COMPREHENSIVE STUDY ON SCHOOL-RELATED FACTORS IMPACTING MENTAL HEALTH AND WELL-BEING OF ADOLESCENT BOYS AND GIRLS IN VIET NAM

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
CAMH	Child and Adolescent Mental Health
CBT	Cognitive behaviour therapy
DOET	Department of Education and Training
DOH	Department of Health
DOLISA	Department of Labour, Invalids and Social Affairs
FGD	Focus Group Discussion
HCMC	Ho Chi Minh City
KII	Key Informant Interview
LGBTQ	Lesbian, gay, bisexual, transgender and queer (or questioning)
MHPSS	Mental Health and Psychosocial Support
MOET	Ministry of Education and Training
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
PED	Physical Education Department, Ministry of Education and Training
PESAD	Political Education and Student Affairs Department, Ministry of Education and Training
PTSD	Post-Traumatic Stress Disorder
UNICEF	United Nations Children's Fund

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Chapter 1
Introduction

Study Problem and Rational

Worldwide about 15% of children and adolescents experience mental disorders and neuropsychiatric conditions are the leading cause of disability in young people (Polanczyk, Salum, Sugaya, Caye & Rohde, 2015). With 50% of mental health disorders beginning by the age of 14 and 75% by the age of 24 (Kessler et al., 2005), child and adolescent mental health has become a global priority. There is a significant worldwide gender gap in adolescent mental health, with girls having worse average mental health than boys (Campbell, Bann & Patalay, 2021). In Viet Nam, evidence suggests that 8% - 29% of adolescents suffer from mental health problems with boys having higher rates of behavioral disorders and girls having higher rates of emotional problems such as anxiety and depression (UNICEF, 2018; Weiss et al., 2014). Mental health problems are a significant burden to adolescents in Viet Nam. Among boys, behavioural disorders are the second leading cause of disability among 10–14-year-olds and the 5th leading cause among boys aged 15-19. Girls face multiple sources of mental health related disability with behavioural disorders and anxiety disorders both leading causes of disability among 10–14-year-olds, and depressive disorders the 3rd leading cause of disability among boys aged 15-19 (UNICEF Country Dashboard, 2019). Poor understanding of mental health problems, social stigma, and limited mental health services and resources contribute to most of these children receiving no treatment or support. When emerging mental health problems are left untreated, these problems severely impact children's development, educational achievement and potential in life.

Adolescence (10-19 years of age) is a critical period for the development of socioemotional skills essential for healthy functioning and well-being. Supportive families, schools and communities enable adolescents to effectively navigate life challenges and develop healthy psychosocial skills. School-related factors can both increase risk for mental health problems and protect adolescents' health and well-being. Extensive evidence indicates that **school climate**, including safety, engagement and environment factors, impacts adolescent mental health (McChesney & Aldridge, 2018). **Academic pressure,** from parents, teachers and peers and related to intensive curriculum and exam requirements, is another school-related factor associated with adolescent mental health problems (Nguyen, Dedding, Pham, Wright & Bunders, 2013). Bullying and other **social stressors** have been shown to negatively impact mental health in adolescent students in Viet Nam (Le et al., 2019).

School-based mental health services are crucial to supporting adolescent student mental health and addressing school-related mental health risk factors. Schools are one of adolescents' most important psychosocial environments, allowing for direct access to central figures in life (teachers, peers). School-based mental health and psychosocial support (MHPSS) allows for relatively easy access to students in need of care, as services are not dependent on the parent or guardian bringing the child to a clinic. And when implemented correctly they can de-stigmatize mental health services by integrating them with education. Research on the use of universal (i.e., targeting all students) and selective (i.e., targeting students at risk) school-based interventions for mental health indicates that schools provide excellent settings for targeting children's mental health, their academic performance, and the important connection between them (Greenwood, Kratochwill & Clements, 2008). In Viet Nam, research supports the use of school-based programmes to support child mental health (Dang, Weiss, Nguyen, Tran & Pollack, 2017).

Significance of the Study

This study analyses primary data regarding adolescent student mental health, including mental health needs and school-based risk factors. The study also includes a review of current adolescent student mental health-related policies and programmes. Analysis of this data offers insights into student mental health needs and potential areas

for programmatic and policy support. Specifically, the study findings and recommendations will be primarily useful to UNICEF Viet Nam and the Ministry of Education and Training (MOET) of Viet Nam, and secondarily useful to the Ministry of Health (MOH) and the Ministry of Labour, Invalids and Social Affairs (MOLISA).

UNICEF has made child and adolescent mental health and well-being a key strategic priority for 2022-2026. This focus reflects the critical role of mental health in child development, educational engagement and success, healthy relationships, and full engagement in life and society. With the global pandemic continuing to present overwhelming challenges for children and youth, prioritization of child mental health needs is needed now more than ever. This study will inform UNICEF Viet Nam's strategic planning and programme development as they work to support the government of Viet Nam in this area.

MOET has shown great commitment to addressing adolescent student mental health needs. Study findings and recommendations will aid MOET as they consider policy supporting student well-being, and as they work to develop effective programmes and services for students in schools. And finally, study findings will inform all ministries engaged in supporting adolescent mental health – MOET, MOH, and MOLISA – as they work to examine areas for potential cooperation and coordinate policy and service provision. Each sector plays a critical role in adolescent student health, development and future success. Thus, we hope that the study will inform each Ministry, and support Ministry-level collaboration.

Key Audiences

Educational policy makers from the Viet Nam MOET are a key audience for this study and report. This research may inform educational policy makers as they consider how to best support adolescent student well-being. Likewise, the report offers data and recommendations likely to benefit policy makers from MOH and MOLISA. Data collected include areas of health and social sector support for adolescent mental health, and recommendations include specific suggestions for each sector. Furthermore, connections between Ministries and cross-sectors are explored in the research with specific recommendations made regarding areas for improved cross-sector support. This research is also intended to inform UNICEF Viet Nam in their efforts to advocate for policy and programmatic progress in the area of adolescent mental health.

Provincial and district-level education, health and social sector administrators, principals, teachers, parents, students will also benefit from this report's key findings and recommendations. International researchers, policy makers and programme developers working within the area of adolescent student mental health may find this research and report useful as well.

Goals and Objectives

This research aims to build understanding of how School-Related factors impact the mental health and well-being of adolescent boys and girls in Viet Nam and the role of the education system in addressing both School-Related MHPSS risks and the delivery of services. This study includes assessment of the relationship between adolescent mental health challenges (anxiety, depression, stress) and school-related risk factors (school climate, academic pressure and social stress). Contextual factors such as age, gender, socioeconomic status (students from both public and private high schools are examined to broaden the economic range) and geographical region (four provinces of Ha Noi, Dien Bien, Gia Lai and Dong Thap are included to represent various regions of Viet Nam and both urban and rural areas). Systemic factors related to the relationship between school factors and student mental health are investigated via qualitative data collected from each level of the educational system (school, district, province, ministry) and across government sectors impacting student mental health (MOET, MOLISA, MOH).

Study Questions

The study addresses two primary questions:

1. What is the relation between school-related factors and mental health/well-being issues of adolescent girls and boys; and

2. What programme interventions targeting schools can improve adolescent mental health and well-being for boys and girls in Viet Nam.

Study Limitations

Study findings are limited in several important ways. The study was conceived and developed in December 2020 - January 2021. During this time, Viet Nam had managed to contain COVID-19. Aside from a significant impact on tourism and other industries reliant on international travel, life in Viet Nam was relatively normal. As the focus of the study is primarily on adolescent mental health and schools, research tools and methods were developed in collaboration with MOET to address the key questions and did not include analysis of the pandemic's impact on student mental health. Then in May 2021 a significant COVID-19 outbreak emerged in the South of Viet Nam prompting nation-wide lockdowns and school closures. While study data had already been collected in the three more rural provinces of Dien Bien, Gia Lai and Dong Thap, data collection in Ho Chi Minh City (HCMC) and Ha Noi was unable to proceed as planned at that time. Data collection was allowed to proceed in Ha Noi in September 2021, using

electronic surveys for children and teachers, and online interviews and focus groups. Data collection in HCMC was never possible due to the extent of the outbreak in that municipality. Potential study limitations related to these events include:

1. The possible impact of COVID-19 related stress on adolescents in Ha Noi, which may be different from the impact of COVID-19 on participants from Dien Bien, Gia Lai and Dong Thap as data collection in those provinces occurred pre-outbreak. Without pre-post outbreak data we are unable to ascertain if participant's reports of mental health symptoms or needs were impacted by the outbreak in Ha Noi. We must assume that to be the case considering research on the impact of COVID-19 related stress on adolescents around the world.

2. Possible reduced generalizability of study findings to students and schools nationwide due to a loss of HCMC data. HCMC represents a unique geographical area of the country in terms of location and urbanization. Study generalizability to urban schools and students is bolstered by inclusion of participants from Ha Noi, but would have been strengthened by including HCMC in the study.

3. The original plan was to have two KIIs each from three ministries, and two KIIs from 3 departments across 5 provinces. This was achieved in the three rural provinces but the May 2021 outbreak led to challenges securing KI interviews within HCMC and Ha Noi. At least 1 KII was obtained from each Department in Ha Noi and from each Ministry. Fewer interviews with sector leaders and experts may have impacted our understanding of key policy and programmatic challenges.

Study findings may be limited by research assumptions as well. The study design is built upon the assumption that certain school-related factors are most likely to impact student mental health and well-being. Previous studies demonstrating the relationship between student mental health and school factors such as school climate, academic pressure and social stress have informed our focus on these factors. The study aims to focus broadly on issues that may be related to adolescent mental health, studying for example family factors such as parental understanding of adolescent mental health, parental academic pressure and parental connection to the school, and community factors such as access to medical or social services for adolescent mental health support. However, the study does not examine the impact of other potential risk-factors including (1) school infrastructure factors such as curriculum, class size, and teacher training; (2) family factors such as parental mental health and well-being and parent-child relationship quality; and (3) social factors such as poor community mental health literacy, community perceptions of gender roles, and community mental health stigma and discrimination towards mental illness, or based on gender identity or sexual orientation. It must be assumed that these and other factors are also important to student mental health and must be considered in a wholistic approach to adolescent health and well-being.

While not a limitation per se, recent structural changes within MOET should be monitored to ensure continued progress towards student MHPSS goals. Prior to June 2021 the Political Education and Student Affairs Department (PESAD) within the MOET held primary responsibility for student mental health and PESAD was an active collaborator in the current research. In June 2021 this responsibility was shifted to the Physical Education Department (PED) within MOET. The transition of student mental health responsibilities to the PED has been smooth indicating that the PED will be equally committed to issues of student mental health.

Chapter 2
Adolescent Mental Health: Global Literature Review

Adolescence is the period of transition between childhood and adulthood. It is a time of great physical, intellectual, emotional and social change in a person's life. This transition holds exciting opportunities for growth, as well as vulnerabilities for young people as they strive to become healthy, happy, and productive adults. Ensuring that adolescents have all the support they need during this critical time is essential.

2.1 Adolescent Mental Health

Mental health underlies healthy and successful adolescent development. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Positive mental health allows adolescents to realize their full potential, cope with the stresses of life, learn and work productively, form and maintain healthy relationships, and make meaningful contributions to their families and communities.

However, many adolescents experience mental health problems which pose a serious threat to their healthy development. Globally, mental health problems pose a major burden of disease for adolescents. In 2019, about 15%, or about 1 in 7, of adolescents around the world experienced mental health problems (Polanczyk, 2015). This means that an estimated 175 million adolescent boys and girls suffer from debilitating emotional and behavioural problems, putting them at risk for poor social, academic and health outcomes at a crucial time of their young lives. Recognizing the enormity of this problem for the health and functioning of individuals and societies, the UN Sustainable Development Goals have included mental health as a key target, aiming to reduce premature mortality from noncommunicable diseases by 1/3 by 2030 through prevention and treatment, and through promotion of mental health and well-being (Target 3.4).

2.2 Common Mental Health Problems in Adolescence

Common mental health problems in adolescence include depression, anxiety and behavioural disorders. Depression in adolescence is characterized by persistent feelings of sadness, loss of interest and energy, irritability, feeling negative and worthless. Globally, depression is the fourth leading cause of illness and disability among adolescents aged 15-19 years and fifteenth for those aged 10-14 years. Girls and young women are up to three times more likely than boys to have depressive disorders and to attempt self-harm (WHO, 2014). All teenagers can be moody or irritable at times, but depression causes severe emotional, behavioural and cognitive changes in young people that make it very difficult for them to engage in school, maintain relationships with friends and family, and envision a bright future. If depression persists untreated, adolescents are at-risk for school drop-out, adult unemployment, substance abuse, early pregnancy/parenthood and depression in adulthood (Clayborn, Varin, Colman, 2019). Poor psychosocial outcomes are often linked and can lead to the propagation of lifelong difficulties.

In severe cases, depression can lead to suicide. Globally, suicide is the fourth leading cause of death in 15-19-year-olds (WHO, June 2021). An estimated 62,000 adolescents died in 2016 as a result of self-harm. 77% of global suicides occur in low- and middle-income countries. While girls report higher rates of suicidal thinking, more males die due to suicide (12.6 per 100 000 males compared with 5.4 per 100 000 females).

Common methods of suicide include ingestion of pesticide, hanging and firearms. Risk factors for suicide are multifaceted, including harmful use of alcohol, abuse in childhood, stigma against help-seeking, barriers to accessing care and access to means. Communication through digital media about suicidal behaviour is an emerging concern for this age group. In Asia, suicide is among the top causes of death among teenagers, and Asian youths have high prevalence rates of ever suicidal ideation

(11.7%) and attempted suicide (2.4%) in six ASEAN member states [Blum, Sudhinaraset, & Emerson, 2012; Peltzer, Yi, & Pengpid, 2017).

Anxiety is another common mental health problem in adolescence. Anxiety is characterized by intense, excessive and persistent worry and fear. All adolescents have stress and worry at times, but young people with an anxiety disorder experience serious emotional, physical and cognitive distress and have difficulty concentrating on things other than their worries or fears. Anxiety disorders are the ninth leading cause of illness and disability for adolescents aged 15-19 years and sixth for those aged 10-14 years. Anxiety disorders are higher among girls than boys and are more common among older adolescents. Adolescents with anxiety disorders are at an increased risk of adult anxiety, depression, drug abuse, and educational underachievement as young adults (Woodward & Fergusson, 2001).

Many adolescents also experience behavioural disorders. Behavioural disorders include attention deficit hyperactivity disorder (ADHD), characterized by difficulty paying attention, excessive activity and acting without regards to consequences, and conduct disorder, characterized by destructive or challenging behaviours. While all adolescents can be distracted, impulsive and risk-takers, those with behavioural disorders often have significant difficulty regulating their attention, emotions and impulses. Furthermore, the negative reaction from peers, teachers and parents towards these behaviours can lead to poor self-esteem and an increase in problematic behaviours, trapping adolescents in a cycle of negative behaviour and worsening outcomes. Behavioural disorders are the second leading cause of disability in young adolescent boys aged 10-14 years and the third leading cause of disability among girls aged 10-14 years. Behavioural disorders are also the 5th leading cause of disability in boys aged 15-19 years (while no longer being a top cause of disability among girls in this age group) (UNICEF Country Dashboard, 2019). Behavioural disorders put adolescents at-risk for school drop-out, substance abuse, and criminal behaviour, and can lead to mental health, family, social, and economic adversity in adulthood (Colman I, Murray J, Abbott R A, Maughan, 2009).

2.3 Risk Factors for Poor Mental Health in Adolescence

Risk factors for adolescent mental health problems include genetics, stress, trauma and violence, identity issues, family environment, poverty, and substance abuse. Other important determinants include the quality of their home life and relationships with peers. Evidence indicates that mental health outcomes are caused by a combination of these factors, and it is clear that the more risk factors adolescents are exposed to, the greater the potential impact on their mental health.

2.3.1 Genetic risk factors

Genetic factors, including epigenetic regulation (genetic interactions with environmental factors) and genetic polymorphisms (DNA changes), place people at risk for mental health problems. However, genetic markers or changes alone will not lead to the development of a mental disorder. A combination of one or more specific polymorphisms and certain environmental factors may lead to the development of a mental disorder. Disorders with a strong genetic basis include bipolar disorder, schizophrenia, and autism spectrum disorder. No mental disorder has 100% genetic risk and environmental factors often strongly influence the development of a particular disorder.

2.3.2 Stress

Stress is a normal part of life that is often harmless (or even helpful). However, the intensity, frequency and duration of stress will be different for each person in each situation. When people are highly stressed, neurochemical changes in the body can trigger the autonomic nervous system, causing the body to react as if it is in danger. Numerous factors can make the experience of stress worse, including limited social support,

difficulty regulating emotions, difficulty tolerating uncertainty, lack of self-confidence, feeling helpless or overwhelmed, and experiencing multiple stressors. When stress becomes overwhelming and prolonged, the risks for mental health problems and medical problems increase. Long-term stress increases the risk of mental health problems such as anxiety and depression, substance use problems, sleep problems, pain and bodily complaints such as muscle tension.

Adolescents often experience stress related to academic pressures, family conflict, desire for greater autonomy, pressure to conform to peers and sexual development. There is increasing evidence that adolescent use of technology may significantly contribute to adolescent stress via cyberbullying, and perceived disparity between an adolescent's lived reality and their perceptions of others' experiences online. There is significant evidence that stressful life events predict to the development of mental health problems in adolescence (Reiss, et al., 2019). High levels of stress in adolescence have been linked to various negative associates, including reductions in academic performance (Kaplan et al. 2005), school drop-out (Dupéré et al. 2015), increased mental health problems (Snyder et al. 2017), and reduced well-being (Chappel et al. 2014).

