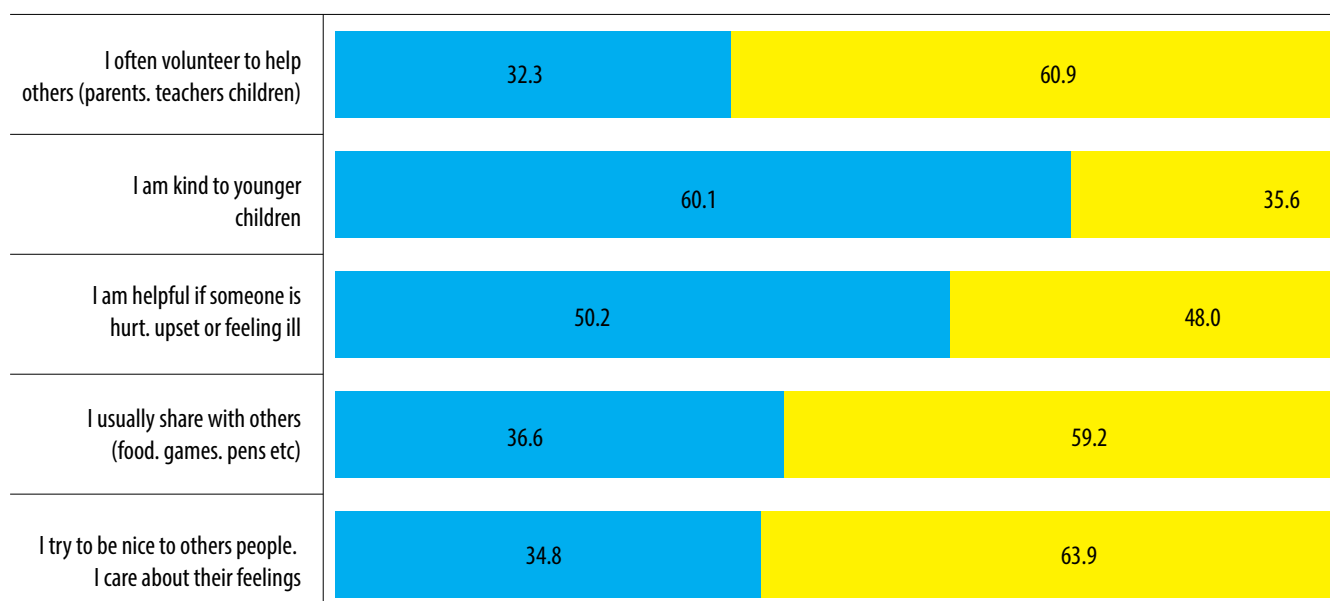
Figure 3: Distribution of the total difficulty score of the SDQ

Mean = 13.9925
Std. Dey. = 4.76766
N= 402
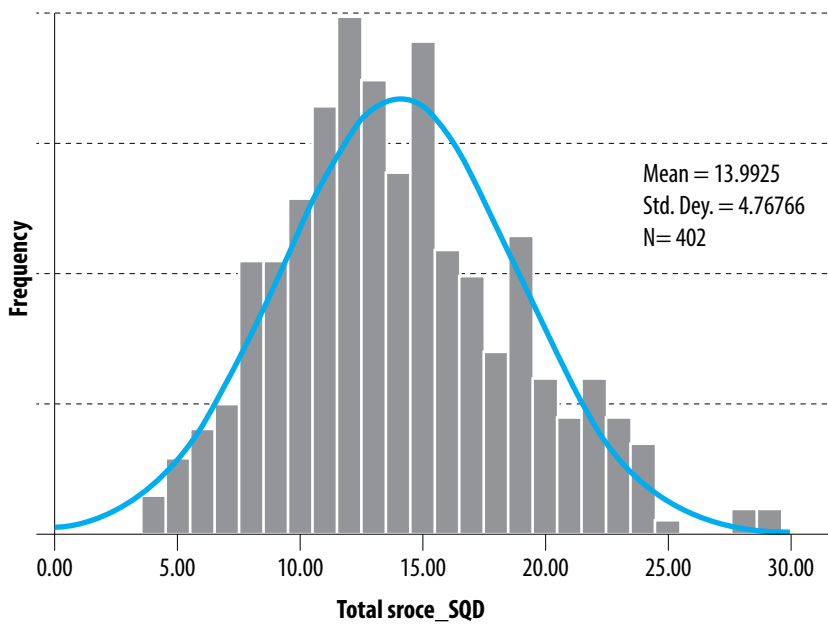
show that 66.9% of the children in the sample scored in the "Normal" band, 19.7% scored in the '*Borderline*' band, and the rest 13.4% scored in the '*Abnormal*' band.

A number of other studies on mental health problems among adolescents (ages 12-16) in Viet Nam have also been conducted using the self-report and parent-report SDQs. For example, Dang Hoang Minh et

al. (2013)found that, with a cut-off point of 15 being used to define likely '*cases*' with mental health problems, the rate of adolescents having problems stood at 10.73% (including 3.89% in the '*Abnormal*' band) for the self-report version, and that figure as reported by parents was 13.2%. Another study by Amstadter et al. (2011) among 1368 Vietnamese

adolescents[21] suggested that 99.1% of the children were considered '*having problems*' according to their SDQ Total Difficulties Scores.

Compared to the results by Dang Hoang Minh et al (2013), the rate of children considered '*abnormal/ having problems*' in this Study is higher by 2.67 percentage points (13.4% versus 10.73%) for the self-report SDQ version, but is almost equal to the parent-report figure (13.4% versus 13.2%). At the same time, it is higher than the rate of children '*having problems*' produced by Amstadter et al. (2011) (9.1%). As such, with the figure ranging from 9.1% to 13.4%, it shows that less than one tenth of the children in Viet Nam were '*having problems*' according to their SDQ scores, and this result is in line with those of other Asian countries, whose rates of children having mental health problems vary from 10 to 20% (Sirath, Kandasamy, Golthar (2010) as cited by Dang Hoang Minh et al., 2013).

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21. SD7, SD21, SD25, SD11, SD14 have been reversed scored: Not True 0= 2; Somewhat True=1; Certainly True 2=0.