2.3.3. Trauma

The term "traumatic stress" generally refers to the physical and emotional response of an individual to life threatening events. In children and adolescents, experiences that may cause traumatic stress include physical abuse, sexual abuse, emotional abuse, neglect, interpersonal violence or victimisation, community violence, and natural disasters. Children and adolescents are especially vulnerable to sexual violence, which has a clear association with detrimental mental health. Exposure to traumatic events is common in youth, with about two thirds of children and adolescents around the world reporting exposure to at least one traumatic event (Saunders & Adams, 2014).

Traumatic stress may cause intense physical and emotional reactions, including an overwhelming sense of terror, helplessness, and horror, and a range of physical sensations such as a pounding heart, trembling, dizziness, nausea, dry mouth and throat, and loss of bladder or bowel control. Exposure to trauma can result in serious trauma-related mental health problems, including post-traumatic stress disorder (PTSD). A meta-analysis of studies published from 1998 to 2011 showed that 15.9% of children and adolescents exposed to a traumatic event developed PTSD [10]. Children from low- and middle-income countries (LMICs) may be at higher risk for trauma exposure and PTSD; a recent study found about one third of adolescents living in LMICs have some PTSD symptoms after experiencing a traumatic event, while nearly one in ten have sufficient symptoms for full DSM-5 PTSD diagnosis. Adolescents at higher risk for trauma include ethnic minority groups, homeless youth, children whose parents have history of criminal behaviour or mental illness, LGBTQ youth, and refugee youth. Exposure to violence (including harsh parenting and bullying) and socioeconomic problems are also recognized risks to mental health.

Early childhood experiences of abuse and neglect by parents or caregivers put children at high risk for mental health problems later in life. Healthy, responsive attachment with parents is critically important for child development. When parents consistently respond to children's basic needs with emotional sensitivity children are able to grow up feeling safe and able to explore the world. Parental abuse, including emotional abuse, and neglect cause significant "toxic" stress in the developing infant/child, severely impacting cognitive, social and emotional development. In addition, the biological stress-response system can be negatively impacted by early abuse and neglect, are increasing risk for anxiety, depression, substance abuse, and chronic health impairments. These early harmful experiences also associated with poor impulse control, high negativity, learning difficulties and poor school achievement later in life. (Lippard & Nemeroff, 2020)

2.3.4. Family-Based Risk and Protective Factors

Studies from around the world have found that positive family functioning and parental involvement in adolescents' lives is associated with reduced risk for poor mental [19, 35, Chia et al., 2020], while a lack of parental warmth and high parental over-control are associated with a wide range of psychological problems, including depression, suicidal behaviour, and self-harm among adolescents [36,37,38].

In Viet Nam, parental involvement, monitoring, and interest in adolescents' free time were significantly associated with reduced likelihood of adolescent bullying victimization and mental health problems. However, high levels of parental control were associated with higher likelihood of adolescents being physically attacked, loneliness and mental health problems including suicidal ideation (Nguyen, et al., 2019).

2.3.5. Environmental Risks

Some adolescents are at greater risk of mental health conditions due to their living situations, stigma, discrimination or exclusion, or lack of access to quality support and services. These include adolescents living in humanitarian and fragile settings; adolescents with chronic illness, pregnant adolescents, adolescent parents, or those in early and/or forced marriages; orphans; and adolescents from minority ethnic, gender identity, sexual orientation or other discriminated groups. There is also emerging evidence that early exposure to air pollution places children at higher risk for emotional and behavioural problems (Salma, Ahmed, Gita, et al., 2022).

Poverty, or family economic stress, has predicted adolescent mental health problems in many countries, including Germany (Reiss, 2019), China (Xu, et al, 2019), and the US (Assing-Murray & Lebrun-Harris, 2020). Ethnic minority status is associated with increased risk for mental health problems (Bains, S. & Gutman, L., 2021) and experiences of racism and discrimination have a profound impact on the mental health of ethnic minority children and adolescents (Trent, Dooley, & Dougé, 2019). Sexual minority adolescents are at greater risk for depression and other mental health problems relative to their heterosexual peers (Marshal, MP, Dietz LJ, Friedman, et al., 2011) and sexual minority adolescents are at greater risk for suicidality (Luk, et al., 2021).

2.3.6. COVID-19 Risk Factors

The COVID-19 pandemic has been catastrophic, resulting in over 2 million deaths worldwide and focusing billions into social isolation. Estimates of global mental health problems among adults indicate that the prevalence of major depressive disorder rose by 27.6% in 2020, indicating an additional 53.2 million cases of major depressive disorder globally. It is estimated that general anxiety disorder rates increased 25.6% globally during 2020, reflecting an additional 76.2 million cases around the world. (Lancet COVID-19 Mental Disorders Collaborators, 2021).

Adolescents are at particular risk due to the COVID-19 pandemic. Ongoing stress regarding family functioning, economic insecurity, fears of infection, social isolation, and disrupted schooling has had a significant psychological toll on adolescent mental health. Family illness and death due to COVID-19 have caused traumatic stress for many children and youth around the world. Violence in the home, including intimate partner violence and physical abuse of children, has increased during the pandemic putting children and adolescents at physical and psychological risk. In addition, adolescents have spent significantly more time online where they have often been exposed to stressful information about the pandemic and to online abuse and cyberbullying. These are all serious challenges given that adolescents are still developing the capacity for resilience and coping putting young people at greater risk for pandemic-related mental health problems. And given that mental health problems in adolescence put people at risk for poor mental health and physical health outcomes over the lifetime, it is crucial that adolescent mental health is prioritized during the pandemic.

Adolescents with prior mental health problems are a heightened risk for pandemic-

related mental health problems. Experiences of isolation, feelings of uncertainty, lack of daily routines, lack of access to health services may also put young people at risk for psychosocial difficulties. Jones, Mitra, & Bhuiyan (2021) conducted a systematic review of 16 quantitative studies conducted in 2019–2021 with 40,076 participants. Globally, adolescents of varying backgrounds are experiencing higher rates of anxiety, depression, and stress due to the pandemic. Adolescents also have a higher frequency of alcohol and cannabis use during the COVID-19 pandemic. However, social support, positive coping skills, home quarantining, and parent–child discussions seem to positively impact adolescent mental health during this period of crisis.

A qualitative study of adolescents in Nha Trang and Vinh, Viet Nam revealed factors affecting mental health and well-being during the COVID-19 pandemic. Findings showed that school closures and online learning had the largest impact on students' well-being and academic performance. Findings further indicated that adolescents were at increased risk for exposure to harmful or addictive internet content due to increased time spent online. Teens were also exposed to a large amount of COVID-19 news, which heightened their feelings of fear and anxiety. Students reported feelings of sadness and depression, as well as social anxiety after time away from friends and socialization. Girls were especially at-risk to thinking related to a negative body-image. Adolescents reported that their parents were concerned about the quality of online learning, and thus pushed their children harder to perform academically often leading to family tensions (Samuels, Ho, Nguyen et al., 2021).

2.4 Global Child and Adolescent Mental Health Treatment Gap

In low-income settings globally, only a tiny fraction of people suffering from poor mental health will ever have access to psychiatric or psychological support. Although effective interventions to reduce mental health symptoms exist, many sufferers do not receive mental health care. As much as 76–85% of people in need of treatment in LMICs do not receive any treatment at all (Patel *et al.* 2011; WHO, 2013). Evidence indicates that the situation may even be worse; Patel found a treatment gap exceeding 90% for common mental disorders and alcohol use disorders in India and China, two relatively well-resourced middle-income countries (Fairburn & Patel, 2016). The lack of a mental health policy, mental health programmes and mental health legislation in many countries, as well as limited resources (both financial and human), a limited infrastructure, stigma and shame are important reasons for low uptake and dissemination of mental health care (WHO, 2008; Munoz *et al.* 2016).

Children and adolescents face a particularly large treatment gap (Morris, et al, 2011). Lack of adequate child and adolescent mental health (CAMH) services across the world was reported in the WHO Child and Adolescent Mental Health Atlas (World Health Organization, 2005). Worldwide, there are very few child and adolescent psychiatrists; in high-income countries the number of child psychiatrists is 1.19 per 100,000 youth, but in LMICs, where the preponderance of the world's children and adolescents live, the number is < 0.1 per 100,000 population (Skokauskas et al., 2019), a higher rate of unmet needs in CAMH training and a wider gap between CAMH needs and available CAMH services in low- and middle-income countries compared with high-income countries (*Morris et al., 2011*). It is also reported that, in comparison with Europe and North America, there have been substantial unmet needs for CAMH resources in Asia, in view of the rapidly growing numbers of youngsters who require mental health evaluation and ongoing care. In 2017, Vietnam reported just 900 psychiatrists and only 10 psychiatrists specialized in CAMH. Vietnam lacks a National Child and Adolescent Mental Health Policy has a need for increased CAMH specialist psychiatrists and specialists. (Hirota, Guerrero, & Skokauskas, 2020). Along with the health sector, there is a global and Vietnam-specific gap in educational and social sector support for child and adolescent mental health.

2.5 Schools and Adolescent Mental Health and Well-being

Schools play a large role in children's lives and have a direct impact on children's mental health and well-being. The school environment, learning experiences, and teacher and peer relationships may either put children at risk for mental health problems, or protect them and promote positive well-being. With schools instrumental to children's mental health and well-being, and with mental health and well-being crucial to both academic and developmental success, it is important to understand the links between school factors, mental health and well-being, and academic performance.

2.5.1 School-Based Mental Health Risk Factors

A number of school factors are associated with student mental health and well-being. School climate, academic pressure and peer relationships, including experiences of bullying, have all been found to impact student mental health.

2.5.1.1. School Climate

Over the past two decades, school climate has emerged as a unifying construct that focuses on a variety of environmental and experiential school experiences and seeks to better understand how those experiences shape student academic, behavioural, and socioemotional outcomes. Efforts to define key aspects of school climate have resulted in a 3-factor model of school climate, including 13 subdomains: safety (perceived safety, bullying and aggression, and drug use); engagement (connection to teachers, student connectedness, academic engagement, school connectedness, equity, and parent engagement); and environment (rules and consequences, physical comfort, and support, disorder) (Bradshaw, Waasdorp, Debnam, & Johnson, 2014). One serious aspect of school climate is corporal punishment which is still widely used in schools in many parts of the world. Children who are physically or sexually abused, harassed or humiliated by teachers often develop emotional and behavioural problems (Hinze, 2021). The resulting psychological stress also impacts negatively on students' cognitive skills and academic performance.

A recent meta-analysis by Wang and colleagues (2020) examined 61 international studies published between 2000-2016 and found that classroom climate was positively associated with student social competence, motivation and engagement, and academic achievement and negatively associated with socioemotional distress and externalizing behaviours (Wang, Degol, Amemiyaa, & Guoc, 2020). A study conducted in South Australia found that students' perceptions of their school climate were positively associated with student well-being, resilience and moral identity (Riekie, Aldridge, & Afari, 2016). In consideration of these findings, a growing number of countries (e.g., Canada, China, England, France, Germany, Israel, Singapore, United States) have focused on improving classroom climate as a central goal of educational reform initiatives in order to promote school quality and student's academic and psychological well-being (Wang, Degol, Amemiyaa, & Guoc, 2020).

2.5.1.2. Academic Pressure

Research indicates that students around the world commonly report high levels of academic-related stress (Pascoe, Hetrick & Parker, 2020). The Organization for Economic Co-operation and Development (OECD) conducted a survey involving 72 countries and consisting of 540,000 student respondents aged 15–16 years (Peña-López, 2016). On average, 66% of students reported feeling stressed about poor grades and 59% reported that they often worry that taking a test will be difficult. The OECD further found that 55% of students feel very anxious about school testing, even when they are well prepared. As many 37% of students reported feeling very tense when studying, with girls consistently reporting greater anxiety relating to schoolwork compared to boys. This data demonstrates that education and academic performance are a significant source of stress to students.

Academic-related stress experienced by

secondary students impacts their mental and physical health and leads to a range of academic problems. In a study of adolescent students in India, adolescents who had academic stress were at 2.4 times higher risk of depression than adolescents without academic stress. Self-expectations and perceived pressure from parents and teachers were the main causes of academic stress. Adolescent girls had higher academic stress than boys (Jayanthi, Thirunavukarasu, & Rajkumar, 2015). The OECD study reported above found that anxiety about schoolwork, homework and tests has a negative impact on students' academic performance in science, mathematics and reading (Peña-López, 2016).

Academic-related stress is strongly related to decreased student academic motivation and academic disengagement. A longitudinal study of 298 Chinese secondary school students found that academic-related stress in Grade 10 negatively predicted intrinsic academic motivation and positively predicted lack of motivation in Grade 12. This indicates that decreasing academic-related stress might preserve students' ongoing intrinsic academic motivation (Liu, 2015). The relationship between academic-related stress, motivation and dropout does not appear to be culturally specific, with similar findings shown from a number of international studies (Pascoe, Hetrick & Parker, 2020; Walburg, 2014). Another study in China examined the longitudinal relationships between adolescents' stress in school and the change rates of their academic achievement. The results indicated that for students whose academic achievement significantly declined over time, the students' stress from teacher–student interactions significantly predicted the change rates of their academic achievement. The findings provided support to the notion that stress is a risk factor in students' academic development (Liu & Lu, 2011).

2.5.1.3. School Relationships

Healthy, positive relationships are critical for student mental health and well-being. Lack of friendships and bullying are two factors that put adolescent students at risk for mental health problems. Adolescents are more likely to have suicidal thoughts when they feel lonely. Previous studies done in Lebanon, Uganda, Tanzania, Sub-Saharan Africa reveal that children are more likely to have suicidal ideation when they have feeling of loneliness (Mahfoud, Afifi, Haddad, & DeJong, 2011; Rudatsikira, Muula, Siziya, & Twa-Twa, 2007; Dunlavy, Aquah, & Wilson, 2015; Page & West, 2011). Adolescent students in Nepal who experienced loneliness were at higher risk for suicidal ideation, while having 3 or more close friends was found to be a protective factor (Pandey, Bista, Dhungana, Aryal, Chalise, & Dhimal, 2019).

Victimization by bullying and cyberbullying is another relationship factor that puts students at risk for poor mental health and well-being. A study of students in Chile and South Africa found that bullying victimization was a significant predictor of children's well-being (Varela, Savahl, Adams & Reyes, 2019). Research indicates that bullying is a key factor for adolescent mental health in Viet Nam. In a study of bullying and mental health among secondary and high school students in Viet Nam, bullying victimization independently predicted student mental health problems and mental health problems predicted students' experience of becoming victims of bullying. Girls with mental health problems were more likely to be victims; whereas boys with mental health problems were vulnerable to both being bullied and being perpetrators (Le et al., 2019). Another study of adolescent students in Viet Nam found that bullying was more common in junior high school compared to senior high school. (Nguyen, Nakamura, Seino, et al., 2019)

2.5.2. Student Mental Health and Academic Success

Aside from impairing overall health and well-being, depression and anxiety symptoms can further adversely affect academic achievement (Bernal-Morales, Rodríguez-Landa, & Pulido-Criollo, 2015). Adolescent depression has a significant negative impact on school performance and puts students at risk for poor educational and occupational outcomes. A 25-year longitudinal study of New Zealand children found that people who had

depression at ages 16–21 had greater rates of welfare dependence and unemployment, demonstrating that the impact of poor mental health in adolescence can have long-lasting impacts (Fergusson, Boden, & Horwood, 2007). Research in the UK of 7th-9th grade students found a strong relationship between student depression symptoms and grade point average, with a stronger association for boys compared to girls. Higher depressive symptoms were associated with lower academic achievement at age 16 years. Depression was associated with difficulties in concentration, social relationships, self-reliant school performance and reading and writing as well as perceiving schoolwork as highly loading. This study indicates that students reporting difficulties in academic performance should be screened for depression (Lopez-Lopez, et al., 2021)

Several key symptoms of depression, such as impaired ability to concentrate, loss of interest, poor initiative, psychomotor retardation, low self-esteem, sense of worthlessness, and social withdrawal may significantly disturb cognitive performance and diminish initiative in learning (Wagner, Müller, Helmreich, et al., 2015). Depression may impair cognitive functioning because the depressed adolescent concentrates on depressive thoughts and interpretations instead of the actual tasks, or because depression directly blocks cognitive resources, or due to both reasons (Hartlage, Alloy, Va´ zquez, & Dykman, 1993).

2.5.3. School-Based Interventions

Schools provide an ideal setting for adolescent mental health and well-being promotion. The OECD highlights that schools are places where young people develop many of the social and emotional skills needed to become resilient and thrive (OECD, 2015). With more than 66% of children in secondary school age were enrolled in secondary schools worldwide in 2018, school-based programmes can reach many groups of adolescents and parents (UNESCO, February 2020). Moreover, school-based mental health services have been associated with a lower stigma and a greater utilization rate, especially among ethnic minority adolescents (Stephan et al. 2007). As such, school-based intervention programmes provide a promising environment for preventative and low-threshold care, with the potential to also reach adolescents who are reluctant to search for care outside the school environment or who live in communities without other care options. Since mental health and psychosocial functioning is beneficial for academic performance and school success, schools may benefit from implementing interventions that aim to improve social and emotional functioning.

A number of school-based adolescent mental health and well-being programmes have been developed and evaluated around the world. Programmes tend to fall into two categories, including universal prevention or intervention programmes (i.e., targeting all students) and selective or indicated (i.e., targeting students at risk) school-based interventions. A number of large-scale reviews and meta-analyses have examined the scope and efficacy of school-based programmes (Wells, Barlow, Stewart-Brown, 2003; van Loon et al., 2020; Greenberg, Domitrovich & Bumbarger, 2000; Hoagwood et al., 2007; Kraag, Zeegers, Kok, Hosman & Abu-Saad, 2006). The literature emphasizes the academic benefits of mental health promotion in schools and there is strong evidence for the effectiveness of interventions to support positive gains in students' social-emotional and academic outcomes (Fazel, Hoagwood, Stephan & Ford, 2014; Sancassiani et al., 2015).

2.5.3.1. Universal School-Based Programmes

Universal approaches to school-based mental health promotion include a variety of intervention types. Some aim to change the culture of the school, enabling, for example, teachers to adopt a different approach to discipline in order to ensure violence free classrooms, or students to reduce bullying behaviour. Others are class-based and aim to deliver a specific curriculum to all children in the class. Some programmes have combined whole school and class-based interventions. The content of school-based mental health promotion interventions varies greatly, and programmes may be aimed violence prevention, social-emotional cognitive skill building, or suicide prevention. Methods of

delivery have included techniques to change behaviours or teach skills, involvement in co-operative or helping activities, training of teachers or parents, and changes in the school environment, systems or culture. Methods of implementation range from a curriculum confined to the classroom, to ongoing changes in the school, to the involvement of parents and the community. (Wells, Barlow & Stewart-Brown, 2003). Policy and legislation prohibiting the use of physical discipline by teachers and school staff are a key intervention aimed at making schools and classrooms safer for students.

Universal school-based programmes have demonstrated effective student stress reduction with some mixed results. Kraag et al. (2006) found that universal interventions for the general school population effectively reduced student stress. However, Loon et al (2020) found that school-based intervention programmes reduced academic stress for subsets of students. Differences in findings may be attributed to the younger ages of students in Kraag (ages 9-14) compared to Loon (10 – 18) with younger children benefiting more universally from school-based interventions. The Kraag meta-analysis 19 randomized controlled trials or quasi-experimental studies found that school programmes targeting stress management or coping skills reduced stress symptoms and improved coping skills among students (Kraag, Zeegers, Kok, Hosman & Abu-Saad, 2006). Das, Salam, Lassi and colleagues (2016) reviewed meta-analyses of school-based adolescent mental health interventions. Findings indicated that factors related to overall programme success include a focus on mental health promotion rather than on mental illness prevention. While there is scant evidence from LMICs, existing research suggests that the majority of the school-based life skills and resilience programmes indicated positive effects on students' self-esteem, motivation, and self-efficacy, (Das, Salam, Lassi, et al., 2016).

The Strengthening Evidence base on School-based Interventions for Promoting Adolescent Health (SEHER) project has been studied extensively in Bihar, India. The programme is a multicomponent health promotion intervention that includes whole school–, class-, and individual-focused components to promote school climate and the health and well-being of adolescents in secondary schools. The programme was evaluated in a trial involving 74 schools and was delivered either by a lay counsellor or by an existing teacher. The intervention included whole school–, class-, and individual-focused components. Students enrolled in grade 9 (aged 13–15 years) were exposed to the intervention for two years. Evaluation 8 months post-programme showed significant results when the programme was delivered by a lay counsellor on school climate, depression, bullying, attitude toward gender equity, violence victimization, and violence perpetration. The effect sizes for these outcomes at end of year 2 were larger than at the end of year 1. Study findings provide strong evidence of the benefits of a multicomponent school health promotion intervention, when delivered by lay counsellor, on school climate and a range of health and well-being outcomes of adolescents. No effects were seen when the same intervention was delivered by teachers. The SEHER intervention was compared to the classroom Adolescence Education Programme (AEP), which teaches life skills, which did not show any effects (Shinde, et al., 2020). One important finding was that school climate mediated the effects of the intervention on all three outcomes of interest. A nurturing school environment, characterized by supportive and engaged relationships with teachers and peers, a sense of belonging, and active participation in school climate predicted lower rates of depressive symptoms, experiences of bullying, and perpetration of violence.

2.5.3.2. Example Programmes from Viet Nam

Dang and colleagues (2016) adapted and evaluated a universal classroom-based mental health and social skills programme for primary school students. The programme, RECAP-VN, is a semi-structured programme that provides students with classroom social skills training, and teachers with in-classroom consultation on programme implementation and classroom-wide behaviour management. The study found that the programme had a positive effect on both social skills and mental health

functioning. Significant treatment effects were found on both social skills (for low-risk students) and mental health functioning (for both low- and -high-risk students). While this programme was for younger children, results show promise for effective implementation of universal school-based mental health programmes in Viet Nam.

Dang, Weiss, Lam, and Ho (2018) also adapted and evaluated a high school problem solving programme called Viet Nam ACES ProS. The ACES ProS programme was tested in Danang with 100 Vietnamese High school students. Findings indicate that the programme had a positive impact on students reported emotional and behavioural problems. The authors discussed issues of programme cultural adaptation related to successful implementation.

2.5.3.3. Selective School-Based Programmes

Selective or indicated school-based intervention programmes are provided for students deemed at-risk for various reasons. These programmes may include classrooms of students all considered at-risk, or may remove subgroups of students from regular class in order to participate in the programme. To reduce stress and improve the well-being of adolescents, these programmes offer different approaches and apply various hypothesized mechanisms of change. For example, mindfulness (i.e., bringing non-judgmental attention to the present moment through meditation techniques and awareness exercises), relaxation exercises (e.g., progressive relaxation, muscle relaxation, visualization-based relaxation) and life skills training, comprising different cognitive-behavioural techniques (e.g., emotion regulation, problem-solving, conflict resolution), are often used.

Evidence from school-based interventions suggests that targeted group-based interventions and school programmes based on cognitive behaviour therapy (CBT) were found to be effective in reducing depressive symptoms and anxiety (Das, Salam, Lassi, et al., 2016). However, with most of the evidence coming from high income countries (HICs), generalizability of the findings for LMICs is limited. Michelson and colleagues (2020) tested a mental health service for adolescents in LMICs called PRemIum for aDoLEscents (PRIDE) among students aged 12-20 years in India. Findings support a low-cost delivery mechanism of a problem-solving intervention for common mental health problems. Within this programme students with elevated mental health symptoms were referred for support and received comic booklets about problems solving and how to cope with common difficulties. This alone resulted in reductions in overall mental health symptoms including internalizing and externalizing symptoms, improved functioning and improved well-being. Students who then received lay counsellor support showed greater reduction in adolescent problems and in perceived stress. Counsellor training included a written manual describing the problem-solving intervention, 5 days of office-based training, 6 weeks of supervised practice, and 3 top-up training days at monthly intervals while the trial was underway. Counsellors also participated in sensitization activities aimed at promoting awareness and acceptability of counselling activities among school staff and pupils.

2.5.3.4. School-Based MHPSS Programme Implementation Success Factors

No matter how successful a programme may be when evaluated, there are many reasons why programmes fail to succeed or are no longer offered over time. Implementation concerns are illustrated by a study of the FRIENDS school-based universal prevention programme in the UK. Study results demonstrated the efficacy of the programme on reducing student anxiety and depression (Stallard, Simpson, Anderson, & Goddard, 2008). However, the programme relied on significant input from training professionals, such as clinical psychologists and school counsellors, making the programme difficult and costly to implement as part of routine practice within schools. Follow-up revealed that the majority of participating schools failed to continue implementing the programme after the four-year trial. These findings affirm the need for innovative school-based programmes that are less time and resource intensive, as well as less

reliant on outside monitoring and support for compliance and implementation.

School-based mental health programme research points to programme implementation factors that increase the probability of programme sustainability and ongoing quality. These key programme components include (a) consistent programme implementation; (b) inclusion of parents, teachers, or peers in programmes; (c) use of multiple modalities (e.g., the combination of informational presentations with cognitive and behavioural skill training); (d) feedback, consultation, and support to teachers (e.g., refresher training sessions, classroom observation, small group discussions) and (e) integration of programme content into general classroom curriculum; and (f) developmentally appropriate programme components (Rones & Hoagwood, 2000). The most successful interventions were more likely to be mental health-promoting programmes which were provided continuously over extensive periods of time, i.e. a year or longer and that aim to involve everyone in the school including students, staff, families and the community, and to change the environment and culture of the school. These approaches may require changes in teachers' attitudes, beliefs or behaviour (Wells, Barlow, Stewart-Brown, 2003).

2.5.3.5. Technology and adolescent mental health interventions

Technology offers potential value for making selective adolescent mental health interventions readily available to students in LMICs. Barriers to uptake and dissemination of mental health care include a lack in mental health policies and programmes, limited resources (both financial and human), limited infrastructure, stigma and shame. As internet penetration and mobile phone ownership in particular is increasing globally, digital technologies offer an opportunity to overcome several of these barriers. Internet and smartphone ownership is increasing globally with an estimated 81% of people (6.37 billon users) owning a smartphone in 2021. In Viet Nam, there is an estimated 63.1% smartphone penetration with about 61.37 million out of 97.34 million people owning a smartphone (Pew Research Centre, 2019)

Examples of mental health technology include MoodGYM, an interactive, online, self-directed CBT programme designed to prevent and/or reduce symptoms of anxiety and depression. The programme has been used by over three-quarters of million people since 2001 and has demonstrated significant reduction in anxiety and depression in adolescents up to 17 years old (Calear, Christensen, Mackinnon, Griffiths, & O'Kearney, 2009; Fairburn & Patel, 2016). Another unguided computerized CBT programme is TreadWill. This programme was designed to be fully automated, engaging, easy to use, and accessible in LMICs. An evaluation of TreadWill's effectiveness and engagement level was performed in a double-blind, randomized controlled trial with 598 adult participants in India (Ghosh A, Cherian RJ, Wagle S, et al., 2021). The use of TreadWill significantly reduced depression-related and anxiety-related symptoms. Overall, online specialized programmes for mental health show promise as scalable interventions. The primary concern is that adherence rates are low. For example, the TreadWill evaluation found that 12.1% of participants engaged with moderate usage, and 5.5% engaged with full completion.

In Viet Nam, Sobowale *et al.* (2016) explored the perceptions of Vietnamese youth and parents towards digital interventions for youth mental health as a first step to implement internet-based treatment in Viet Nam. Findings suggest that internet-based programmes for youth mental health, particularly interventions incorporating psychoeducation and social networking components, will be well received in Viet Nam.

Chapter 3

Adolescent Mental Health in Viet Nam Literature Review

3.1. Context of Viet Nam

The Socialist Republic of Viet Nam has a population of over 96 million people. One of the top three Southeast Asian countries with high GDP growth, Viet Nam is experiencing rapid socio-economical changes in society, such as increased internal migration from rural to urban areas, changes in family structure, and changes in roles of parents in modernized families. In spite of these changes, most (65.6%) of the country's 96 million people continue to live in rural areas and rely on subsistence agriculture. The average annual household income per capita was $2,236 in 2019, with major disparities between urban and rural areas. (2021 CEIC Data). Gross primary school enrolment is high at 117% as of 2020 (World Bank).

There are 54 ethnic groups in Viet Nam, with the Kinh constituting the majority of the population (84%). Some ethnic groups are small, with less than 1,000 members, and apart from the Hoa (Chinese) group, ethnic minorities are disproportionately poor, less educated and generally live in more remote locations. Members of ethnic minority groups make up 15% of the country's population but account for 70 percent of the extreme poor (measured using a national extreme poverty line). There is significant evidence of health inequalities facing ethnic minority groups. Governmental policies and programmes have not been culturally adapted and sensitive, and there are reports of bad attitudes and discrimination from health staff toward minority people. At the same time, there are examples of traditions and patriarchic structures within ethnic minority groups that also maintain harmful health behaviours. (Badiani-Magnusson et al., 2012; Malqvist et al., 2013)

3.2 Mental Health Care and Treatment in Viet Nam

The mental healthcare industry in Viet Nam is still developing. Until recently mental health care and treatment in Viet Nam was provided almost exclusively by the health sector (primarily for only the most severe mental illnesses). The educational sector developed school counselling policies starting in 2005 and the social sector adopted community mental health policies beginning in 2011. See Chapter 7 for more detail about the mental health related policies and programmes of each Ministry. The Vietnamese government has established the National Mental Health Programme (NMHP), however the NMHP only covers approximately 30 percent of the country and only includes a limited list of mental illnesses. While the government estimates that approximately 15 percent of the population requires mental health care services, independent research suggests that the figure is closer to 20 to 30 percent of the population (Mah, 2018).

The World Health Organization (WHO) surveyed the country in 2014 and found that only 0.91 psychiatrists were available per 100,000 people. The psychiatrists available per 100,000 population in Viet Nam is comparable to its ASEAN neighbours: Malaysia has 0.76 psychiatrists available per 100,000 people and Thailand has 0.87 psychiatrists for 100,000 people. However, it is far behind developed economies like Singapore, with 3.48 psychiatrists per 100,000 people, and the US, where there are 12.40 psychiatrists available per 100,000 people. The Department of Psychiatry at Ha Noi Medical University and the National Institute of Mental Health provide programmes for psychiatrists in training. General medical students can choose to do a one-year specialization in psychiatry—although interest remains low relative to other medical fields. There are very few child and adolescent mental health providers in Viet Nam (Dang & Weiss, 2012).

The medical mental health network includes inpatient programmes and outpatient treatment for psychiatric care. The psychiatric hospital system in Viet Nam has 36 hospitals established across the country, with approximately 6,000 beds. The system delivers services through a network of state-owned hospitals; there are two National Psychiatric Hospitals, one located in the north in Ha Noi and the other in Bien Hoa city in the south. The remaining 34 provincial psychiatric

hospitals are disseminated across the country. Hospitalization for patients in severe conditions, typically schizophrenia, bipolar disorder and epilepsy, are given the care in these inpatient hospitals. Access is also limited by geographic distribution of providers as psychiatrists are stationed at psychiatric hospitals, where mental health care is centred. Viet Nam has about 600 outpatient mental healthcare facilities available for locals who are looking for short-term care. These outpatient facilities are primarily located in the major urban centres of the country.

The Viet Nam Ministry of Health has begun expanding community outreach through primary care facilities to reach those afflicted with mental illness. However, effectiveness of treatment in primary care is limited by lack of adequate training to screen for mental disorders and the community expansion initiative primarily focuses on schizophrenia and epilepsy, which are not the most common mental illnesses in Vietnamese youth (Ng *et al.*, 2011). Since 2015, the MOH has expanded its target programme to reach people suffering from anxiety and depression, and pediatric patients with autism and attention deficit hyperactivity disorder. These efforts have faced many challenges due to the health sector's lack of training and experience in child and adolescent mental health (Cuong, 2017).

Stigma is a serious barrier to mental health care and treatment in Viet Nam. Mental disorders are sometimes imbued with shame and disgrace in the country, which can prevent individuals from speaking openly about their distress. For example, "bác sĩ tâm thần" is Vietnamese for psychiatrist; however, it directly translates in English to "doctors who treat madness." Mental disorders are often viewed as signs of personal or familial weakness. Discrimination towards people with mental illness can result in difficulties finding employment, getting married or even having family members get married.

A study conducted by the UK-based Young Lives Project found that poverty-related stressors compromise healthy child development (Thang & Hang, 2018). Across both urban and rural areas, vulnerable youths and women lack adequate resources for their needs. Care is especially lacking for those living in rural areas that do not have accessible transport to major cities – like Ha Noi and Ho Chi Minh City – where services are more widely available. However, the limited number of mental health care professionals currently working in the field are unable to provide the demands vulnerable segments of the population need, especially when resources are limited.

3.3 Adolescent Mental Health Problems in Viet Nam

3.3.1. Studies of Depression, Anxiety and Behavioural Problems

Studies of adolescent mental health in Viet Nam indicate that Vietnamese youth experience a significant burden of mental illness. Research on the prevalence of adolescent mental health problems in Viet Nam have found varying rates. Weiss et al., (2014) conducted a nationally representative mental health epidemiological study of 1,314 children 6 to 16 years of age from 60 sites across Viet Nam and estimate that 12% of the child and adolescent population (over 3 million young people) have a mental health problem in needs of services. This study found higher rates of emotional problems in girls compared to boys, and higher rates of behavioural problems in boys. In this study higher socioeconomic status was associated with higher rates of ADHD symptoms.

In a study of parental styles and mental health problems among Vietnamese high school students from Ha Noi, Hue and HCMC, 16.4% of 757 participants reported mental health problems. Findings showed that being female, being in grade 12, and having an overprotective mother were risk factors to mental problems while father's warmth reduced the risk of having mental problems among adolescents. (La et al., 2020).

A study of 1,161 students aged 15–19 years examined the burden of mental health problems among secondary school students in Can Tho City, Viet Nam. The prevalence of clinically significant symptoms

of depression and anxiety were 41.1% and 22.8%, respectively. (Nguyen et al., 2013). Female students had three times the odds of having anxiety symptoms as compared to male students. In another study of adolescent depression, Nguyen and colleagues (2013) found that 18.7% of 1,100 high school students had depressive symptoms consistent with major depressive disorder. According to the Survey Assessment Vietnamese Youth (SAVY I), 32% of 14-25-year-old reported feeling sad about their life in general (MOH, 2005).

A study of over 4,500 youth in Ha Noi, including a high percentage of migrants, found a 6-month prevalence of depression of 36% (Nguyen *et al*., 2012). Depression was positively associated with current drinking: the higher likelihood of depression, the more likely one drinks. A risk factor for depression in this study was migration status, with adolescents who had migrated to Ha Noi showing higher rates of depression compared to non-migrants.