Table 2: Mean scores, standard deviations of SDQ and Caseness (Symptoms score)

Scale	Mean, Standard Deviations		Caseness (Symptoms score)		
	Mean	**Std. Dev**	**Normal**	**Borderline**	**Abnormal**
Total difficulties (0-40)	13,99	4,76	66,9 (0-15)	19,7 (16-19)	13,4 (20-40)
Emotional Problems (0-10)	4,34	2,32	68,7 (0-5)	11,7 (6)	19,7 (7-10)
Conduct Problems (0-10)	2,63	1,29	77,4 (0-3)	15,2 (4)	7,5 (5-10)
Hyperactivity (0-10)	3,85	1,92	81,6 (0-5)	10,0 (6)	8,5 (7-10)
Peer problems (0-10)	3.16	1.58	62,4 (0-3)	30,6 (4-5)	7,0 (6-10)
Prosocial behaviours (10-0)	6.96	1.66	80,6 (6-10)	14,9 (5)	4,5 (0-4)

This Study also recognizes that the most common symptoms among the children are of Emotional problems. According to the SDQ Scores, the percentage of children having '*Abnormal*' emotional problems stood at as high as 19.7%, and this Scale's mean score (4.34; SD = 2.32) is also the highest among all Scales. The rate of children scoring '*Abnormal*' in the Emotional problems Scale is more than twice as high as those in other Scales, which suggests that emotional problems are what children struggle with the most during adolescence, which is by nature the most difficult stage of life for children to adapt themselves.

This result is fairly similar to that of the study by Nguyen Anh Hong et al. on behavioural and social problems among Secondary school children in Hochiminh City, which found that 16% of the children were having emotional problems (as cited by Lam & Weiss, 2007 – as cited by Dang Hoang Minh et al., 2013).

The rate of children having Hyperactivity Scores within the '*Abnormal*' band was 8.5%, which should be a matter of concern as it is remarkably greater than the numbers produced by Dang

Hoang Minh et al. (2013) (self-report 2.85% and parent-report 2.69%). The WHO Study in both developed and developing countries showed that there is correlation between substance abuse and impulse-control disorders and dropping out of school. In the case of Brazil, children with ADHD have high rates of failing exams, being suspended or expelled from school. A substantial number of children who dropped out from the first year of primary school also suffered from behavioural disorders and delayed mental development (Kieling & cs, 2013, as cited by Dang Hoang Minh et al., 2013).

Regarding the Conduct problems Scale, the percentage of children having '*Abnormal*' scores is 7.5%, higher than those in the Study by Dang Hoang Minh et al., 2013, which were 2.68% (children self-report) and 3.36% (parent-report). However, this figure is significantly lower than the 24% rate of school children with behavioural problems in HCMC as provided by Nguyen Anh Hong et al. (as cited by Lam & Weiss, 2007 – as cited by Dang Hoang Minh et al., 2013).

On the contrary, the number of children scoring in the '*Abnormal*' band in the Peer problems Scale only made up 7%, considerably lower than the parent-report rate in the study by Dang Hoang Minh et al. (2013) (22.18%), but higher than the children self-report rate (3.18%).

Nevertheless, what is the most noteworthy about this survey sample is that the percentage of children having Borderline scores in the Peer problems Scale was 2-3 times as high as that in other Scales (30.6% as compared to 10-15% in other Scales). This indicates that a sizeable portion of the children were on the threshold of suffering difficulties in developing social relationships.

In terms of Prosocial behaviours, the majority of the children in the survey sample had positive social relationships (80.6% scoring in the '*Normal*' band), while only 14.9% and 4.5% were in the '*Borderline*' and '*Abnormal*' bands, respectively. The mean score for this Scale is 6.96 (SD=1.66). Compared to study results by Dang Hoang Minh et al. (2013), the rate of children having '*Abnormal*' scores for the Prosocial Scale in this Study is higher (4.5% versus 2.18% (children self-report) and 2.69%

Figure 4: The frequency distribution of the SDQ total difficulties score and prosocial behaviour score (%)
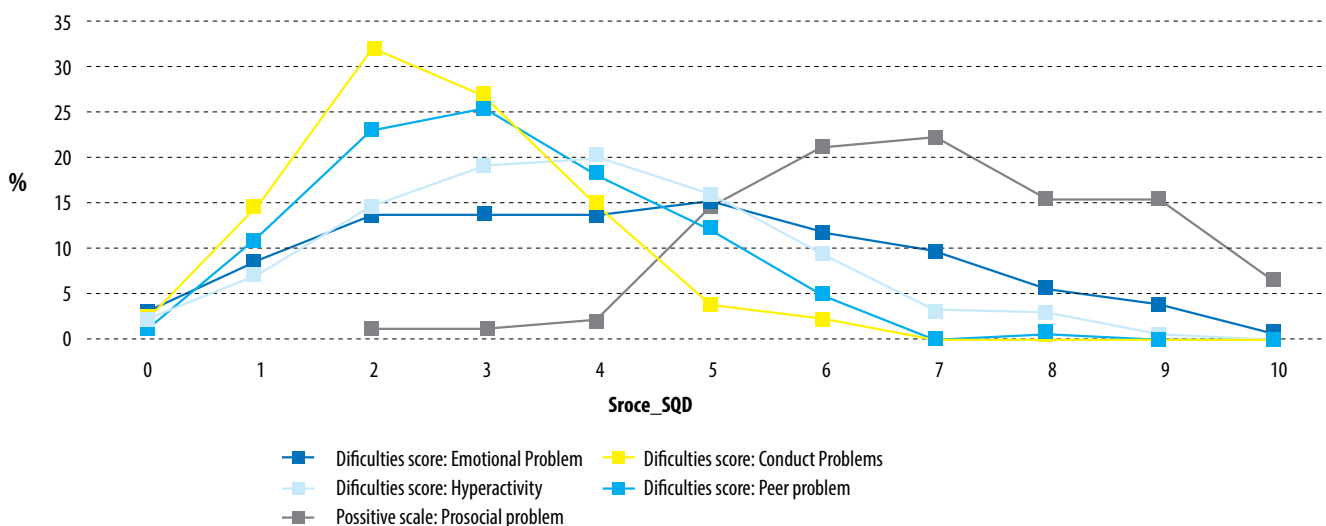
(parent-report)), and the mean score is just slightly lower (6.96 versus 7.94 (SD=1.77) (children self-report) and 8,43 (SD=1,76) (parent-report)).

Figure 4 represents the distribution of the Difficulties Scores of each problem Scale and the Prosocial Scale Scores. As can be observed from the Prosocial Scale line (positive scale), the majority of the children had scores of 5 to 9, whereas in the opposite direction, the Difficulties Scores lines (negative scales) show that the majority of the children stood at lower scores. For example, most of the children scored 2 to 5 for the Emotional Problems and Hyperactivity Scales, and scored 2-4 for Conduct Problems and Peer Problems Scales.

The rates of children having emotional and conduct problems by demographic and social characteristic

Table 3, Table 4 and Figure 5 display the Total Difficulties Scores and the separate Scale Scores broken down by the children's demographic and social characteristics. The results show that children of the older age group and higher education level face more problems than children of the younger age group and lower education level. Girls appeared to have more difficulties than boys. The mean Total Difficulties Score of children age 16 or older is 0.8 point higher than that of those under 15 years old (14.36 vs. 13.56), and that of high school students is higher than that of secondary students (14.36 vs. 13.56). The mean Total Difficulties Score of girls is higher than that of boys (14.15 vs. 13.75). Analysis using the one-way ANOVA method shows no statistically significant differences between the mean total Difficulty scores between children of different demographic characteristics (Table 3 & 4).