Variable prevalence rates across studies may be due to study methodical factors, including different sample sizes, tools and research methods. It also may be that studies only looking at adolescents in major urban centres find higher rates of mental health problems (e.g., Nguyen et al., 2012) compared to studies that include children living in rural areas (e.g., Weiss et al., 2014). Robust adolescent mental health prevalence data is expected soon via a National Adolescent Mental Health Survey (Erskine et al., 2021).

3.3.2. Studies of Suicide Risk

Of great concern is the risk of adolescent suicide related to depression and other mental health problems. Studies of suicidality in adolescents in Viet Nam have found high rates of suicidal ideation. In 2012-2013, Le et al. (2016) surveyed 1745 students aged 16-18 years in ten schools in Ha Noi, asking "During the past 12 months, did you ever seriously consider attempting suicide?" Results demonstrated that 21.4% of girls and 7.9% of boys reported suicidal thinking during the prior 12 months. Prior year suicidal plans were reported by 7.8% of the girls and 4.0% of the boys. Students in the study reported exposure to multiple forms of victimization,

including child abuse and neglect, witnessing family or neighbourhood violence, property victimization and cyber bullying with 94.3% having experienced at least one form of victimization during their lifetime and 31.1% having experienced ten or more forms. Students with ten or more victimization experiences demonstrated significantly increased symptoms of depression and anxiety, likelihood of health risk behaviours, suicidal behaviours and poorer health-related quality of life among both girls and boys (Le et al., 2015; Le et al., 2016b).

Other research has studied prevalence of suicide attempts among adolescents. Thai (2010) studied 1,226 adolescents and found that 5.8% reported attempted suicide in the past 12 months. A joint study (2015) between UNICEF, Overseas Development Institute (ODI), and The Ministry of Labour, Invalids and Social Affairs (MOLISA) surveyed the rural area of Dien Bien, in northwest Viet Nam and documented 333 attempted suicides, including 73 completed suicides. Within the 333 attempts, 140 attempts were made by children 19 years or younger. Within the 73 completed suicides, 16 were children. Alarmingly, the survey found that suicidal tendencies are a pressing issue among Vietnamese youths within the province. The authors note that the availability of poisonous leaves in Dien Bien appears to facilitate suicide attempts particularly among Hmong girls, who live near to where the poisonous leaves grow.

3.3.3. Studies of Mental Health Risk Factors

One determinant of adolescent mental health problems is exposure to maltreatment and abuse. Research indicates high rates for maltreatment and abuse among Vietnamese children. The recent Viet Nam Sustainable Development Goal indicators on Children and Women (SDGCW) survey (2020 – 2021) of child discipline found that 69% of children age 10-14 experienced violent discipline within the previous month, and that boys were more likely to be violently punished than girls. A survey of 2,591 Vietnamese adolescents aged 12-18 years (Nguyen et al., 2010) found that 39% reported experiences of emotional abuse, 47% reported experiences of physical abuse, nearly 20% reported that they had experienced sexual abuse and 29% reported that they had experienced neglect. This study found higher rates of neglect and emotional abuse among girls, and higher rates of physical abuse among boys. Similarly, Akmatov (2011) found that more than 55% of adolescents in Viet Nam had experienced moderate physical abuse perpetrated by their parents, with 29% of adolescents reporting severe physical abuse. Males experienced higher rates of physical abuse in this study as well. Larger households and poorer economic status were associated with higher rates of abuse.

Connection to parents and schools also impacts adolescent mental health. A recent survey of high school students in Viet Nam (Le et al., 2018) found poor communication between parents and adolescents had a negative impact on young people's mental health, and contributed to low self-esteem, feelings of sadness and loneliness and suicidal thoughts. Adolescents' sense of belonging and connectedness to their schools also play a role in their mental health. Data from the Survey Assessment of Vietnamese Youth (SAVY) I and SAVY II showed that adolescents who felt connected to their schools were less likely to report psychological symptoms (Phuong et al., 2013).

Another important risk factor for Vietnamese adolescent mental health is caretaker mental health. Stratton et al (2014) studied caregivers' mental distress and general health status (using the Self-Reporting Questionnaire-20) and reports of adolescent mental health using the parent version of the Strengths and Difficulties Questionnaire (SDQ). Caretaker mental health was positively associated with adolescent mental health, with the association significant after controlling for other relevant demographic variables and caretaker general health status.

Overall, it appears that major risk factors for adolescent mental ill-health include female gender, older adolescent age, migrant status, poor caregiver mental health, poor parent-child communication, feelings of disconnection from school, and experiences of abuse, trauma and neglect.

Chapter 4
Methodology

A **mixed-methods design** was utilized to investigate the research questions. The study included literature review and primary quantitative and qualitative data collection. The mixed-methods design allowed for a systematic integration of data, validated findings from different sources of information, and expanded knowledge in several key areas. Key study questions were answered with integrated data. For example, to better understand the prevalence of common mental health problems among adolescent students in Viet Nam our research combined (a) literature review of previous study findings, (b) original quantitative data from students on their self-reported mental health problems, and (c) qualitative data regarding perceptions of student mental health problems from students, teachers, parents and school, district and ministry-level administrators. Integration of these data points provides a robust understanding of adolescent student mental health.

An example of how the mixed-methods design allows for validation of study findings can be found in data analyses related to what government and school system administrators understand about existing mental health policies and MHPSS programmes. By comparing policies and programmes with understanding and perceptions of various stakeholders, we are able to learn about what policies and programmes are viable, effective responses to adolescent mental health problems, and what policies and programmes may need strengthening or revising in order to better address students' needs. And final, the mixed-methods design offered opportunities for expanding our knowledge and understanding in many situations. For example, quantitative data regarding the relationship between student mental health problems and school climate indicators can suggest areas of mental health risk and inform recommendations. Likewise, qualitative data regarding stakeholder perceptions of how to improve student mental health yielded a rich trove of ideas from highly experienced stakeholders who understand systemic barriers and opportunities, and thus can offer feasible ideas with a high potential for positive impact.

Quantitative data was collected from students and teachers. Students responded to a self-report survey which included measures of student mental health, perceived school climate, academic stress, study time, academic performance and cyberbullying experiences. A teacher survey provided quantitative data regarding teacher perceptions of student mental health and well-being, teacher training re: student mental health, teacher capacity to support student mental health and well-being and teacher perceptions of school resources for students in need of mental health support. Qualitative methods included (1) FGDs with students, parents, teachers and (2) KIIs with principals, district-level staff from provincial DOET, DOH and DOLISA and Ministry-level experts from MOET, MOH, and MOLISA.

4.1 Specific Aims, Activities and Research Methodology

Specific Aim 1: Provide an overview of available evidence and an analysis of i) the current situation of mental health problems of adolescence in Viet Nam, ii) School-Related factors affecting mental health issues of adolescents in Viet Nam and iii) the key stakeholders, policies, legislations, standards and programmes relating to mental health and well-being among adolescents in Viet Nam. A literature search was conducted using relevant databases (EBSCO, PubMed, psycINFO, VN databases). Literature review included an overview of (a) recent epidemiological data regarding common mental health problems, (b) School-Related factors impacting mental health including school climate (safety, engagement and environmental factors), academic pressure and peer-related social stress, and (c) existing school-based MHPSS services and programmes in Viet Nam. Review of policy documents, legal documents and relevant standards and guidelines from government agencies (MOET, MOLISA, and MOH) was conducted to understand the independent and interdependent conceptual frameworks, roles, responsibilities and existing services provided by each agency in support of adolescent mental health in schools.

Specific Aim 2: In-depth analysis of key School-Related risk factors and their impacts on mental health and psychological well-being of adolescent boys and girls in Viet Nam including primary qualitative and quantitative data. A systems research approach was utilized to address this aim. Systems research is based on the concept that a system is a function of its parts, or components, and that each component interacts, interconnects, interrelates, and in some cases influences each other. To this end, people from each level of the school system in Viet Nam were invited to participate, including students, parents, teachers, principals, district-level government officials, and national ministry-level government officials. See Primary Data Collection Methodological Approach section below for more detail.

Specific Aim 3: Map existing policies and schools' strategies and actions in recognizing, mitigating and addressing mental health issues of adolescents in and outside school. Evidence from the literature review, policy document review, and KIIs with Ministry level (MOH, MOLISA, MOET), provincial and district level (DOH, DOLISA and DOET from 5 provinces) and principals of participating secondary and high schools informed the mapping of policies, strategies and services related to providing primary, secondary and tertiary support for adolescent student mental health in schools in Viet Nam.

Specific Aim no 4: Examine the effectiveness of existing policies, systems and human resources and their limitations. Policies regarding school-based adolescent mental health support were compared to data collected regarding the development and implementation of programmes and services. Policies and guidelines related to inter-agency cooperation were compared to data collected regarding local school, health and social sector coordination in the care and treatment of mental health problems. Qualitative analysis of KII data identified themes related to perceived effectiveness of existing policies, services and systemic coordination of services.

Specific Aim 5: Suggest recommendations and action plans on the role of education system in the provision of MHPSS and how the education system can mitigate and prevent School-Related mental health risks to promote positive mental health as well as prevent mental ill health. Consider different modalities for reaching younger and older adolescents. Recommendations are provided based on the results of the above analyses. Risk factors, protective factors, gaps in policy and/or MHPSS programme implementation will inform recommendations with a focus on school-based MHPSS programmes and system-wide strategies that are most likely to be effective for adolescents in Viet Nam. Evidenced-based recommendations are offered to provide guidance to each level of the system (Ministry, Provincial and School) and to each sector impacting on adolescent mental health, with a primary focus on the education sector and secondary focus on health and social service sectors. Recommendations highlight opportunities for improved collaboration across system levels and sectors.

Specific Aim 6: Include disaggregated data and analysis from gender lenses, and considering income, geographical, ethnicity, sexual orientation and gender identity, age and disability disparities, whenever applicable. Data analyses by gender, age, socioeconomic status, and geographical region are included. Ethnic minority students are included (particularly from schools from Gia Lai and Dien Bien provinces). A small group of LGBTQ students were included from Ha Noi.

4.2 Primary Data Collection Methodological Approach

4.2.1 Collaborative Research Process

The research team worked closely with UNICEF and MOET Department of Political Education and Student Affairs to determine specific research activities and procedures. MOET was instrumental in selecting appropriate provinces for inclusion in the study (based on goals for geographical representation,

urban/rural representation, and inclusion of ethnic minority communities). While the original proposal did not include Dong Thap, the province was included based on MOET suggestion so as to include a province from the Mekong Delta region. MOET also asked to increase the study sample size in order to strengthen statistical power.

Data collection in each province was conducted by the senior national researcher, Dr. Dang Hoang Minh, and by two MA level psychologists with training in research and data collection methods. In each province, the research team first met with the provincial DOET to review study aims and objectives. DOET worked with the research team to identify participating secondary and high schools, schedule school-based data collection (surveys, Principal KIIs, and FGDs), and schedule KIIs with district level education, social and health departments. Data collection in each province took place over a 4-day period (approximately).

4.2.2. Data Collection Methods

Data collection took place at Ministries in Ha Noi and in four provinces representing various geographical, cultural and urban/rural areas of the country, including Ha Noi, Dong Thap, Gia Lai and Dien Bien. The initial plan to include HCMC had to be changed due to a serious COVID-19 outbreak that prevented data collection efforts there. We collected data using the following methods: (a) key informant interviews (KII) with high-level administrators from the government and school systems; (b) focus group discussions (FGD) with students, parents, and teachers; and (c) surveys to collect quantitative data from students and teachers.

4.2.3. Participants

1. Key government ministry personnel. KII with 1 key personnel each from MOET, MOLISA and MOH for a total of 3 KII with ministry-level government officials.

2. KII with **UNICEF Child Protection Section Chief** on relevant previous studies and key government documents.

3. Key government provincial and district-level personnel. In Dien Bien, Dong Thap and Gia Lai provinces, key personnel from DOET, DOLISA and DOH participated (2 per agency). In Ha Noi, due to the COVID-19 outbreak only 1 key personal each from DOET and DOH was able to participate (while 2 from DOLISA). Thus, a total of 22 KIIs with provincial and district-level government officials were included.

4. School principals. KIIs took place with principals from 2 schools in each province, including 1 secondary school and 1 high school. In Ha Noi, the two schools included a semi-public school. This resulted in total of 7 KIIs with school principles.

Key Informant Interview Participants

	KIIs	# Participants
Ha Noi	**Principals**	2
	DOH	1
	DOLISA	2
	DOET	1
Gia Lai	**Principals (*)**	2
	DOH	2
	DOLISA	2
	DOET	2
Dien Bien	**Principals**	2
	DOH	2
	DOLISA	2
	DOET	2
Dong Thap	**Principals**	2
	DOH	2
	DOLISA	2
	DOET	2
Ministry	MOET	1
	MOH	1
	MOLISA	1
Other	UNICEF	1
TOTAL		**34**

(*) In Gia Lai, a head teacher participated in the interview when one principal was unavailable.

5. Teachers. Teacher survey data was collected from 6 teachers/school for a total of 66 teacher surveys (85% female, Mean age 40 years, 61% secondary school). Teacher FGDs in the three provinces of Dien Bien, Gia Lai and Dong Thap took place April – May 2021. Two teacher FGDs took place in Ha Noi in October 2021. Each FGD included 7 teachers for a total of 35 secondary school and high school teacher participants. See Appendix 3 for detailed teacher demographic information.

6. Parents. Parents from Dien Bien, Gia Lai, and Dong Thap provinces participated in FGDs in April and May 2021. Seven parents participated in each group for a total of 21 parent participants. A parent FGD in Ha Noi did not occur due to schools' concerns regarding parenting stress and COVID-19 restrictions during the COVID-19 outbreak at that time.

7. Students. Student participants included 668 students (66% female, mean age 14.2 years, 54% ethnic minority). Student FGDs in the three provinces of Dien Bien, Gia Lai and Dong Thap took place April – May 2021. Two student FGDs took place in Ha Noi in October 2021. Student FGDs included 7 students each. An additional FGD was held for a group of LGBTQ-identified students in Ha Noi in September 2021 (4 students). A total of 39 students participated in FGDs for the project. Students are included from both secondary schools (students ages 10-14) and high schools (students ages 15-19). The student FGDs in Gia Lai and Dien Bien consisted of ethnic minority students. Students from one semi-public school was included from Ha Noi to broaden the socioeconomic range of participants. Quantitative data was collected via surveys from about 60 students/school for a total of 668 student surveys. See Appendix 3 for detailed student demographic information.

4.3 Student Survey Measures

1. Student Mental Health was assessed using the Strengths and Difficulties' Questionnaire – 25 (SDQ25) which is a brief self-report behavioural screening questionnaire for children ages 3 – 16. The adolescent self-report version used in the study is suitable for young people aged around 11-16 (Goodman et al., 1998). The SDQ25 items ask about nonspecific psychological distress including symptoms of depression, anxiety and somatoform disorders. These 25 items are divided between 5 scales: emotional problems (5 items), conduct problems (5 items), hyperactivity/inattention (5 items), peer relationship problems (5 items) and prosocial behaviour (5 items). The 20 items from the 4 psychological problems scales are added together to generate a total difficulties score. The SDQ25 has been widely used around the world and has been adapted, validated and widely-used in Viet Nam (e.g., Weiss et al., 2014).

2. School Climate was assessed using the Adapted Maryland Safe and Supportive Schools Climate Survey (MDS3) which was developed by the Johns Hopkins Centre for Youth Violence Prevention. The MDS3 for students is comprised of 56 core items based on previously validated indicators of safety, engagement, and the school environment (Bradshaw, Waasdorp, Debnam & Johnson, 2014). All answer choices are scored on a 4-point Likert scale from strongly agree to strongly disagree, whereby higher scores represent a more favourable school climate. The 56 items assess the following areas of school climate:

a. **Safety** (perceived safety, bullying and aggression, general drug use)

b. **Engagement** (connection to teachers, student connectedness, academic engagement, whole school connectedness, culture of equity, parent engagement)

c. **School environment** (rules and consequences, physical comfort, support, disorder)

3. Student academic stress was assessed using the Educational Stress Scale for Adolescents (ESSA) developed and validated with Chinese adolescents by Sun and colleagues (2011). The ESSA includes 16 items rated by students on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree) with higher scores indicating greater stress. The scale covers five dimensions of educational stress including study pressure (4 items), worry about grades (3 items), despondency (3 items), self-expectation (3 items), and workload (3 items). The ESSA has demonstrated good internal consistency with Cronbach's alphas of .81 for the general scales and a range of .66 to .75 for each dimension (Sun et al., 2011). Truc and colleagues (2012) validated the ESSA within the Vietnamese context. In the Vietnamese study the ESSA demonstrated good general scale internal consistency, factorial validity and concurrent validity, similar to the original study.

4. Time spent studying after school. Students were asked "On average, how many extra hours per day did you spend for self-study after school in the previous semester?" (Almost none, less than one hour; 1–2 hours; 2–3 hours; and more than 3 hours). This measure was used in a study with a Chinese sample by Sun (2012) and a Vietnamese sample by Thai (2010).

5. Time for private tutoring. Participants were asked to state their actual time (hours) spent for one-to-one private tutoring and group private tutoring. Time (hours) spent for private tutoring was measured by using the question: "How many hours per week did you spend for one-to-one private tutoring/group private tutoring after school or during the weekend in the previous semester?"

6. Academic Performance. Participants were asked to state their actual average scores of 2 main subjects and overall performance (Maths, Vietnamese, and GPA) in the previous semester. In Viet Nam, 10-point grading scale has been used throughout school system with 10 is the highest and 0 is the lowest (Viet Nam Ministry of Education and Training, 2011). Students were provided with response options for scores less than 5, 5-6.9, 7-7.9, and 8-10.