The children's conduct and emotional problems differed by residence area. Analysis of the Total Difficulties Scores and the separate Subscale Scores revealed noticeable differences between children from different residence areas (Table 5). The children in An Giang have a higher mean Total Difficulties Score than those in the other 3 areas of Dien Bien, Hanoi and HCMC (14.67 versus 13.23 to 13.99). The children's mean Total Difficulties Score is higher in rural areas than urban areas, and the South than the North.

With regard to emotional problems, the children in Dien Bien and An Giang provinces scored higher in this Scale than those in the two biggest cities of Viet Nam – Hanoi and HCMC (4.75 and 4.66 versus 3.92 and 3.82). Similarly, the children in rural areas also have a higher Emotional Problems Scale score than those in urban areas (4.76 versus 4.15).

The girls appeared to face more emotional problems than the boys, with scores for the Emotional Problems Scale of 4.77 and 3.67 respectively. In contrast, the boys faced more peer problems than

Table 3: Mean scores (standard deviations) by characteristics of children

Scale	All children (N=402)	Age		Sex/Gender		Educational Level	
		<=15 (n=186)	16+ (n=216)	Boys (n=160)	Girls (n=242)	LSS (n=186)	USS (n=216)
Total difficulty score							
	13,99	13,56	14,36	13,75	14,15	13,56	14,36
	(4,76)	(4,68)	(4,81)	(4,53)	(4,91)	(4,68)	(4,81)
Emotional Problem	4,22	4,22	4,44	3,67	4,77	4,22	4,43
	(2,32)	(2,26)	(2,37)	(2,15)	(2,33)	(2,26)	(2,37)
Conduct problems	2,63	2,62	2,64	2,65	2,62	2,62	2,64
	(1,29)	(1,38)	(1,22)	(1,42)	(1,20)	(1,38)	(1,22)
Hyperactivity	3,85	3,49	4,16	3,99	3,76	3,49	4,16
	(1,92)	(1,82)	(1,95)	(2,01)	(1,86)	(1,82)	(1,95)
Peer problems	3,16	3,22	3,11	3,42	2,99	3,22	3,11
	(1,58)	(1,56)	(1,60)	(1,56)	(1,58)	(1,56)	(1,60)
Prosocial		* (P=0.024)		* (P=0.011)		* (P=0.024)	
	6,96	7,16	6,79	6,70	7,13	7,16	6,79
	(1,66)	(1,64)	(1,67)	(1,83)	(1,52)	(1,64)	(1,67)

the girls, scoring 3.42 for the Peer Problems Scale, as opposed to 3.11 among the girls. The children in the older age group (age 16 and older) showed more hyperactivity problems than the younger ones (under 15 year olds) (scoring 4.16 and 3.49 respectively for the Hyperactivity Scale).

The children living in urban areas and big cities seemed to have more hyperactivity problems. The children's Hyperactivity Scale score is higher in urban areas than rural areas (4.15 versus 3.62). Particularly, the score of HCMC is higher than those of the other 3 provinces and city (4.14 versus 3.66 – 3.89).

Concerning prosocial behaviours, there are significant differences between children living in different areas. The Prosocial score is higher

among children in rural areas than urban areas (7.15 versus 6.71), and higher in Dien Bien and An Giang provinces than the rest, and in the North than in the South. Correlation analysis results show differences between the prosocial scores of different children groups by age, sex, level of education, study site and residence area. Boys, lower secondary students and rural children scored higher in the prosocial scale than the other groups. These differences are statistically significant (P<0.05, P<0.001), which indicates that these correlations did not happen by chance (Tables 3 & 4).

The data in Table 5 shows that the percentage of children having '*Abnormal*' problems is considerably higher among children age 16 or older (14.8% vs. 11.8%), among girls

than boys, among rural areas than urban areas, and in the North than in the South. Comparative analysis results suggest a considerably higher rate of '*abnormal*' problems among rural children than urban children (10.4% vs. 15.7%), and this difference did not happen by chance (statistical significance p-value <0.05).

Figure 5 reveals differences in the rates of children having '*Abnormal*' scores between the study provinces/sites. The number is highest in Dien Bien (18.3%) – a Northern mountainous province, and then An Giang (15.3%) – a province in the Mekong Delta, almost twice as high as those in the other two sites (10,8% in Hanoi and 7,7% in HCMC) (Figure 5).

Table 4: Mean scores (standard deviations) by residence area

Scale	Provinces				Areas		Regions	
	Hanoi (n=102)	Dienbien (n=104)	An Giang (n=118)	HCMC (n=78)	Urban (n=173)	Rural (n=229)	Northern (n=206)	Southern (n=196)
Total difficulty score	13,23	13,98	14,67	13,99	13,90	14,07	13,61	14,40
	(4,55)	(5,56)	(4,41)	(4,32)	(4,40)	(5,03)	(5,08)	(4,38)
Emotional Problem	3,93	4,75	4,66	3,82	4,15	4,76	4,34	4,32
	(2,33)	(2,32)	(2,28)	(2,23)	(2,31)	(2,32)	(2,35)	(2,29)
Conduct problems	2,62	2,36	2,71	2,91	2,69	2,59	2,49	2,79
	(1,32)	(1,36)	(1,26	(1,16)	(1,15)	(1,39)	(1,34)	(1,22)
Hyperactivity	3,77	3,66	3,89	4,14	4,15	3,62	3,71	3,99
	(1,86)	(2,08)	(1,90)	(1,79)	(1,88)	(1,92)	(1,97)	(1,86)
Peer problems	2,89	3,20	3,39	3,11	2,90	3,36	3,04	3,28
	(1,77)	(1,62)	(1,34)	(1,57)	(1,50)	(1,61)	(1,70)	(1,44)
	*** (P=0.000)				** (P=0.009)			
Prosocial	6,58	7,53	7,01	6,61	6,71	7,15	7,06	6,85
	(1,45)	(1,56)	(1,67)	(1,82)	(1,68)	(1,62)	(1,58)	(1,74)

Table 5. Caseness (Symptoms score) by characteristics of children

Variable		Caseness (Symptoms score)		
		Normal	Borderline	Abnormal
	Total difficulty score	66,9	19,7	13,4
Age	>=15	71,5	16,7	11,8
	16+	63,0	22,2	14,8
Sex	Boys	70,0	18,8	11,3
	Girls	64,9	20,2	14,9
	Lower Secondary School	71,5	16,7	11,8
	Upper Secondary School	63,0	22,2	14,8
Area * (P=0.023)	Urban	64,2	25,4	10,4
	Rural	69,0	15,3	15,7
Region	Northern Viet Nam	69,9	15,5	14,6
	Southern Viet Nam	63,8	24,0	12,2