7. Cyberbullying was assessed using a tool adapted from the Revised Cyber Bullying Inventory (RCBI) (Topcu & Erdur-Baker, 2010) for use with Vietnamese adolescents (Tran, Nguyen, Weiss, Nguyen & Nguyen, 2018). The RCBI demonstrated satisfactory internal consistency with Cronbach's alphas of .82 and .75.

The Revised Cyber Bullying Inventory - Viet Nam includes 18 items regarding student experiences on the internet during the previous 6 months, including frequency of experiences and distress regarding the experiences. Higher scores on the scale reflect greater frequency of cybervictimization and greater associated stress.

4.4 Teacher Survey

Secondary and High School teachers (N=66) from participating provinces completed a survey developed for this project assessing teacher perceptions of student mental health and well-being, teacher training experiences in student mental health, teacher capacity to support student mental health and well-being, and teacher perceptions of school resources for students in need of mental health support. The survey took 15-30 minutes to complete.

4.5 Student, Parent, Teacher Focus Group Discussions

FGDs explored perceptions of student mental health needs, experiences with School-Related risk factors and perceptions of existing services and interventions. See Appendix 1 for FGD Guidelines and Questions. FGDs lasted approximately 60 minutes each and included the following participants:

4.6 Principals, District and National Government Key Informant Interviews (45-60 minutes each) explored perceptions of student mental health needs and School-Related risk factors, understanding of relevant policies, and knowledge and understanding of existing MHPSS programmes. See Appendix 2 for KII Guidelines and Questions.

4.7 Data analysis

Qualitative data, including all FGDs and KIIs, were first transcribed and then translated into English for analysis by the primary author. Preliminary review of transcripts was conducted to search for broad themes and categories. Data were inputted into Nvivo 12 for analysis and coded according to 24 codes (including 32 sub-codes). These codes were organized into themes and sub-themes.

Quantitative data, including student and teacher survey data, was analysed using SPSS 28. Descriptive data was analysed for demographic and key variable data (e.g., student mental health). Pearson correlations examined associations between key variables (e.g., student mental health and school climate variables; student mental health and academic pressure variables). T-tests examined mean differences in key variables by gender and educational level (e.g., academic pressure by gender). Analysis of variance (ANOVA) examined differences in key variables by province (e.g., 3 school climate sub-scales by 4 provinces).

4.8 Ethical Concerns

Ethical concerns included the sensitive nature of qualitative and quantitative data content. Student surveys included information regarding student mental health, which may have negative consequences for children if shared. Teacher surveys included perceptions of school support for students with social-emotional problems, which may displease supervisors at the school or at higher levels. Qualitative data included information shared about participants' personal experiences with mental health problems, and concerns about school or system response to student mental health and well-being. For these reasons, surveys were de-identified and kept in a secure location. Audio recordings were transcribed and de-identified. Only research team members had access to the data.

A second concern was that students could feel pressured to participate given that data collection occurred at school and with school administrator support. To mitigate this risk, students were informed that their participation was entirely voluntary and that they were free to withdraw participation at any time without repercussions.

Another concern was for the welfare of student participants. While unlikely, it is possible that students could become upset while responding to the survey or when participating in a focus group. The data collection team included 2 MA level psychologists and was led by a PhD clinical psychologist (Dang Hoang Minh). The data collection team was trained to look out for signs of student distress and to offer support or referrals if needed. No incidents of distress were reported.

The research protocol received ethical review and approval from Viet Nam National University's IRB Board. IRB review included consent forms for students and parents.

Chapter 5

Adolescent Student Mental Health and Well-Being in Viet Nam Study Findings

Key Findings

1. Student self-reported mental health symptoms indicate that about 26% of adolescent students are at moderate- or high-risk for mental health problems. Problems with peers (including experiences of bullying) and emotional problems (symptoms of depression and anxiety) were the most common problems at 32% and 31% respectively. About 14% of students report symptoms of hyperactivity, including impulsivity and poor concentration, and 11% of students report behaviour problems, including disobedience and lying.

2. Adolescent girls report significantly higher rates of emotional problems (symptoms of depression and anxiety) compared to boys.

3. Parents often lack knowledge of common mental health problems and normal child development and are eager for information.

4. All principals, school administrators and Ministry-level experts (from all 3 sectors) interviewed expressed serious concern regarding adolescent student mental health and well-being. and concern for the negative impact of student mental health problems on student learning and socioemotional functioning.

5. Girls are often seen as more vulnerable to psychological problems, and adult behaviour towards girls may serve to "protect" girls in ways that may not always support female resiliency and MHPS strength.

6. Teachers and administrators are concerned about ethnic minority student social isolation, lower rates of help-seeking and risk for suicide.

7. LGBTQ students are concerned about their mental health and well-being. Family relationships and fears of stigma and discrimination are sources of stress and mental health challenges.

5.1 Student Life

Students were enthusiastic participants and had much to share about their lives, mental health and well-being. Adolescent students generally attend school 6 days/week (including a half day on Saturday). Most students reported taking two or more extra classes outside of school each week including classes in math, physics, and English. When adolescents are not in school or in extra classes, they are engaged in a variety of activities including studying, housework, and leisure activities.

What asked what they do for **relaxation**, students often stated that they spend time on social media and chatting with friends via messaging apps. Other students share that they surf Facebook or "hóng tin" (follow gossip news for entertainment). Some students play sports, including badminton, football, basketball, yoga and swimming. A few students reported playing instruments, singing and song writing. Other students like listening to music, watching movies, photography and reading books. Students value family time as demonstrated by one student who expressed feeling "so happy" when his whole family played badminton together. Some students noted the positive impact of activities on their health and well-being. As a student in Ha Noi shared, "I don't have a lot of time, but between classes there are two hours for me to take a break. I use that time to play with dogs and workout. Then I notice my body is healthier and I feel a little more relaxed."

In addition to academic responsibilities, students reported many **responsibilities at home.** Students help with housework, including "laundry, sweeping the floor, and clearing the table." A few students cook dinner, and many students are responsible for looking after younger siblings. A student from Dien Bien reported, "[I] don't have time to go out. My parents ask me to watch my sister until she is asleep. Because if I go out, I won't know if she cries." While many students felt the level of household work was reasonable, a few students indicated that they felt overwhelmed by these responsibilities. One student shared, "Being the eldest sister is something I find difficult since my parents have too many expectations and neglect me sometimes."

Students shared challenges at home including **stress related to family conflict**. Some students reported that parents are often angry, often "shout" and "swear." One student described, "when my parents come home from work, they are tired and they take it out on me. They get mad if I don't listen. They get angry easily."

5.2 Student Mental Health and Well-being

5.2.1 Student Perceptions of their Mental Health and Well-Being

In discussions of mental health, students often identified feeling stressed or tired. When asked to share more about the impact of stress, students discussed feelings of fear, anxiety, frustration and sadness, mostly in regard to their academic performance and their future. They note that these feelings can impair their ability to study and engage with friends.

Aside from "stress," students did not demonstrate much knowledge about mental health. When asked about depression, students in Dien Bien responded that it is "being scared of everything around," "having too much pressure then they become quiet and don't want to contact or talk to anyone," "being angry whenever seeing someone," and "being distant." And students did not know about the nature and symptoms of anxiety disorders.

Students expressed concerns about mental health sigma and discrimination. When asked how teachers, parents and other adults view people with mental health problems, students from Dien Bien said "They gossip. They said what was wrong with those people" and "they discriminate." When asked if teachers would help a student who is having emotional problems the participants said yes, they would "give encouragement and comfort."

Adolescents shared strategies that they know of or use to manage stress and improve their mental health. Students most often said that they would talk or text with a friend when they feel sad or stressed with one student noting,

"My friends can help me to unwind the stress and sadness." Some teens shared that they found talking with family and teachers helpful. Students know that they can receive different types of support from different people, as a student from Gia Lai explained, "My head teacher would nicely explain to me how to look at things in a positive light while my best friend would talk straightforwardly with me in a ruthless way to make it so negative that I would go do something about it." Several students also stated that they look to nature to reduce stress, stating that they enjoy being in a garden or walking in the fresh air. Two students from Dien Bien shared that they find it helpful to write their feelings in a journal when they are stressed or upset. Other students shared that when they play video games, "the sadness disappears." And students understood that physical health was important to mental health with one student from Dong Thap sharing, "you can eat good food, with many vitamins to help light up your spirit."

Quantitative data provides more information about adolescent student mental health and well-being (see Appendix 3 for full Quantitative Data tables and results). Findings from the SDQ25 assessing student mental health indicate that 26.1% of adolescent students are at moderate- or high-risk for mental health problems. The most common types of problems reported were peer problems (e.g., "Other children or young people pick on me or bully me", "I get along better with adults than with people my own age"), found in 32% of students, and emotional problems (e.g., "Many worries or often seems worried", "Often unhappy, downhearted, or tearful"), found in 30.9% of students. Hyperactivity symptoms (e.g., "easily distracted, concentration wanders", "Thinks things out before acting") were reported by 14.4% of students and behaviour problems (e.g., "Generally obedient, usually does what adults request", "Often lies or cheats") were found in 11% of students. Boys and girls report similar rates of problems except for Emotional Problems (symptoms of depression and anxiety) where we see significantly higher rates of emotional problem symptoms in girls compared to boys. School level is also a major factor in adolescent student mental health with high school students indicating significantly more behaviour problems, hyperactivity, emotional and total problems compared to students in secondary schools.

5.2.2. Teacher Perceptions of Student Mental Health and Well-Being

Teachers generally agreed that most students are generally healthy and happy. As a teacher from Ha Noi reported, "Most of the time, teachers see students in their prime energy with optimistic outlooks... I think the schooling environment has encouraged students to feel comfortable and joyful."

However, teachers did express a number of concerns about student mental health. As one teacher from Dong Thap stated, "I think that about 85% of students seem to be happy. However, about 10% or 15% get stuck in the opposite circumstance. They always wear face masks for any occasion, as if they were suffering from depression. They are also unable to concentrate on listening to what we teach them in class. They often look around the classroom and stay quiet instead of talking or hanging out with friends, and when we come closer to talk to them they are startled." A teacher in Ha Noi agrees with the concern for "introverted" students who rarely speak or show emotion. Other teachers shared concern for students who lack confidence and engagement in class.

Teachers identified underlying student deficits that they believe lead to mental health problems. A teacher in Ha Noi voiced concern for students' ability to solve problems and see that this deficiency leads to increased stress, "students nowadays are not very keen or skilful in finding solutions to overcome or amend their limitations." Another teacher agreed that students often lack problem solving abilities and intrinsic motivation for learning and believes that these problems lead to stress and mental health problems which interfere with learning.

Teachers sometimes shared confusion regarding the nature of student problems. A teacher from Dong Thap shared an example of a student who was talking to himself at home and disengaging from school and social interactions. She was concerned and suspected the problem was depression. She did not

refer the student to a hospital but gave more attention to the student at school.

Quantitative teacher data from 66 teachers provides more insight into teacher perceptions of adolescent student mental health and well-being. Survey results indicate that almost all teachers are concerned about their students' stress and well-being (91%) with 53% of teachers reporting they are "Very concerned." Similarly, almost all teachers are concerned about their students' mental health (95%) with 54% of teachers reporting they are "Very concerned." Most teachers (34 teachers) estimate that 10% or fewer of their students experienced stress problems in the past month, although 15 teachers estimated higher rates of between 10-20% of students having stress problems in the past month. Teachers also report low rates of mental health problems among students, with most teachers (50 teachers) estimating 10% or fewer students having mental health problems in the past month. The most common adolescent student mental health problems reported by teachers include Poor Attention, Lack of Confidence, Low-energy/Tired and Anxiety. Moderately common problems reported by teachers included Anger/Aggression, Sadness/Depression, and Disruptive Behaviour. Teachers indicated that the least common problems were Oppositional or Defiant Behaviour, Alcohol/Substance Abuse, and Serious Peer Conflicts.

5.2.3. Parent Perceptions of Student Mental Health and Well-Being

In general, most parents reported satisfaction with their children's well-being finding them often happy and well-behaved. When parents were asked about student mental health concerns, parents often initially spoke of issues related to puberty, sexual/romantic relationships, phone use, and child displeasure regarding studying. Many parents were concerned about child irritability, anger or defiance at home. Parents expressed concern about children being disrespectful. As one parent from Dong Thap shared, "There is this outburst quality, compared to when I was at the same age, there are [more] outbursts and disagreement. In general, I find him quite unruly." Several parents believe that disrespect towards parents is a modern problem and are concerned that it reflects changing values. As one parent noted, "Kids these days are easily angered [compared to] us back when we were that age. For example, back then, we would have stayed silent and ignore when parents yelled at us, but now only one or two sentences and the kids talk back." Parents also report lacking confidence in how to respond to children's disrespect and anger.

Initially, parents did not often think of common mental health symptoms such as loss of energy, lack of interest, worries, etc. When parents in Dien Bien were asked if their secondary school children experienced stress they initially thought no. However, when the facilitator described signs and symptoms of stress, parents then reported that their children did experience stress. These patterns of responses indicate that parents lack understanding regarding common mental health problems and related symptoms.

Parents expressed confusion regarding normal adolescent development and were not sure when behaviours indicated a problem. Gia Lai parents reported problems such as irritability, distractibility and tiredness. and wondered if these behaviours could be due to puberty. A parent from Dien Bien asked the facilitator what to do about adolescent disrespect towards parents. Parents from each province reported signs of anxiety and depression but were unsure how best to support their children or how to seek information or support.

5.2.4. Key Informant Perceptions of Student Mental Health and Well-Being

All principals interviewed expressed concern regarding adolescent student mental health and well-being. Discussion of common mental health problems in students included stress, anxiety and depression but there was also some discussion of behaviours considered immoral. For example, a principal from Gia Lai reported student smoking, having inappropriate relationships that lead to conflict, and spending time on phones or the internet. Another principal was concerned about student lack of motivation. She and the school faculty struggle with how to motivate students and find that family intervention does not help much.

Some principals shared concerns regarding skill deficits that they believe underlie student mental health and functioning problems. A principal from Dien Bien reported that students often lack necessary problem-solving skills and stated, "If students are not equipped with problem-solution skills, they will certainly be faced with situations where they cannot deal with issues in friendships and relationships with teachers."

Principals also shared a concern for the negative impact of student mental health problems on student learning and socioemotional functioning. As a high school principal from Ha Noi reported, "[mental health problems] reduce their ability to learn, their ability to focus and deal with situations. They wouldn't be interested in any subjects or any career options in the future." Another principal described a cycle of mental health problems and poor performance, "students become irritable, quick-tempered, and over-reactive. [When they face] things are light and casual, now they feel like they are being stung, been called out, been criticized. Then they don't focus, their results get lower, and this gets repeated over and over. They completely lose the confidence that they had before and their previous ability is no longer there."

Principals reported that mental health problems are often misunderstood and misidentified at school. A principal from Ha Noi shared an example of an 8th grade student with severe sleeping problems who withdrew from school. In this example, the school and parents missed signs of an emerging mental illness so did not seek professional help. The child developed a serious mental illness, was later hospitalized, and never returned to school.

All DOET administrators interviewed share these concerns about adolescent student mental health. An administrator from Ha Noi expressed the importance of supporting adolescent student mental health, "I think mental health should be deemed more important and indisputably vital for a student's growth, which can even be ranked at higher importance than academic achievement. I think it is better to teach students how to control themselves before throwing them math knowledge such as sin, cos, tan, cotan."

DOH administrators also viewed adolescent

mental health as a serious issue. Experts shared that depression and anxiety were problems among students. A participant from Dong Thap stated, "There are stresses that the kids keep inside and don't talk about because they see so many expectations from the school and from their parents, while they themselves can't fulfil these expectations. Occasionally this leads to a state of hiding, withdrawal from everything so they end up not communicating." Health officials often discussed the impact of mental health problems on adolescent development. An DOH official from Dien Bien remarked, "The matter of psychological-mental health in adolescence is really crucial since this period has a huge impact upon the educational goals of adolescents. Mental health decides whether the kids will be distracted by something or whether they gain the direction they need in order to succeed in life. Once the adolescents are psychologically stable, can they be directed in the right career path. If the kids are left with no guidance to control the psychological distractions, their lives can go astray."

Likewise, DOLISA administrators expressed concerns regarding adolescent student mental health. A Ha Noi DOLISA expert sees that adolescents lack ability to solve problems and to develop relationships and finds that these skill deficits put students at risk, "The first problem is that children are quite weak in the ability of solving problems in their lives, and their ability to connect with their surroundings. I think their relationships and social connections, and their help-seeking, are not good and not enough people are paying attention. [These problems] explain why there are suicide cases that surprise parents and the child's friends, since many of them feel that the child was just stressed."

Experts from MOH, MOET and MOLISA agree that adolescent student mental health represents a serious challenge for society. An expert from MOH reported an increase in mental health problems over the last 10-20 years due to "economic-social development, industrialization, modernity, information technology development, and changes in living standards. These changes put pressure on the younger generation which often leads to problems. " This expert also noted that mental health problems may seem more prevalent now due to increased awareness of these problems. He stated, "In the past, there might have been a few cases [of adolescent mental illness] but people didn't care so they didn't recognize the problem. Now people's knowledge is expanding, and they are more likely to identify those cases."

5.3 Data and perceptions regarding how student mental health needs vary by gender, ethnicity, and LGBTQ status.

Beliefs about gender differences related to adolescent mental health were sometimes expressed in the FGDs and KIIs. In general, parents and administrators shared perceptions of girls as more vulnerable to mental health problems. One parent in Dien Bien expressed a belief that girls are not as healthy as boys stating, "I have a girl and you know girls do not have as much health as others, which is why examinations always put make me worry. Moreover, I do help my daughter with everything, things that she may not be able to do all the time, such as helping her with housework so the rest of the time can be spent on studying only. This is due to my daughter's health condition. Otherwise, she may show signs of insomnia which has to be supported by medication." Another parent from Gia Lai expressed a belief that boys were less effected by mental health problems, speculating that it was because "boys are usually bolder."