Figure 5: Caseness (Symptoms score) by provinces (%)
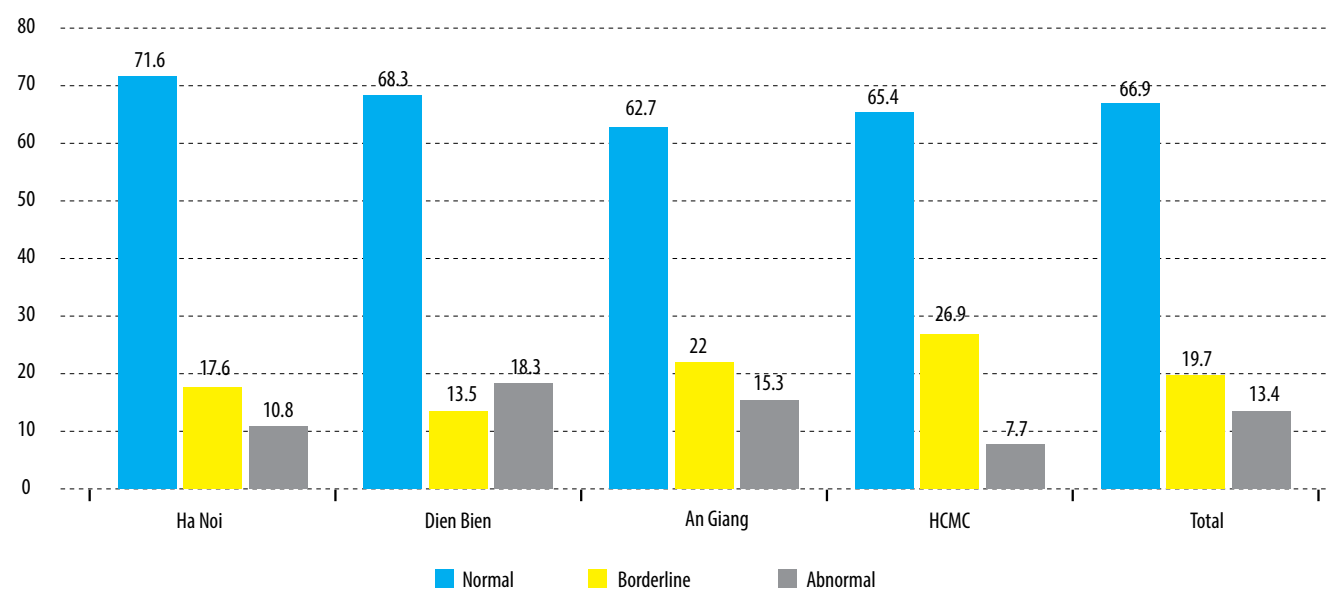
Self-efficacy

Children's self-efficacy

Self-efficacy is an important quality to school-aged children. Those with higher self-efficacy are more motivated and determined in studying. There is a lot of research about how self-efficacy is beneficial to school-aged children, college students can also benefit from self-efficacy (Schunk, 1990; Multon, Brown & Lent, 1991; Hoover Dempsey, Bassler & Brissie, 1987). When self-efficacious students attain their goals, they continue to set even more challenging goals (Schunk, 1990). This can all lead to better performance in school in terms of higher grades and taking more challenging classes (Multon, Brown & Lent, 1991). Students with high academic self-efficacies might study harder because they believe that they are able to use their abilities to study effectively (Hoover-Dempsey, Bassler & Brissie, 1987).

Educational and psychological researchers also believe that a child with higher self-efficacy is more serious about studying and works harder, and at the same time, more optimistic, less dependent or avoidant, more persevering and less anxious, hence better performance in school and in life in general. As such, an individual's self-efficacy, can have substantial influence on his or her success or failure in studying and achieving life goals. Psychologists call it "the Effective Self" and consider

it a predictor of a student's academic performance. Moreover, children with high self-efficacy are often less likely to depend on others or avoid difficult tasks, and are highly determined to pursue their goals. When faced with barriers, they know how to handle them or will try to find every way possible to reach their goals regardless of the situation.

Table 6 presents the data of how the children perceived their self-efficacy based on the 10 Items of the Self-Efficacy Scale. The results show that, except for the two Items of '*I am confident that I could deal efficiently with unexpected events*' and '*Thanks to my resourcefulness, I know how to handle unforeseen situations*' which have lower percentages of '*Moderately True*' and '*Exactly True*' responses, only around 50% (45.3% and 53.0% respectively), the responses to the 8 other Items reflect relatively high perceived self-efficacy among the children when challenged by difficult situations, such as: '*I can always manage to solve difficult problems if I*

try hard enough', '*If someone opposes me, I can find the means and ways to get what I want*", "*It is easy for me to stick to my aims and accomplish my goals*", "*I can solve most problems if I invest the necessary effort*", "*I can remain calm when facing difficulties because I can rely on my coping abilities*", "*When I am confronted with a problem, I can usually find several solutions*", "*If I am in trouble, I can usually think of a solution*", and "*I can usually handle whatever comes my way.*' The rates of children choosing the '*Moderately True*' and '*Exactly True*' responses to these Items are very high, varying from 60.7% to 80.8%. On the contrary, the proportions of children answering '*Not at all True*' to the 10 Items are fairly low, ranging from 1.5% to 11.2%, while the mean scores for these Items are quite high (from 2.45 to 3.11), which suggests that *many of the children in the survey sample have relatively high perceived self-efficacy in life*.

Overall, when caught in *unforeseen/unexpected situations*, the number of children thinking they had

enough confidence to cope with the situation is lower than those who thought they were able to handle trouble, even very difficult problems. When faced with unforeseen/unexpected situations, only about half of the children believed in their abilities to handle the problems that arose: 45.3% thought they '*could deal efficiently with unexpected events*', and 53% believed that '*Thanks to my resourcefulness, I know how to handle unforeseen situations.*'

Meanwhile, when *actively* facing trouble or problems, the majority of the children felt that they could come up with their own solutions (60-80%). In particular, in the face of difficulties or challenges, a great number of children believed in their coping abilities; they thought that they could keep calm to solve the problems, as well as believed in their efforts in dealing with difficulties, or their abilities to focus, pursue and achieve their goals.

Theoretically, higher scores indicate higher levels of self-efficacy. Analysis

Table 6: The frequency distribution, mean score and percentage mean of the children self - efficacy

	Frequency (%)				Mean scores			N
	Not at all true	Hardly true	Moderately true	Exactly true	Mean	%	SD	
I can always manage to solve difficult problems if I try hard enough	2,5	20,4	55,0	22,1	2,97	74,2	0,72	402
If someone opposes me, I can find the means and ways to get what I want	8,0	31,3	43,5	17,2	2,70	71,5	0,84	402
It is easy for me to stick to my aims and accomplish my goals	3,0	29,9	45,8	21,4	2,86	67,5	0,78	402
I am confident that I could deal efficiently with unexpected events	11,2	43,5	34,3	10,9	2,45	61,2	0,83	402
Thanks to my resourcefulness, I know how to handle unforeseen situations	7,2	39,8	40,8	12,2	2,58	64,5	0,79	402
I can solve most problems if I invest the necessary effort	4,0	15,2	46,5	34,3	3,11	77,7	0,80	402
I can remain calm when facing difficulties because I can rely on my coping abilities	7,0	26,4	40,8	25,9	2,86	71,5	0,88	402
When I am confronted with a problem, I can usually find several solutions	4,2	25,9	47,0	22,9	2,89	72,2	0,80	402
If I am in trouble, I can usually think of a solution	1,5	25,1	50,5	22,9	2,95	73,7	0,73	402
I can usually handle whatever comes my way	4,2	23,6	37,1	35,1	3,03	75,7	0,87	402
Total score (0- 40)					**28,38**	**71,0**	**4,23**	

* Percentage mean: Convert from the mean column to mean percentage out of 4 means

Table 7. The frequency distribution of the Perceived Self - Efficacy in 2 scales

	False	True	N
I can always manage to solve difficult problems if I try hard enough	22,9	77,1	402
If someone opposes me, I can find the means and ways to get what I want	39,3	60,7	402
It is easy for me to stick to my aims and accomplish my goals	32,8	67,2	402
I am confident that I could deal efficiently with unexpected events	54,7	45,3	402
Thanks to my resourcefulness, I know how to handle unforeseen situations	47,0	53,0	402
I can solve most problems if I invest the necessary effort	19,2	80,8	402
I can remain calm when facing difficulties because I can rely on my coping abilities	33,3	66,7	402
When I am confronted with a problem, I can usually find several solutions	30,1	69,9	402
If I am in trouble, I can usually think of a solution	26,6	73,4	402
I can usually handle whatever comes my way	27,9	72,1	402

results show a fairly positive level of self-efficacy among the sampled children: 7 out of the 10 items, as self-reported by the children, have a mean percentage score of over 70%. Overall, the mean scores of the 10 items vary from 2.45 to 3.11[22] (highest for the item '*I can solve most problems if I invest the necessary effort*'). The mean total self-efficacy score among the children in this Study stood quite high at 28.38[23] (SD = 4.23) (within a range of 16 to 40).

To understand the **children's perceived self-efficacy,** the Study bases on the rate of children who answered Moderately true and Exactly True to each item. As such, from the collected responses, we would separate them into 2 groups: 1 – True and 0 – False. Specifically, the 1-True group would include the two responses of Moderately true and Exactly true (score values of 3 and 4), and the 0-False group would include the other two responses, Not at all true and Hardly true (score values of 1 and 2).

22. In many samples the mean was around 2.9 (Ralf Schwaizer, 2014)

23. In a sample of N = 3,494 German high school students (12 to 17 years old), the mean was found to be 29.60, standard deviation equalled 4.0 (Ralf Schwarzer, 2014).
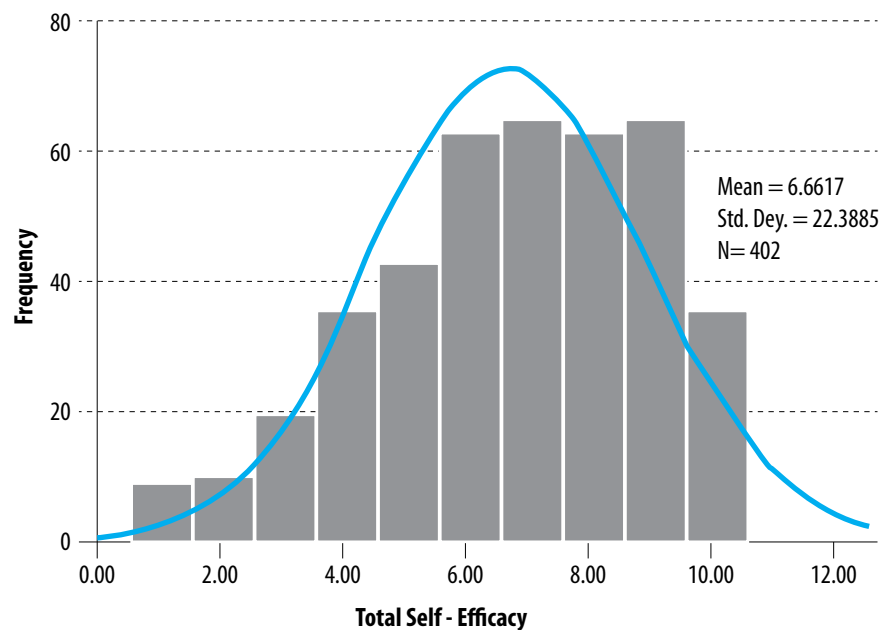
Figure 6. The frequency distribution of the total Self - Efficacy

Mean = 6.6617
Std. Dey. = 22.3885
N= 402

Table 7 provides the rates of children having '*True*' answers to the items of the Self-efficacy Scale. The analysis results show that more than 75% of the children had '*True*' responses to 2 out of the 8 Items, which are: '*I can always manage to solve difficult problems if I try hard enough*' (77.1%) and '*I can solve most problems if I invest the necessary effort*' (80.8%). This figure for the rest of the Items only reached 45.3% - 73.4%.

Figure 6 illustrates the children's perceived self-efficacy levels on a scale of 0-10. It can be seen from the graph that the children's self-efficacy is relatively high, with a mean score of 6.66 (SD=2.23). Only 18.2% of the children have lower-than-average self-efficacy scores (0-4), 41% have average scores (5-7), and 40% have mean scores of 8-10. These numbers imply a fairly high level of self-efficacy among the children.

Children's Self-efficacy by demographic and social characteristics

The analysis found that the self-efficacy levels of the children in this sample did not differ much by age or education level, but some differences were recognized between different sexes and residence areas, as seen in Table 8 The self-efficacy levels appear to be higher among children in urban areas than those in rural areas. The children in urban areas showed higher self-efficacy than those in rural areas (mean score 6.86 (SD = 2.30) versus 6.51 (SD=2.17).

Results of correlation analysis show differences between self-efficacy levels by gender, province and region, which are statistically significant (P<0.05, P<0.001, P=0.000). The self-efficacy levels seem to be higher among boys than girls, with a mean scores 6.99 (SD=1.93) versus 6.44 (SD=2.39) (P<0.05). The children in An Giang and Hochiminh City showed higher self-efficacy than those in Hanoi and Dien Bien Province (P=0.001). The self-efficacy levels of those in the South were considerably higher than those in the North (mean score 7.07 (SD 2.20) versus 6.26 (SD=2.20) (P=0.000).