The mental health and well-being of ethnic minority students was a concern for a number of participants. Of particular concern was ethnic minority student social isolation, lack of help-seeking and risk for suicide. A DOET administrator in Dien Bien noted that ethnic minority students in his school district are vulnerable to mental health problems, "The Mong students only consider hanging about with students from the same ethnicity and so they end up rarely playing with or getting acquainted with the Thai people. Therefore, the issues remain in a particular ethnic group, which is why it is so difficult to sort out everything. Students rarely take the initiative to share their concerns and would rather take the events in their hands alone. And many times, the

way they deal with these events is drastically negative in nature. For example, in case of romantic love issues, a girl or a boy could have conflicts in the relationship and decide to self-isolate and not share the story with anyone. This can lead to suicidal ideation and death. The students have a natural resource of (poisonous) heartbreak grass, which can serve the idea of suicide pretty easily. To conclude, the difficult thing about getting to know a student's mental health lies in the students themselves, who do not have skills for sharing about difficult personal issues in order to get help untangle their minds." An administrator at DOH in Dien Bien also expressed concern about suicide among Mong adolescents via "heartbreak grass" poisoning. Family reluctance to seek help for children's problems was also noted as a concern regarding ethnic minority students. A DOLISA administrator from Dien Bien noted that ethnic minority communities are less likely to access health care when their children are sick leading to incidences of serious illness (including mismanaged epilepsy) among adolescent students at times.

LGBTQ students report concerns with their own mental health and well-being. While the study included only a small group of LGBTQ students, results indicate a need for concern and further research. Students shared feelings of anxiety regarding relationships and school performance, negative self-image and insecurity, and emotional instability. Students reported feeling overwhelmed by negative emotions at times. For example, one student shared, "I mostly go to the more negative direction when I'm so stressed, and I don't know how to let it out, there's no way that I can forget, so after that I do some self-harming. Before, I used to use knives. Then after that, I didn't want to cut my own body so I threw anything sharps in the house away and then I started to switch to other methods - such as banging my head against the wall or pouring boiling water on my hands." While this student reported that s/he had received some psychological counselling they did not find it helpful as they perceived the counsellor to be judgmental and not empathic.

Family relationships can be a significant source of LGBTQ adolescent stress. Students reported anxiety regarding coming out to their parents. Several students shared that parental negative reactions to their sexual orientation and gender identity have been a source of sadness and pain. As one student expressed, "For me the most stressful [relationship] is the relationship with my family. Actually, I have been independent from my family pretty early. Since secondary school when I chose to be far away from my family until now, I haven't talked much to my mother, my father or my siblings. When I came out, my father and my family cut off all support for me, including financial support for my studying. They kind of accept it but still haven't supported me as a gay person." Students whose parents ultimately support and accept them as LGBTQ shared that this is a source of resiliency. As one student shared about coming out to his/her mother, "My mother, being very tense and serious, clasped her hands and bowed to me and she prayed for me to live like a normal person. That day I was very hurt but after a while, my mother showed that she was very supportive, she told me that she won't care who I love as long as I'm happy. So I'm very lucky to have a supportive mother."

While coming out can be a stressful process for adolescents, some adolescents find it ultimately positive. One student shared, "Personally, I feel that coming out officially as a LGBT person was kind of liberating. I've been hiding it for a long time. I don't need to be afraid of how my parents will get hurt, but I feel more comfortable like I feel more confident. People used to tease me with names like 'manly chick' and such and it made me uncomfortable. But when I share about how I am, people respect it. Plus, when I come out, I have found more friends in the community the same as me, and I see there are a lot of talented people in the LGBT community."

LGBTQ students shared a variety of feelings regarding the future. Some students reported feeling positive and excited about the future. As one student shared, "in general, I am also quite positive towards the future because I go to the school I like, with my friends who love me, to study a major that I like and feel confident about." However, another student expressed pessimism about the future, stating "I don't know what to do, the future is pretty bleak."

Chapter 6

School-Related Factors Impacting Student Mental Health and Well-being in Viet Nam

Key Findings

1. A significant number of adolescent students report low school engagement and connection with teachers. Students do not often feel comfortable going to teachers for academic or socioemotional support.

2. Principles, administers and ministry experts expressed concerns regarding teacher-student relationships. Key barriers to improving teacher-student relationships include teachers' lack of time and administrative support.

3. Student survey data demonstrates that students who feel less engaged in school (e.g., less connected to teachers) have higher rates of mental health problems. Importantly, girls report feeling less engaged in school compared to boys.

4. Bullying is a serious risk factor for student mental health problems and well-being. Teachers do not always recognize the negative impact of bullying on students.

5. Almost all participants expressed critical concern regarding student experiences of academic pressure and the impact of that pressure on student mental health, well-being, and learning. Workload, pressure from teachers and parents, and systemic factors underlie high levels of student academic pressure.

6. Parental lack of mental health knowledge is a risk factor for student mental health problems.

7. The COVID-19 pandemic has had a negative impact on student mental health and well-being. All participants expressed concerns regarding the impact of social restrictions and isolation on student psychosocial development and the impact of online education on student mental health and learning.

8. Ethnic minority students are at increased risk for problems with mental health and well-being. Family poverty, with related pressure on students to work (during school hours), marry young and remain in the community, is a specific risk factor for ethnic minority students. Lack of family-school connection and poor mental health literacy among the ethnic minority community are additional risk factors.

9. LGBTQ students are at increased risk for mental health problems and face specific challenges, including stigma, discrimination, bullying and family relationship stressors.

Student and teacher perceptions of school climate, including the school environment, student engagement and school safety, suggested several important risk-factors for adolescent mental health problems. See Appendix 3 for quantitative data tables and results.

6.1. School Environment

Young people generally reported that they were happy with their schools. School environment was important to students, with many students independently bringing up positive or negative traits regarding the environment. Many students commented on the "nice facilities" of their school. While one student reported to like his school because of the "green and tidy environment," other students expressed dissatisfaction regarding noise levels and general disorder. One student stated, "I don't like students who make noises in class and come to other classes and prevent others from studying, even though there are school rules for them to follow but they remain the same." The noise, disorder and lack of consistent implementation of rules have a negative impact on student satisfaction at school.

Quantitative student survey data indicated that less satisfaction with the school environment is significantly related to higher rates of student mental health problems. No differences between boys and girls emerged regarding perceptions of school environment. Students in Ha Noi were the most satisfied with their school environment compared with students from other providences.

6.2 School Engagement and Teacher Support

School engagement includes factors such as student connection to teachers, student connectedness, academic engagement, whole school connectedness, culture of equity, and parent engagement.

While some students shared that they felt supported by teachers, the majority of students reported feeling disconnected from teachers. Some of the concerns focused on a lack of learning support. In Ha Noi, students felt that teachers often only quickly reviewed basic material before focusing on advanced content. Students in the group discussed how they often don't understand the basics and then have to struggle to review that content on their own using the internet. When asked if they can share with their teachers about needing more support they expressed worry about how they would be perceived by teachers.

When asked about going to teachers for support with socioemotional problems, students expressed a number of reservations. They do not always feel connected to teachers. As one student shared, "Between me and the teacher, it is a very long distance." There was also a concern that teachers would not understand their problems and would just say "Yeah, stay strong." Another student shared a concern that they would be perceived as weak by teachers stating, "I think the teachers would think this problem is comical because they don't understand why normal things make me feel pressured." And students shared concerns about their teachers' time, "Teachers are pretty busy, so we don't want to bother them with our little private matters."

Principal, district-level administrators, and ministry-level experts often shared concerns regarding student school engagement and relationships with teachers. One DOH administrator from Ha Noi described two schools with very different school climate, "In one high school, teachers are more open. Students can talk to teachers like their friends. When they talk to teachers, they are open and free to speak out their opinions. On the other hand, when we worked with [the other] school students were excited and talked openly until teachers came in. When teachers came in, they were quiet. They didn't talk and teachers had to ask questions and call out a name to answer those questions. They were too shy to express their opinions. So…I think that teachers and parents have an impact in students' mental health."

Several administrators shared concerns that teachers lack time and support for developing

relationships with students. As one administrator from Ha Noi DOLISA stated, "When I think back to our time, teachers could know each student's family situation very well. But now, if I were to talk about the homeroom teachers, I think that would be too big of a requirement for the teachers because the pressure of teaching is so great." Other administrators shared that this problem is compounded by large class sizes that make it difficult for teachers to get to know each student.

Student survey data provided evidence that students who feel less engaged in school (i.e., less connected to teachers, to other students, less whole-school connection) have higher rates of mental health problems. Importantly, girls reported feeling less engaged in school compared to boys. Students in secondary school report higher levels of school engagement compared to students in high school. Students from Dien Bien reported the least school engagement, while students from Dong Thap were the most engaged.

6.3 Peer Relationships and Bullying

Students generally reported feeling safe and having good friendships at school. They acknowledged that arguments and problems can happen among friends, but shared strategies for managing those problems including apologizing and taking time to cool down before "making peace." Students spoke about the importance of friendships and shared difficulties navigating problems with friendships. One student said, "We are kind of in the ongoing period of psychological development, so even a small problem or a misunderstanding between friends can cause a break in the friendship. So, every time the friendship breaks it's a very difficult thing to overcome. Sometimes tears can appear, especially when we believe in friendship." When peer conflicts occur, they have a negative impact on student's experience at school. As a student in Ha Noi shared, "There are some friends who are constantly having conflicts with each other. It makes the class lose its unity and makes us who do not participate in that it, makes us more stressful."

Teachers agreed with students that peer relationships are an important factor for student well-being. Like students, teachers shared that some students have peer conflicts that leads them to disengage from other relationships and from school, and to feel isolated and despondent.

Students and teachers agreed that physical fights among students rarely occur at school. While students appear to generally feel physically safe at school, students may not always feel emotionally safe. Students shared many examples of bullying among peers. One student stated that a classmate was "boycotted and abandoned by everyone in the class" for several months. After a period of time a teacher advised students to be kind and inclusive towards the targeted student. This informal support from the teacher was appreciated by the student participant. But she reported that (a) many students do not feel comfortable sharing with their teachers about social or emotional difficulties and (b) no other school support was provided to address the bullying or to support the victim. Students from many schools also reported this type of "boycott bullying." A student in Ha Noi shared a personal experience, "When I was in 6th grade, I was bad-mouthed behind my back by everyone. They talked bad about me like… they thought that my mother gave my teacher a gift and that was why the teacher favoured me. They said bad things about me... that my parents bribed. Honestly, I felt very hurt."

Student survey results indicated that student perceptions of school as less safe were significantly associated with higher rates of mental health problems. Data also showed higher rates of bullying in secondary school compared to high school. Students in Ha Noi reported higher perceptions of school safety compared to students in the other three providences. Students in Gia Lai reported significantly less school safety compared to students in the other providences.

Teachers disagreed amongst each other on the frequency and impact of bullying. Some teachers reported that there is very little bullying at school, while others saw it as a frequent occurrence. A teacher in Ha Noi shared a story

of peer conflict in a class involving bullying. She believed that teachers and parents successfully intervened to resolve the problem. She reported that such experiences were normal in childhood, and that children often learn and grow from these experiences, "The time when the children were apart, they were not close, and talked badly about each other. That is very normal for children. Then later it will become very useful lessons for them. They must learn how to live in the group, must know how to accept other people's differences."

Students were particularly upset about bullying that focused on how a student looks. They said that students are often teased for being "fat" or "short" with girls most often targeted. One student described the experience, "Like teasing you until you get frustrated. To the point where you are crying. Then feeling helpless. You feel like you can't do anything about it." They reported that while both boys and girls tease girls this way, it is mostly boys who do this type of teasing. When asked why they think boys tease girls this way, they thought the boys enjoyed hurting the girls' feelings, stating, "Like, they laugh out loud when they see someone sad. They laugh over the sadness of other people."

Cyberbullying is also a serious problem for students. All the students reported use of the internet and social media and many students reported observing both friends and strangers being bullied online. Student survey data explored the issue of cyberbullying with the item, "Have you ever been cyberbullied?" Most students (47.3%) report that they have never been cyberbullied. About 30% of students have only "rarely" been cyberbullied, 20.2% report "sometimes," and 2.1% have "often" been cyberbullied. No significant gender differences or providence differences were detected. Cyberbullying frequency and associated distress differed significantly by school level. High schoolers are significantly more likely to experience cyberbullying and report significantly more distress related to cyberbullying compared to students in secondary schools.

Principals and education administrators shared concerns about cyberbullying. A principal in Ha Noi described that students, "call out each other, beat each other or insult each other or gang up on each other online. An "online gang-up" is when our students gather online together to smear, to insult, to aim at only one person. And all of that affects the psychology of both the person being attacked and the ones who actively attack."

6.4 School pressure

6.4.1 Academic Pressure

Students all reported experiences of academic pressure and the FGDs explored the nature and impact of the academic pressure. A few students believed that the pressure was helpful in motivating them to study with one student saying, "I think without the stress accompanied by studying, I wouldn't have had the attention needed to focus on studying for the highest score." However, most students described being overwhelmed by the pressure and stress and believed that the pressure has a negative impact on their health and academic performance. Students expressed high level of stress related to workload, pressure from teachers and parents, exams and extra classes.

Most teachers who participated in the FGDs expressed concern regarding the amount of academic pressure students experience, and the impact of that pressure on their mental health and well-being. Teachers report sources of academic pressure including workload, pressure from competitions and exams, teachers, parents and student self-expectations. Teachers noted age differences in causes of school-based stress. They reported that younger aged students have anxiety related to adjusting to new a school environment which includes more classes and work, and to trying to make new friends. Older students experience pressure related to making important life decisions and preparation for taking specialized exams. As one teacher said, "Their choice here is crucial in order for them to have the best turning point later in life, which can be very stressful."

Gender is a significant factor in students' reported academic pressure. Survey results indicate that girls experience significantly higher levels of academic pressure including

pressure to study, worries about grades, self-expectations, and despondency regarding academics. This is in spite of similar perceptions of academic workload among boys and girls.

School level also impacts experiences of academic pressure. Findings suggest that high school students report significantly more academic pressure compared to secondary school students. The academic stress comes from pressure to study, self-expectations, workload, and their experience of greater despondency. Students from different provinces show significant differences in academic pressure experiences. Adolescents report higher levels of academic pressure in Gia Lai and Ha Noi compared to Dong Thap and Dien Bien provinces.

6.4.2. Workload and Academic Pressure

One cause of academic stress is the workload required to obtain good grades. Almost all students, from both rural and urban areas, agree that the workload is too heavy. As one student from Ha Noi jokingly shared, "I have a law called the 'Law of Endless Schoolwork.'" She explains, "I cannot have much entertainment. I have extra classes, then every Saturday morning I have to do the homework of the week. Sunday I also have extra classes."

The high workload is reflected in student survey responses regarding time spend **studying** outside of school. Results indicate that over 50% of students are studying more than 2 hours after school each day, with 28% of students reporting more than 3 hours of study each night. Students are also spending a significant amount of time in private tutoring or extra classes each week. While about 50% of students report 2 or fewer hours of extra classes or tutoring per week, the other 50% of students report more than 3 hours per week, including 15% of students spending more than 9 hours a week in extra classes/tutoring.

Teachers share students' concerns regarding the heavy workload and the consequent lack of time for other activities. Many teachers felt that the high student workload prevents them from learning important skills. A teacher in Dong Thap shared, "Nowadays students' life skills and soft skills are not as good as ours. They can't swim in the river as well as us. I don't know if this metaphor makes sense, but it is a fact that students nowadays are just like industrial chickens. We make them study all the time and that's all they know. They have no ideas of other things. [This other teacher] cares about her child and her child can play piano, communicate with peers, and play sports to improve her physical health, which is a very good thing. I think that parents and teachers, like us, should also give children some time and space to do something else besides studying."

6.4.3. Academic Pressure from Teachers

Many students expressed anxiety regarding teacher reactions to students' poor performance. When students do not perform well, they reported that teachers are "unhappy," may "shout," and "make comparisons." Students seemed especially distressed when teachers compared them to other students who performed better, stating this this felt "unfair" and made them feel "sad." One student explained their reaction to this by saying, "teachers often ask difficult questions belonging to the gifted classes, and when you can't answer that, it leads to comparison with other classes and resulting in students feeling hatred towards that teacher, and when their class comes, no student wants to raise their hands." Teachers' negative reactions to student performance can decrease student engagement and academic success. As one student stated, "When we are stressed, we don't feel good, or feel anxious when you have to recite the lesson to the teacher since you are scared of having bad answer and making teacher unhappy."

6.4.4. Academic Pressure from Parents

Students also discussed the stress of parental academic pressure. Many students reported that parents pressure them succeed and have high standards that reportedly stress the students to "study 24/24." As one student described, "My parents don't force me, but a lot of the time my parents have expectations. So often when I have low scores my parents don't scold me but I feel I have let them down. Those things make me stressed out." Another student stated, "I usually get stressed due to scores since my parents want me to achieve

Two Schools, Two Approaches to Learning:

A Comparison of School Models and Student Well-Being

Teachers from two schools in Ha Noi shared views indicating different perceptions and approaches to academic pressure and workload. Teachers at one school expressed concern regarding academic pressure sharing, "Teachers are really concerned with students' mental health since they understand that students cannot study well while feeling stressed and I especially don't want them to feel pressured." Teachers reported giving minimal homework that allowed students to review and explore class topics but did not overwhelm them with work. They described thinking creatively about homework. For example, a Chemistry teacher spoke about "assignments dealing with experiments that encourage them to follow the evidence and observe real life phenomena" that students could share with the class via videos. Still, teachers at this school expressed concern for the amount of studying students do, and wondered if it could ultimately have a negative impact on learning. As one teacher stated, "I remember studying much less than students do now and I played most of the time actually. I felt like balancing my time between study and entertainment surely made me absorb the knowledge better and more efficiently. However, when I look at students nowadays, many kids are seen studying all the time, from dawn till dusk." Teachers in this school believed the structure, curriculum and teaching approach at their school reduced student stress. Students are in small classes that are not organized by merit or rank so there is less competition among students. The school nurtures their strengths and encourages them to study and major in subjects that they are good at. The school offers clubs and activities to help students cultivate interests and skills, including leadership, teamwork, and organization.

This approach to academic pressure and workload is different from the approach of another Ha Noi school. Teachers in the focus group from this school do not see academic pressure or stress as a problem. Teachers at this school believe that only a small number of students are significantly impacted by stress. As one teacher stated, "When that situation does happen, their teacher, family and friends will help them quickly to avoid the situation and help them quickly return to their jolly, normal state." Teachers here do not see that stress impacts learning very much. As one teacher described, "In regard of learning ability, [stress] will have little effect, tiny effect, and mostly unmentionable, and the students will overcome it quickly and not get affected much." Teachers are aware of the large workload placed on students at this school and see this as necessary for students in a competitive school. As one teacher states, "About my school, it is one of the top schools of the city, and of course, if they want to excel in school then certainly the intensity and quantity of work will definitely have to be more than other schools. The time spend for studying is a lot, almost all week, even Saturday and Sunday they still have to stay at home. They rarely go out and on weekends they use the time to attend extra classes."

Teachers here see that some children struggle, but do not necessarily identify that this can be caused by stress or mental health problems, or that the stress and failure can lead to worsening mental health. For example, one teacher reported, "From what I see, for example in the Excellent Student Contest, they are very stressed, worried, feel pressure about this exam, worried about the percentage of students who win this. The knowledge they must learn is huge, but they are extremely determined. Those who have the strong determination and great effort, they turn the stress into motivation to overcome that stage in a very excellent and spectacular way. But others who have weaker personal competence, their self-control is poor. Sometimes after even small failures then they suddenly fail. With good support and good determination, if they are closely supported, they will overcome this problem well and the destination will be very fruitful. But if [they get] a little neglected, for example, if the parents neglect them and they themselves are not resilient enough, they will slip and fall harder. Then it will be difficult for them to get back on track."

The contrast between these two schools demonstrates two very different approaches to school curriculum, teacher-student relationships, and educational objectives. It is clear that the school culture of the first school places student-teacher relationships and student well-being at the center of the school curriculum. This approach is likely to provide greater socioemotional support for more students, thereby enabling more students to positively engage and succeed in school and beyond. Educational administrators and leaders may consider these, and other, models as they work to meet educational and vocational goals.

a certain score and getting an Excellent title." A student in Ha Noi said, "I don't have much time to take a break, because I'm really weak in math right now, so after finishing school my dad always makes me go do math." All four 8th grade students in the Dien Bien student group reported feeling pressure from their families regarding their future plans. The students shared that they "dream about becoming something, and then trying" but perceive that their parents are not interested in their dreams. Parents, from their perspective, "lead us to do what they want" and the children must "study to become what parents want." They shared that parents want them to "work-in-an-office kind of jobs" in "places that we can easily get into because parents have connections there." Unfortunately, the students agreed that these tend to be "places that we don't like."

6.4.5. Systemic Causes of Academic Pressure

Administrators and experts from education, social and health sectors discussed underlying systemic causes of academic pressure. Almost all key informants expressed concern regarding the impact of academic pressure on adolescent mental health and well-being. An expert from DOLISA in Ha Noi noted that academic pressure comes from parents, teachers and students and noted that the educational curriculum does not teach children how to solve problems, including how to cope with school stress. The underlying systemic problems were described as an "achievement illness" within the school system. An expert from MOH agreed and expressed concern regarding the school curriculum. This expert believes that the curriculum is too focused on intensive exam prep at a young age and student competitions. When describing how the competitions impact student workload, pressure and quality of education, he stated, "It's obviously a credit-driven system. It brings good reputation for schools and puts pressure on students."

Teachers and administrators explored underlying causes of teacher pressure. DOET administrators noted that the system for teacher performance evaluation leads to increased academic pressure on students. Teacher performance is based on student achievement and the system includes competition between teachers for teacher rewards and promotions. As one DOET expert noted, "Just imagine the scenario where teachers are required to possess high achieving students in order to level up class ranks and then some classes get ranked lower just because some students were not able to make it and then somebody judges you and your performance. It is hard indeed." Higher rates of school enrolment contribute to this problem as more students mean it is harder for students and teachers to achieve top ranking placing both students and teachers under increased pressure. A DOET administrator from Ha Noi agreed and shared her previous experience as a teacher stating, "I was mainly concerned with student achievement and I had to resort to discipline in order to push students no matter what it takes so that they can finish assignments on time. Little did I care about their emotions and all that I cared for in the short term is assignment completion." She believes this teacher mentality continues to this day and strongly contributes to the academic pressure put on students.

6.4.6. Impact of Academic Pressure: Mental Health and Well-Being

Students provided a great deal of evidence regarding the negative impact of academic pressure, including stress and other mental health problems, poor concentration and memory, lack of sleep, and social problems. Of primary concern is the relationship between academic pressure and student mental health. Correlational analyses from the student survey data indicate a highly significant, moderate-to-strong relationship between student experiences of academic pressure and student reported mental health. Study pressure, worry about grades, despondency related to academics, self-expectations, and workload were all significantly related to all mental health problems. There is a strong relationship between total academic pressure and total mental health difficulties. As correlational analyses cannot prove the direction of the relationship, it may be that (a) academic pressure may influence student mental health, (b) student mental health may influence student experiences of academic pressure, (c) they both may influence each other or (d) something else may influence

both academic pressure and student mental health.

Students in Ha Noi report high levels of academic pressure and shared many examples of the negative impact of academic pressure on their mental health and well-being. One student shared, "When we are so stressed, we don't have time to exercise or walk or relax. Even if it weren't for the epidemic, we wouldn't be able to go anywhere comfortably. Because now wherever I go I have to think about my homework. I think about it all the time – school, homework, and stuff. When there is too much work and I can't do it in time or something is lacking, it's pretty scary. I have a fear of being scolded by teachers or parents. When I'm stressed, I can't sleep peacefully. For example, if it's before the exam, when I study the subject of literature, when I sleep my head is still thinking about literature. I can't sleep." Other students note that they study so much that their mind often wanders and then she isn't able to concentrate. She can sit for many hours and still not get work done.

Teachers shared a number of examples of academic pressure leading to poor mental health and functioning problems. Teachers in Dong Thap spoke about the link between academic pressure and mental health, and believed academic expectations should be tailored to individual student's ability in order to engage them in school successfully. A teacher in Ha Noi shared, "Last year I had a student who specialized in Chemistry. At first, they had high hope for the Excellent Student Contest but due to the heavy pressure they put on themselves during the revise phase, it backfired, and they got too stressed out. They were heavily stressed and couldn't overcome it. It took parents and teachers a lot time and effort before the entrance exam to high school to help them to find out where they want to go."

There is widespread concern among administrators and experts regarding the impact of academic pressure on student mental health and well-being. An administrator from Ha Noi DOLISA expressed concern about burden of academic pressure and workload stating, "The children are under too much pressure so they worry, they are stressed, they can't eat, and they can't sleep. That's why a lot of students - I know there are a lot of them – a lot of students after the exams are very depressed. It's really not worth it for the children, I think." An expert from MOET agreed with this concern and shared a personal experience of a friend's child who was a good student but when it came time for the university entrance exam she struggled to study, "At that time she was feeling a down and had low self-esteem. And after that, she withdrew and didn't interact with anyone. If [parents and teachers] had discussed her difficulties and helped her on another path she could have found a different direction. Now this person is a mental patient who is being treated for a long time at the hospital. If she had received timely intervention, at that stage, I think she would have been a different person, not a mental patient like now."

Experts were concerned about the high levels of academic pressure placed on students in competitive schools. An expert from Ha Noi DOET shared that students at a local competitive school are "blacklisted" if they don't finish all their homework, meaning that those students are reported to the school and parents. He asked, "Don't you think that is a bit too much pressure? It would be fine if students were able to manage all that but in real life even outstanding students had their unsatisfactory moments and failures. That leads to disappointment and negative thinking. They end up losing motivation and being pessimistic. They hate things and avoid things."

Students also shared how academic pressure and related stress negatively impact their learning and academic performance. Students discussed how they sometimes study very hard only to find they have no memory of the information when it comes time for the exam.

High school students report higher levels of academic stress. Many students reported staying up until 2 or 3:00am nights before an exam. Students reported that the stress of studying for exams made them feel "restless" and "tired". One student reflected, "I find it hard sometimes since studying for exams gives me restlessness despite my effort to study all there is and be prepared but somehow I still feel restless and later sleepy in the morning."

Many students reported that they do not get enough sleep. One student shared, "Normally, I sleep between 2 am and 4 am, or 1 am to 5 am. So, in class I can't concentrate. I'm too tired to write. It's getting worse. I actually feel like I cannot keep up with things." He stated that he is noticing difficulty concentrating in class and remembering things. A secondary student from Dong Thap noted "When I'm stressed, I'm usually tired and I don't want to talk much with other people, which makes other friends in the class poke at me and I don't like that."

6.4.7. Impact of Academic Pressure: Student Learning

Along with concern for student mental health, participants expressed concern that academic pressure had a negative impact on student learning. A DOLISA administrator from Gia Lai finds that schools now only care about academic achievement, which has a negative impact on students' intrinsic interest in subjects and passion for learning. She stated, "Some schools now are achievement-oriented with many teachers putting pressure on students. [Students] study as they should but are not really conscious or invested in their study. Students these days I found many of them to be not as good as the generation before."

A number of participants expressed concern about the impact of lack of sleep on student learning. A principal in Ha Noi expressed concern about the link between lack of sleep and poor emotion regulation and learning. She stated, "The biggest problem of students is not having enough sleep. And at this age, when [they] do not get enough sleep, it will lead to sluggishness. They are almost always in a state of sluggishness and drowsiness. They are unfocused. And when this state lasts for a long time, it leads to very negative reactions. They become easily angry, quick tempered, and even less focused on learning. And when they are not concentrating, their school results are not high."

6.5. Family-related Factors

6.5.1. Family Risk Factors for Poor Mental Health and Well-Being

Key informants expressed concern regarding other risk factors for poor student mental health, including family factors. Family-based risk factors include family economic stress, parental neglect, family conflict, and lack of parenting skills.

Participants observed that family economic problems place students at risk for socioemotional problems. Administrators and experts noted that financial stress in families can cause children anxiety and impact their school performance. Family poverty can also result in student low self-esteem. A DOET administrator from Dien Bien stated, "you can see how students who want to integrate into social life are stopped by the lack of financial support. For example, if they want something that would take some money to buy it ultimately pushes them to shy away more. They try to recoil into themselves."

Several principals and administrators identified parental neglect as a potential risk for adolescent mental health problems. They expressed concern that parents often had to prioritize work or business over spending time with their adolescent children. One DOET administrator noted that parents are often focused on business and other things, and do not always consider it important to listen and empathize with their children. A DOLISA administrator agreed and shared, "The most important thing is still the time that the parents spending with the child. Parents don't have time to spend with their children, so they just give out a phone for them. That is a root cause of the children's mental health being affected." The DOET administrator believes more research on parental risk factors is needed, along with training for parents on their children's mental health and well-being needs.

6.5.2. Parental Mental Health Knowledge and Support

Teachers and administrators from several provinces noted the importance of parental engagement in terms of supporting students with mental health concerns. As one teacher in Ha Noi stated "I find that even for the students who do not have any major mental health problems, the coordination and concern of

the parents for the child's psychology is the most important thing. If the parents care, as soon as there is a very small sign of change in the psychology of the child, early intervention will be effective immediately. But if the family doesn't understand the problem then it becomes a big problem."

Many participants were concerned about parents lacking knowledge and skills regarding adolescent mental health and well-being. A participant from Ha Noi DOLISA expressed concern for parent mental health knowledge stating, "The problem is parents lack skills to be able to accompany the child, to discover their problems, to spend time with the child. The pressures in life and the problem of making money is a problem, but also in very rich families there is not much time for children. [Parents need] to understand why the child is having psychological changes in order to be able to understand and help them. To do all that, the parents must have knowledge."

6.6. Technology-Related Risk Factors

Many participants expressed concern regarding the amount of time that students were spending using technology, including time spent surfing the internet, gaming and social media. Concerns exist regarding both the impact of adolescent exposure to negative or unhealthy content and the impact of the amount of time spent using technology rather than engaging in real world interactions with peers and family. A DOET administrator remarked that adolescent mental health problems are "intensified by the impact of technological advancement, the dark side of devices such as smartphones, video games or social media. All of these things can severely affect the mental health of students."

6.7. COVID-19, Mental Health and Well-Being

All stakeholders expressed concern regarding the impact of the COVID-19 pandemic on student mental health and well-being. Concerns included the impact of social restrictions and isolation on student psychosocial development and the impact of online education on student mental health. Students reported concerns about social isolation during COVID-19. A student in Ha Noi shared, "When staying at home, the number of people I communicate with is more limited, because there aren't many people the same age as me there. It's like my feelings are not being best understood."

Teachers and school administrators were also concerned about the pandemic's impact on students. Concerns included social isolation, lack of access to normal healthy developmental activities, and the impact of the pandemic on the exam schedule and resulting student stress. A teacher from Ha Noi reported, "Studying online means in many cases you are at home most of the time, which prevents you from going out much and therefore causing more stress, which is worsened by the increasing loads of work due to COVID impact." Likewise, a principal in Ha Noi expressed concern about the impact of the pandemic on socioemotional development and learning. The principal reported that children who enjoy sports and arts are suffering more as they don't have those outlets and opportunities to achieve and be recognized by peers and adults for their talents. S/he is concerned that many students are losing confidence in themselves during this time.

There is specific concern for senior students as they prepare for university exam and admissions. An expert at MOET shared, "due to the influence of the epidemic, senior students are very worried when taking the high school graduation exam or the exit exam, because the epidemic situation have severely affected them. There must be timely intervention. For example, policies to solve those problems quickly like reducing the workload or facilitating conditions for them to take the final exam so that they can go to universities or colleges. Without these [interventions], it will lead to stress or psychological trauma."

6.8. Ethnic Minority Student Risk Factors for Mental Health and Well-Being Problems

Many participants were concerned about school-based risk factors for ethnic minority

student mental health problems. Family socioeconomic factors are recognized to be key risk factors for poor mental health. In Gia Lai, an administrator notes that parental divorce and domestic violence negatively affect students' well-being. S/he also notes that ethnic minority students are often pressured to marry in adolescence and to stay home to take care of their parents. This administrator notes that even highly successful ethnic minority students become hopeless about the future as they are pressured to marry and stay in their village where job opportunities at home are scare. "They see with their own eyes that after education, there is no job opportunities. [They could go to] university and master's degree, but when they go home they stay at home." Ethnic minority student schooling is also impacted by a number of events, including seasonal farming duties and funerals. Administrators in Gia Lai expressed concern that frequent school absences decrease student engagement and put students at risk for drop-out.

An administrator from Gia Lai DOET reports that ethnic minority student mental health barriers include language barriers for many students and families. However, an administrator in Dien Bien finds a lack of socioemotional skills to be more fundamental, "Once they have reached the 5th, 6th grade, their Vietnamese language will be quite OK. The problem remaining is the skill barrier; soft skills in terms of conduct, problem solving, and communication skills not being adequate."

One issue expressed by teachers and school administrators, is the difficulty engaging ethnic minority parents in concerns about mental health. As an administrator at Dien Bien DOET explained, "[One concern] is the parents are mostly from minority communities and therefore unable to understand this issue. That is the case we have and we can see how the mental health problems of ethnic minorities or people in rural areas has been lacking attention." These concerns emphasize the importance of building effective family-school partnerships and increasing caregiver mental health literacy.

Parents of ethnic minority students did not share concerns regarding school climate, academic pressure or adolescent mental health. They did report that exam periods are a time of high stress for children, but found that children generally led a balanced life otherwise. Parents of ethnic minority children enrolled in the Gia Lai boarding school reported intense "round the clock" studying with little time for activities and play. In found this schedule satisfactory and were pleased with the school and it's "military style" structure.

Another concern regarding ethnic minority student risk factors is their geographical isolation. The DOET administrator from Dien Bien explained, "[For the] minority groups, the most notable issue we can see is isolation. Whenever a student studies far away from home, it is harder for them to adapt and you can see the more they try to adapt, the more they grow increasingly shyer, and unconfident."

6.9 LGBTQ Student Risk Factors for Mental Health Problems

LGBTQ students report varying experiences with school environments and related risk-factors. In general, LGBTQ students share common stressors as non-LGBTQ students in that they are concerned about heavy workload, upcoming exams and other sources of academic stress. In addition, LGBTQ students shared sources of stress regarding discrimination and bullying regarding their LGBTQ status. A couple of students in the FGD attended schools that were highly supportive of LGBTQ students. These students were very positive about their schools, with one student sharing, "Because I study at [school], everybody has a very open view about LGBT-related issues, and lecturers care a lot about LGBT students. Most students at the school are not judgmental about our gender identities. They talk to us like normal people." Students in supportive school environments shared examples of teachers caring about students and taking the time to support them emotionally. Other students reported experiencing discrimination at school. One student felt disrespected and misunderstood when a teacher spoke to the class about LGBTQ being a "trend."