Conclusions

Studying mental health and self-efficacy among school-aged children is highly complicated, but plays a critical role in the development of mental wellbeing among children. To identify and assess mental health and self-efficacy problems among school-aged children in Viet Nam, the research team used the two tools of SDQ and SE Scale to collect and analyse data. The study findings also contribute to verifying the relevance of the SDQ in identifying mental health problems among children in Viet Nam. Preliminary analyses built on samples of children aged 12-17 from secondary and high schools in 4 provinces/cities, representing the two regions of Viet Nam, have allowed the authors to reach a number of conclusions as follows:

In terms of mental health problems

Of the four domains of behavioural **a**nd emotional problems, this Study recognised emotional problems as the most common symptoms among the children. The rate of children scoring '*Abnormal*' in the Emotional problems Scale is more than twice as high as those in other Scales, which suggests that emotional problems are

what children struggle with the most during adolescence, which is the most difficult stage of life for children to adapt. The rate of children having conduct problems in this Study also appears to be quite high; the most common symptoms include getting angry and losing temper easily, and lack of self-control. That many of the children are somewhat prone to these behaviours is a matter of concern to families and schools, because children with such conduct disorders will face difficulties not only in building social relationships, but also in their personal development. The majority of the children in the survey sample showed problems or symptoms of hyperactivity. Very few of the children were confident that they possessed good attention, judgement and ability to analyse and complete tasks effectively. These signs are often ignored by parents and schools and rarely addressed with appropriate education methods.

The analysis of children having mental health problems based on the SDQ scores found that the number of children having '*Abnormal*' symptoms of Peer problems was considerably lower than the figures provided by some other studies. However, the

Table 8: Mean scores (standard deviations) of SE by characteristics of children

All children (N=402)	Age		Sex/Gender		Educational Levels	
	<15 (n=186)	15+ (n=216)	Boys (n=160)	Girls (n=242)	LSS (n=186)	USS (n=216)
			* (P=0.015)			
6.66	6.66	6.66	6.99	6.44	6.66	6.66
(2.23)	(2.14)	(2.32)	(1.93)	(2.39)	(2.14)	(2.32)

Provinces				Areas		Regions		
Hanoi (n=102)	Dien Bien (n=104)	An Giang (n=118)	HCMC (n=78)	Urban (n=173)	Rural (n=229)	Northern (n=206)	Southern (n=196)	
** (P=0.001)						*** (P=0.000)		
6.40	6.13	7.22	6.84	6.86	6.51	6.26	7.07	
(2.31)	(2.09)	(2.15)	(2.26)	(2.30)	(2.17)	(2.20)	(2.20)	

percentage of children having Borderline scores for the Peer problems Scale was 2-3 times as high as that for other domains of problems. A significant portion of the children seemed to be rather solitary, have few friends, not liked by other children their age, prefer hanging out with adults, and especially, some of them were even victims or at risk of being bullied by their peers. This suggests that peer relationships are a difficult problem for school-aged children.

The behavioural and emotional problems mentioned above differed according to the children's demographic and social characteristics. The children of the older age group and higher education level face more problems than those of the younger age group and lower education level; girls appeared to have more difficulties than boys. The girls faced more emotional problems than the boys, while in contrast, the boys have more peer problems than girls. Hyperactivity seems to be more of a problem among older children and in urban areas and big cities.

The total difficulties scores as calculated from the children's self-report SDQ of this sample is fairly high compared to the results of some other studies on mental health of children in Viet Nam in which SDQ was used. However, the rate of children having '*Abnormal*' symptoms in this Study is in line with other studies on children in Viet Nam. Overall, this result is also within the range of rates of children having mental health problems among children in Asian countries. The children's Total Difficulties Scores differed by residence area; the children's mean Total difficulties Score is higher in rural areas urban areas, and in Southern Viet Nam than Northern Viet Nam.

Similarly, the Study also discovered differences in the rates of children

having "Abnormal" symptoms by age and residence area. This rate is considerably higher among children aged 16 or older, girls, children in rural areas, and in the North. Noticeably, the percentage of children having '*Abnormal*' symptoms is highest in Dien Bien – a Northern mountainous province and An Giang – a province in the Mekong Delta. However, the correlation analysis results only confirm the statistical significance of the difference between the rates of children in the "abnormal" band by region of residence.

Regarding prosocial behaviours, the majority of the children in the survey sample had positive social relationships. The mean Prosocial Score is higher among children under 15 years of age, girls, secondary school students and children living in rural areas. Correlation analysis results suggest a link between factors such as age, sex, educational level, study site and region of residence of the children and prosocial behaviours.

Children's self-efficacy and perceived self-efficacy

Analyses have revealed a relatively positive perception of self-efficacy among the children in the sample, both in unexpected/unforeseen situations and especially when actively facing difficult problems, although the number of children having good self-efficacy in coping with unexpected events is a bit lower. Particularly, in the face of difficulties and challenges, many of the children believed in their coping abilities. They could keep calm to solve the problems, and were confident in their own efforts and abilities to focus on pursuing and achieving their goals.

Correlation analysis results found statistically significant differences between self-efficacy levels of children by sex, province and region. The boys seemed to have higher

self-efficacy than the girls. Self-efficacy also appeared to be higher among children in urban areas than those in rural areas, and in the South than in the North. In the present context of Vietnamese society, where globalisation is becoming more widespread and children and young people are being increasingly exposed to a range of competing worldviews, self-efficacy is becoming more and more important. This self-efficacy needs to be, nurtured and developed by parents, families and schools, so that children can grow up to be highly independent and confident in their own abilities to make decisions and cope with difficult situations in school and in life.

References

Amstadter, Richardson L, Meyer A, Sawyer G, Kilpatrick DG, Tran TL, Trung LT, Tam NT, Tuan T, Buoi LT, Ha TT,Thach TD, Gaboury M, Acierno R. 2011. Prevalence and correlates of probable adolescent mental health problems reported by parents in Viet Nam. In Psychiatry Psychiatr Epidemiol. Feb. 46(2):95-100, http://www.ncbi.nlm.nih.gov/pubmed/20012859

Bandura, A. 1986. Social Foundations of Thought and Action: A Social Cognitive Theory. Prentice Hall

Bandura, A. 1977. Self-efficacy: Toward a unifying theory of behavioral change, Psychological Review, Vol. 84, No.2, p.195-215, https://www.uky.edu/~eushe2/Bandura/Bandura1977PR.pdf

School Mental Health Program, Mai Huong Psychiatric Hospital, http://www.maihuong.gov.vn/m/suc-khoe-tam-than-tre-em/62-chuong-trinh-suc-khoe-tam-than-hoc-duong.html

Dang Hoang Minh, Bahr Weiss, Nguyen Cao Minh. 2013. Mental health of children in Viet Nam: Situation and Risk Factors. National University, University of Education

Hoang Cam Tu, Dang Hoang Minh. 2009. Situation of mental health among secondary students in Hanoi, and the needs for school mental health counseling. Journal of Social Sciences and Humanities, Volume 25

Lynne Omes, Lynda B.Ransdell (2010) A pilot study examining exercise self-efficacy as a mediator for walking behavior in college-age women in Perceptual and Motor Skills 110 (3 Pt 2):1098-104. June 2010

Nicholas A Keks, Graham D Burrows. 1997. The essential practice of mental health care . Medical Journal Autralia (MJA), Volume 167, Issue 3

Nguyen Viet Thiem. 2002. Community Mental Health. Post-graduate teaching material. Hanoi Medical University

Schwarzer, R. & Jerusalem, M. 1995. Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston (Eds.), Measures in health psychology: A user's portfolio. Causal and control beliefs (pp. 35-37). Windsor, UK: NFER-NELSON

Vu Dung. 2008. Psychology Dictionary. Encyclopedia Publishing House

WHO. 2003. Investing in mental health. Geneva, World health organization

Nguyen Dinh Tho, Nguyen Thi Mai Trang. 2009. Principles of Marketing. Labour Publishing House

Hoover-Dempsey, K. V., Bassler, O. C., & Brissie, J. S. (1987). Parent involvement: Contributions of teacher efficacy, school socioeconomic status, and other school characteristics. *American Educational Research Journal, 24(3)*, 417–435

Schunk, D. H. (1991). Self-efficacy and academic motivation.*Educational Psychologist, 26*(3–4), 207–231

Shojaei T, Wazana A, Pitrou I, Kovess V. 2009. "The strengths and difficulties questionnaire: validation study in French school-aged children and cross-cultural comparisons". Soc Psychiatry Psychiatr Epidemiol. Sep, 44(9):740-7

Annex 4: Policies and legal documents related to mental health, social work and children

Legislative documents addressing children's health care:

The Law on Child Protection, Care and Education, first promulgated in 1991 and then amended in 2004, contains specific provisions on healthcare for children, albeit without explicitly addressing mental healthcare. Article 15 of the Law specifies: '_Children have the right to health care and protection_' (Item 1) and '_Children under 6 years old are entitled to primary health care and free medical examination and treatment at public medical establishments_' (Item 2). The Law also devotes 17 Articles to describing the responsibilities of the State, the family and the society in protecting and realizing the rights of children as stated by the Law. According to Item 4 of Article 27, '_the State shall adopt policies to develop the health cause, diversify medical examination and treatment services; exempt or reduce medical examination and treatment as well as rehabilitation service charges for children; and assure medical examination and treatment funding for children under 6 years old._'

Item 3 of Article 27 also identifies the responsibilities of a number of State management agencies involved in the field of healthcare for children: '_The Ministry of Education and Training has the responsibility to organize school healthcare. The Ministry of Health has the responsibility to coordinate with the Ministry of Education and Training in guiding the application of measures to prevent school diseases and other ailments for children._' Item 2 of the same Article assigns the duties of public medical establishments: '_Public medical establishments have the responsibility to guide and organize the primary health care, disease prevention and treatment for children,_' while the responsibilities of the family in caring for children's health are mentioned

in Item 1: '_Parents and guardians have the responsibility to implement the regulations on health check, vaccination, medical examination and treatment for children._'

The 1989 Law on Protection of People's Health includes a number of provisions related to children's healthcare and healthcare priorities for children with disabilities and ethnic minorities. Item 1 of Article 46 reads: '_Children are entitled to be managed by grassroots-level public healthcare system, vaccination, and medical examination and treatment services._' Item 1 of Article 42 affirms that '_the State shall set aside an appropriate budget for strengthening and expanding the healthcare network and services to ethnic minorities, especially the grassroots-level public healthcare system in mountainous and remote areas._' Moreover, this Law also stipulates the responsibilities of the family and society in healthcare for children. As stated in Item 2 of Article 46, '_the health sector has the responsibility to develop and strengthen the health care and protection network for children._' The family's role is defined in Item 3 of the same Article: '_Parents and guardians have the responsibility to implement the regulations on health check and vaccination according to the grassroots-level healthcare system's plans, take care of children in times of illness and follow the healthcare practitioner's decisions in examination and treatment for children._' Meanwhile, Article 47 establishes the responsibilities of the State in caring for children with disabilities: '_The Ministry of Health, the Ministry of Labour, Invalids and Social Affairs and the Ministry of Education and Training have the responsibilities to organize the care and application of rehabilitation measures for children with disabilities._' This legislative regulation is crucial to the mental health care for children

in the context that the Vietnamese legal system currently puts people with mental disorders (schizophrenia and epilepsy) under the category of people with disabilities, and these patients are entitled to mental health care policies under The National Target Program (NTP) on People's Mental Health Care, which was launched in 1999.

The 2006 Law on Gender Equality, although does not directly provide for healthcare for boys and girls, does have a number of related provisions which serve as legal grounds for children's healthcare on the basis of gender equality. As put forward by Article 18, Item 4, boys and girls are given equal care, education and provided with equal opportunities to study, work, enjoy, entertain and develop. Furthermore, this Article also implies the need to prevent mental health risks should discrimination between boys and girls exist in the family in terms of labour division, especially in the Vietnamese culture where boys are often favoured with regard to housework sharing. This can potentially result in feelings of inferiority/certain psychological and emotional difficulties faced by girls in their relationships with parents and brothers. Item 5 of the Article reads: '_Female and male members in the family have the responsibility to share housework._'

The 2007 Law on Domestic Violence Prevention and Control identifies domestic violence acts that are strictly forbidden. This helps reduce the risks of violence not only between husband and wife, but also between parents and children – a factor that exacerbates children's mental health risks. This is even more meaningful given the present context of Viet Nam, where the use of violence as a form of discipline by parents to their

children is still relatively common. In particular, Item e) of Article 2 of this Law categorises forcing early marriage as acts of domestic violence. As such, if this regulation is well promoted and disseminated among ethnic minority communities where child marriage exists as a tradition, it will help mitigate the risks of depression, which is a potential cause of suicide among children who are forced to get married by their parents.

Programmes, strategies and policies which have been the most influential to the healthcare for children in Viet Nam in the past years:

The National Program of Action for Children in the period of 2001-2010 was approved by the Prime Minister in Decision No. 23/2001/QD-TTg of 26 February 2001. The overall goal of the Program was to build a safe and healthy environment for Vietnamese children to have the opportunity to be protected, cared for, educated and develop in all fields, and have a better life. Some of the Program's objectives addressed children's entertainment needs, an aspect that promotes the mental wellbeing of children. The Program also emphasised the necessity of strengthening communication activities to raise the awareness and sense of responsibility of families, schools, State agencies, financial and social organisations and individuals in protecting, caring for and educating children; the importance of counselling, social work and direct mobilisation of families and communities to improve their skills to protect, care for and educate children; focusing on communication and education activities in ethnic minority groups, mountainous areas, islands and disadvantaged or specially disadvantaged areas in terms of socio-economic conditions, and other population groups who face limitations in fulfilling their responsibilities to children.

The National Program of Action for Children in the period of 2012-2020 (following the Prime Minister's Decision No. 1555/QĐ-TTg of 17 October 2013). This Program continues with the research and improvement of the welfare policy system in the fields of health, education, social assistance, entertainment, sports, tourism, information, communication and realizing the child's right to participation. In relation to health, the Program assigns the Ministry of Health to lead and collaborate with relevant Ministries, departments and local authorities to promote and carry out objectives of nutrition and healthcare for children, develop child-related programs and proposals under the Ministry's scope of management, develop nutrition and healthcare programs for children, direct and organise effective implementation of health examination and treatment policies for children under 6, children in special circumstances, and poor children, provide rehabilitation for children with disabilities, and pilot types of health services specifically designed for children.

The National Strategy on Protection, Care, and Improvement of the People's Health in the period of 2001-2010 (Decision No. 35/2001/QD-Ttg of 19 March 2001). This Strategy set forth fundamental viewpoints and objectives for the development of the health sector and healthcare for people and children. The Strategy paid a lot of attention to children as a target group. Seven out of the 21 health indicators to be achieved by 2010 were directly related to children; however, the main concerns included healthcare for children under 6, reduction of mortality death rate among children, and improvement of children's nutrition and issues of prenatal and postpartum care for mothers. The Strategy clearly stated that the State played the leading role in investing in the health sector and step by step increasing the proportion of public spending on health sector. The top priorities were

given to poor, mountainous and remote areas in terms of preventive medicine, primary care at grassroots healthcare units, medical services for the poor and target populations of social welfare policies, protection of the health of mothers and babies. In this Strategy, such terms as '*mental*', '*suicide*' appeared under the category of non-communicable diseases to be prevented and controlled; however, there was a lack of specific objectives of mental health care for children.

The National Strategy on Protection, Care, and Improvement of the People's Health in the period of 2010-2020, with vision to 2030 (Decision No. 35/2001/QD-Ttg of 19 March 2001). This Strategy also proposes various issues related to children's healthcare; nevertheless, specific provisions on mental healthcare in general and mental healthcare for children in particular are still absent. The Strategy sets important objectives of reforming and improving Viet Nam's healthcare system towards Equity – Efficiency – Development: Ensuring that all citizens, especially the poor, ethnic minorities, children under six, target populations of social welfare, people living in underprivileged, remote, isolated areas and vulnerable groups have access to basic and quality health care services; Reforming operation mechanism and health financing in public institutions and accompanied by rationalising the roadmap toward universal health insurance to quickly adapt to the socialist-oriented market economy in health care activities; Reducing morbidity, mortality and disability; contain infectious diseases, keep common diseases and emerging diseases under control. The Strategy stresses the objectives of limiting and step by step controlling the risk factors of non-communicable diseases, environment, lifestyle and behaviour-induced diseases, food safety, hygiene, nutrition, and school health problems. The mentioning of school health problems (albeit in absence of specific criteria and guidance)

shows that this is an important policy basis for the development of programs related to mental health risk prevention for school children, such as school violence, and mental problems related to studying stresses. Moreover, like the previous National Strategies and Programs, this Strategy continues to raise the responsibility of strengthening the healthcare human resources for rural, mountainous, remote and isolated, border areas and islands.

Legal documents relevant to social work in healthcare sector

1. **Decision to approve the Plan for "Development of the Social Work Profession, period 2010 – 2020".**

On 25 March 2010, the Prime Minister signed Decision No. 32/2010/QD-TTg, approving the Plan for Development of the Social Work Profession in the period of 2010 – 2020. The goal of the Plan is to develop social work as a profession in Viet Nam, which encompasses establishing a network of social work officials, staff and collaborators that is adequate in terms of both quantity and quality, together with developing social work service provision structures at all levels, contributing to the development of an advanced social security system. This is a critical legal document to the development of the social work profession in Viet Nam within the health sector.

2. **Decision No. 2514-QĐ-BYT on approving the Plan for "Development of the Social Work Profession within the healthcare sector, period 2011-2020"**

On 15 July 2011, the Ministry of Health promulgated Decision No. 2514-QĐ-BYT on approving the Plan for "Development of the Social Work Profession within the healthcare sector, period 2011-2020" with the overall goal of establishing and developing the social work profession in the healthcare sector, contributing to the improvement of quality and efficiency of the protection, care and enhancement of the health of the people.

In this document, MOH stresses that planning for the development of the social work profession within the healthcare sector for the period of 2011-2020 is highly necessary to put Decision No. 32 of the Prime Minister into practice, which will contribute to addressing urgent healthcare needs, improving service quality as well as increasing people's satisfaction with healthcare services.

The Document also mentions that in recent years, a number of National-level hospitals have initiated social work activities with the participation of existing health staff and volunteers in supporting doctors in classifying patients, providing consultation and referrals, caring for patients to help lessen their difficulties in accessing and using healthcare services etc. However, the current social work activities in the healthcare sector are still spontaneous, lacking planning and regulation by legal documents. Those who participate in the provision of social work services, despite their devotion and experience, are mostly untrained for the job, hence lack professionalism and efficiency.

3. **Circular No. 43/2015/TT-BYT regarding regulations on the responsibilities and organization of social work activities in hospitals.**

On 26 November 2015, the Ministry of Health issued Circular No. 43/2015/TT-BYT, determining the responsibilities and organisation of social work activities in hospitals. This document provides regulations on hospitals' social work responsibilities and forms of organisation.

In terms of responsibilities, the Circular defines 5 social work responsibilities of hospitals, namely: (1) Support, consult patients and their families on issues related to social work during the healthcare service provision process; (2) Provide information, communication and education about the law (communicate to patients about policies and legislations related to healthcare services); (3) Raise and receive funds (to support disadvantaged patients); (4) Support health staff; (5) Provide social work training (for interns, health staff etc.); (6) Organize a network of social work volunteers for the hospital; and (7) Organize the hospital's charity and social work activities in the community (if any).

In terms of organisation of hospitals' social work activities, the Circular specifies that based on the number of beds, capacity of human resources, budget and areas of specification, the hospital director shall decide on establishing or report to the relevant authority to decide on establishing one of the following organizational structures: a Social Work Department within the Hospital, or a Social Work Team under a hospital Ward, or the Nursing Department, or the General Planning Department of the hospital.

In terms of human resources, the Circular requires that the Social Work Department/Team should consist of officials and staff with specialisation in social work, or in communication, health or other social sciences with additional training on social work.

This Circular has been in effect from 01 January 2016.