Chapter 7:
School-Based Adolescent Student MHPSS Policies and Programmes in Viet Nam

Key Findings

1. Starting in 2005 MOET has established several policies in support of student mental health. These policies direct the development of school counselling programmes, provision of inclusive education for children with disabilities, address the negative impact of the COVID-19 pandemic on student mental health and well-being, and, most recently, promote student mental health awareness and mental health skills via a comprehensive School Health Programme (2021-2025).

2. Adolescent students believe there is a need for school-based mental health support, including professional counselling and general mental health promotion activities. They are reluctant to seek help from teacher counsellors due to concerns about confidentiality and discomfort related to sharing personal information with a teacher.

3. Teachers, administrators, and experts identified current challenges to providing mental health support for adolescent students at school.

    a. School counselling programmes are usually staffed by teachers with limited training and limited time for counselling support.

    b. Schools often lack a dedicated, private space for student counselling.

    c. Stakeholders identify strong, supportive teacher-student relationships as essential for early identification and support for student mental health problems. However, teachers, principals, and administrators see many barriers to supportive teacher-student relationships including large class sizes, lack of attention to the issue within teacher training programs, and lack of prioritization within the educational curriculum.

    d. The secondary and high school curriculum is focused on rigorous and competitive academic classes. Students have few opportunities for life skills, arts, and sports.

4. Related to teachers' ability to support student mental health and well-being is their ability to effectively motivate students and manage classroom misbehaviour. In the past corporal punishment was used to motivate and discipline students. Teachers may still believe in physical discipline or may not know of other strategies for motivating students and managing student misbehaviour.

5. Most principals and DOET administrators recommend the creation of a specific position for a professional school counsellor.

6. Many participants suggested the need for a comprehensive approach to supporting adolescent student mental health and well-being, including professional counsellors, mental health literacy programs for students, teachers, and parents, systems for screening and assessment of students, improving teacher-student relationships, and offering life skills and well-being classes for students.

7. There are many barriers to obtaining professional treatment for students with severe mental health problems, including a lack of community resources and the impact of stigma on parents' attitudes towards help-seeking.

8. Ethnic minority adolescent students have specific mental health and well-being needs that are not yet fully met within schools. These students often experience poverty, discrimination and marginalization related to high risk for school drop-out and poor mental health. School counsellors face challenges communicating with and engaging ethnic minority families.

9. LGBTQ students express a need for professional counselling services at school and would like to see comprehensive sex education school programmes include LBGTQ knowledge to reduce stigma and discrimination towards LGBTQ students.

7.1 MOET Policies

In 2005 MOET issued **Official Letter No. 9971/BGDDT-HSSV** Implementing School Counselling for General Students and Higher Educational Students. This offered guidance for the development of school counselling and prompted the initial development of training in school counselling. Public schools in major urban cities launched school counselling programmes. However, programme development was developed on an individual school basis without research evaluating programme efficacy and without standards for programme development. Furthermore, the number of schools to develop such school counselling programmes was limited.

In 2017, MOET issued **Circular No. 31/2017/TT-BGDDT**, a legal document establishing school counselling in all public schools in Viet Nam. This policy outlines a school counselling programme that functions to support students' mental well-being with a focus on student age, gender, marriage, family, adolescent pregnancy, morale, wellness, relationships, learning skills and career development. The policy also states that experienced teachers with school counselling skills can take the role of school counsellor and provide mental health counselling to their students, in addition to their main teaching duties. Teachers taking on the role of school counsellor must be provided with relevant professional development by the DOET, Schools of Education and psychological experts. Moreover, Circular 31 sets policy guidelines for the establishment of school counselling facilities in every school in Viet Nam.

Related MOET policies address education for students with disabilities. **Decision 338** from January 2018 issues the comprehensive Education Plan for People with Disabilities for the 2018 - 2020 time period to advance inclusive education goals. **Decision 1438** followed in October 2018 and issued goals for the 2020-2025 time period to further advance protection, care and education of children with disabilities nationwide. While these policies may provide for children with severe mental illness, they focus primarily on physical disabilities and would not be relevant to most children with mental health problems.

Directive No. 31/CT-TTg of the Prime Minister dated December 4, 2019 establishes policies for strengthening ethics and lifestyle education for pupils and students. While not directly related to mental health, the development of lifestyle education may include aspects of mental health life skills education which offers important universal mental health problem prevention strategies.

MOET policy has also supported the mental health of students impacted by the COVID-19 pandemic. **Directive No. 800/CT-BGDDT**, dated August 24, 2021, of the Minister of Education and Training directed the implementation of tasks for the school year 2021-2022. This policy directs the Education sector to carefully attend to student mental health and well-being in consideration of the impact of the pandemic, and to develop support for students in need. Further consideration of student mental health and well-being needs was addressed in **Dispatch No. 136/CD-BGDDT** dated February 8, 2022 regarding support for students when they were to return to school after a long period of online learning due to the pandemic.

An important policy regarding cross-sector collaboration for support of student mental health and well-being is **Decision No. 4969/QD-BGDDT** dated December 30, 2021. This policy issues a plan for developing social work in the education sector during the period of 2021-2025.

A comprehensive School Health Programme for the 2021-2025 period was developed by The Ministry of Education and Training (submitted to the **Prime Minister Decision No. 1660/QD-TTg** dated October 2, 2021). The content of the programme focuses on the care, protection and management of students' health, including assessment of risk factors for mental health, strengthening communication and health education, improving students' knowledge about mental health, and providing developmentally appropriate counselling on psychophysiology and mental health in schools. **Decision No. 4659/QD-BGDDT** dated December 14, 2021 of the Minister Education and Training issued a plan to implement **Decision No. 1660/QD-TTg**

dated October 2, 2021 of the Prime Minister promulgating the School Health Programme for the period of 2021-2025. The Prime Minister approved the School Health Programme for the 2021-2025 period in **Decision No. 85/QD-TTg** dated January 17, 2022. One important aspect of this Programme is a plan to link school health programmes with community health care services in order to improve the quality and effectiveness of student health care activities. A MOET expert shared that this Programme will promote mental health awareness among students and teaching students strategies for improving mental health and well-being. As the MOET expert noted, "After this intervention programme, the problem will receive widespread attention. [The students] will be consulted more regarding mental health. I think when this programme is issued, the issue of mental health will be promoted more."

7.2 Perceptions of School-Based MHPSS Services and Programmes (availability and effectiveness)

7.2.1 Student Perceptions

Students discussed how their schools support adolescent mental health. Students often shared about **informal teacher support** provided at school. A student from Gia Lai reported, "My teachers would, for example, give us advice if we were to do something not appropriate and encourage us into better performance to alleviate the sadness. The school would help the students reconcile with classmates for amiable friendships and help us alleviate the stress so I can interact with others more freely."

Students also discussed **counselling services** provided by their schools. Students in Dong Thap were aware of a school counselling team comprised of teachers and administrators at their school. However, the students had difficulty remembering which teachers were on the team. As one student put it, the team is "not quite in memory as I have only heard about it briefly." When students in Dien Bien were asked if their school had any resources they said "Yes. Miss [name of the teacher] and another teacher. She told us to talk to her if anything happened. But no one did." They reported that they thought that students would meet the teachers in person if needed but did not know anyone who had met with the counsellor teachers. Students in Ha Noi were not all in agreement about the school counselling services. While some students did not know about a counselling room and service, two students were confident that a room existed and that a Civic Education teacher provided counselling services. When asked if they might use the counselling room in the future if they needed support, students generally agreed that they likely would not. Reasons included fears that what they share would be shared with others and because it would be "embarrassing."

7.2.2. Teacher Perceptions

Teachers in Dong Thap describe a counselling service involving head teachers and the principal offering weekly counselling meetings. These teachers also recognized that teacher-student relationships are key, and that teachers must know each child and tailor instruction to the strengths and needs of each child.

Teachers in a semi-public school in Ha Noi reported that their schools have a psychological counselling room staffed by a teacher with some counselling training. They shared that students use the counselling services and believe the counselling teacher and school are dedicated to supporting students psychologically. They understand the counselling is confidential and believe that all students are aware of the room and counselling service. One teacher reported, "This year, the school will hire a full-time staff who specializes in mental health work, rather than part-time. I think hopefully it will be more effective." Beyond the counselling room, teachers did not identify other formal programmes for student mental health support stating, "There hasn't been any typical programme specialized in supporting student's mental health problems. Most of the time, school administration only functions through one consultant room represented by the Department."

Teacher quantitative data regarding school resources and programmes for student mental health and well-being finds that 81% of

teachers report knowledge of policies and/or basic programmes for student mental health, including school counselling facilities and the school nurse. When asked about details of programmes, some teachers shared about scholarship programmes for poor students, and about sexual reproductive health and social skills education. When asked if existing resources and programmes were adequate for supporting students, 58% of teachers said they were not. See details in Appendix 3.

7.2.3. Principals, Administrators and Ministry Experts' Perceptions

Principal interviews made it clear that programmes and services are provided inconsistently across the country. A principal in Gia Lai was unfamiliar with MOET policies regarding student mental health. When asked about support or programmes for students with socioemotional needs, s/he shared about the extracurricular programmes and activities offered at the school

A principal of a school in Ha Noi believes her school provides effective socioemotional support for students. This principal reports on the school counselling room and service, but focuses on how school class structure and curriculum support students by prioritizing teacher-student relationships and a supportive school culture. Homeroom teachers have two periods with students each day so they have stronger relationships with students and are able to observe students closely and recognize signs of problems early. The school is also able to have smaller class sizes which allow for improved teacher relationships and observations of emerging difficulties. As this school is an experimental school, the principal acknowledges that the school is able to adopt this approach while other schools are not.

Another Ha Noi principal identified three components to the school's approach to supporting the mental health and well-being of adolescent students including a counselling room and service, teacher relationships with students and families which allows them to provide informal counselling support for struggling students, and changes to the curriculum that are designed to provide more psychological support for students. The principal describes, "First, every school in the city has a counselling department. The second thing is the support from teachers, who are close to students and their family. Teachers have counselling skills. They are not specialized in counselling, but they have experience. The fact that they give advice and talk to students and parents is an effective way of support. The curriculum system from 2018 has been changing related to tests and evaluation. There are improvements in the curriculum that support students better psychologically. There are activities that support students psychologically and [improve] their skills."

DOET administrators agreed that a fundamental aspect of school-based student support is the relationships between teachers and students. Students must have trusted teachers whom they can go to if they are in need of support.

An expert from MOET expressed confidence in current mental health and well-being programmes, and in the mental health support available to adolescent students. The expert shared that there already are many programmes including "counselling on health and on physiology, in addition to training regarding students' learning. On the subject of organizing and adding activities to support mental health for students, there are very successful ones related to clubs, for example sports-related clubs or health clubs or extracurricular activities or face-to-face conversations. Life skills education can also help children first develop their talents and interests, secondly let them balance between learning and entertainment, so that children can have a comfortable learning spirit which means they are both physically and psychologically comfortable so that they can study effectively in the best way." The MOET expert reported that schools have counselling rooms, counsellors, coordination with parents and teachers for "timely support of students", extra-curricular activities such as life skills education lessons. They also noted that some schools are able to work closely with the medical unit for student mental health screening so that they can offer timely counselling for students. The expert shared a goal of expanding screening capacity around the country.

7.3 Teacher and School Leadership Perceptions of School and Teacher Capacity to Provide Student Psychosocial Support

Teachers expressed concern and sensitivity for students in need of psychosocial support. They shared examples of situations when they were confused about how to best support students. For example, a teacher in Dong Thap was unsure of how to help a struggling student, "In my class, there was a student that acted as if she suffered from autism. That student hardly ever spoke in complete sentences, and sometimes when she looked at a math problem or a paragraph on the board in class, she understood it but always spelled and wrote it down incorrectly. Sometimes I stood next to her and told her to rewrite the sentences, and she made the same mistakes again. When I contacted her parents for cooperation, they said that she was just like that at home." The teacher's confusion regarding the nature of the student's difficulties and how best to support her reflect a lack of capacity.

Other **teachers reported lacking skills** for motivating students. One teacher shared about how teachers used to be able to spank students to motivate them and now that is not permitted. This teacher reported difficulties finding new ways of motivating students and managing the classroom.

School counselling rooms are most often staffed by a teacher who has received some basic training in student counselling. The teacher who provides that service at a school in Ha Noi was in the FGD and shared a bit about her experience. She reported that she has many students coming for support, often regarding life problems and difficulties communicating with others. She connects with students in person, over email or via messaging apps. She expresses that her role is often to listen and share and give guidance, and to be available for students when needed and over a long period of time. She believes it is this caring and supportive relationship between her and students that allows them to overcome challenges and emotional difficulties. Beyond this counselling service, teachers in this group agreed that there was no specialized mental health programmes for students at the school.

A primary barrier to effective counselling service at schools concerns the issue of **teacher-counsellors' time**. Teachers at a school in Ha Noi noted the limitations of the counselling services provided; "I think the consulting service at my school has existed for 1 to 2 years. Students have been given basic mental support but the time for counselling tasks has been quite limited due to the counselling teacher having to teach in many classes."

Administrators also expressed concern regarding **teacher capacity** to provide mental health support. A DOET administrator from Gia Lai described problems with teachers' attempts to provide informal support, including difficulties accurately identifying students in need, and inconsistently engaging family. This expert also found problems associated with the current counselling service provided, including that the counselling programme is not properly and consistently staffed due to teachers being assigned counselling duties when they have a gap in their schedule. This results in inconsistencies in the counselling team which undermines student trust and relationships with counsellors. Another key problem identified is that the teachers assigned to counselling do not receive proper training to take on the role. The Gia Lai DOET administrator noted that funding is an underlying problem since schools are not provided funding for training.

DOET administrators shared concerns regarding **teacher training and the curriculum** lacking support for students' mental health and well-being. As one administrator from Ha Noi shared, "I have studied teaching methodology class in college the most they teach us is how to teach lessons so that students understand and not so much to do with caring for students unfortunately. The class goes into teaching various steps including first stage- class greeting, step 2-lesson review, 3- teaching new lessons and then the last step is testing and assessment and then one more task is concluding the lessons then greeting. That is pretty much it. That is what happens in classes and what us teachers do actually." She also shared concerns about teacher training

in classroom management strategies, stating that, "People still have the impression that if you spare the rod, you spoil the child. Yet it is indeed more humane to think that with love and compassion comes better results and overall more positive outlooks."

A MOET expert shared barriers to school-based mental health including a lack of facilities (including private counselling rooms) and the lack of adequately trained human resources for counselling. The expert noted, "If school staff are providing counselling in schools, question is "whether these "kiêm nhiệm" teachers ("kiêm nhiệm" is the employee in charge of many areas at the same time) are adequately trained or not. If these teachers don't have adequate training or counselling abilities as well as mental health knowledge, this will be a limitation."

Teacher quantitative data indicate that most teachers feel confident in their basic knowledge about student mental health, although a sizeable group (about 36%) believe they do not have enough information about mental health. Teachers also largely agree that identifying and supporting students with mental health problems is part of their role.

When asked about training in adolescent student mental health, most teachers (86.4%) report that they have received no training. See detailed survey results in Appendix 3.

7.4 Student, Teacher and School Leadership Perceptions of School-Based MHPSS Needs

7.4.1 Student perceptions of school-based MHPSS needs

When asked about what else they would want from the school to support their well-being, students stated that they would very much like to have someone designated to talk to at school about their problems and would like a private space to talk about sensitive topics. Students recognized a need for psychological evaluation at school. One student in Gia Lai shared, "I know a friend in my class who kept sitting alone at breaktime, so I decided to go talking with that friend to cheer her up. I think the school administration should examine her psychologically." Other students considered how the school could facilitate discussions on mental health and well-being topics. One student suggested that "the head teacher in the class could organize a period in which there would be a total session spent on having an intimate conversation between members of the class and teacher once a month." And a student from Gia Lai suggested, "I think the school should add more events such as the programme 'Teens Speak' to help students give out their intimate moments in front of teachers and friends."

One issue of concern for teens is teachers' reaction to student relationships and sexuality. One student from Gia Lai shared, "I think the teachers should not have too much problem with the love story development between students as many students consider romantic love as something normal as long as you don't go over the line in any way. Meanwhile, my teachers always condemn romantic love as something really forbidden and evil as they want students to live abiding by the rules in the mindset of students being innocent as they are and not wanting them to go astray."

Students noted that having organized celebrations on a regular basis at school would help reduce their stress and improve moral. Students in Dien Bien would like for teachers to "organize playing activities like sports, propaganda activities, students sharing opinions… things like that." Students in Ha Noi also like activities organized by the school and find that activity days reduced their stress. Students were concerned about vulnerable peers and one student suggested, "I think I would love to see the school organize more entertaining activities on holidays as well as launch a movement on holidays such as Tet Holiday in which students in difficulty could have a gift endowment to encourage them living a normal life like others."

Students also wish schools would reduce the academic pressure put on students and see this as an important issue in reducing their stress. Students in Ha Noi suggested that the school could assign fewer academic exercises to reduce the workload and that teachers should not scold students.

7.4.2. Teacher, Principal, Administrator Perceptions of School-Based MHPSS Needs

Teacher quantitative survey results include teacher perceptions of major barriers to providing more services for children with mental health needs at school. Teachers identified several major barriers, including lack of human resources (like counsellors), lack of interest / concern from parents, lack of training opportunities for school staff, and lack of policy to guide services. See Appendix 3 for detailed results.

School faculty and leadership identified ways to improve MHPSS at schools. Most principals and DOET administrators, including those from Gia Lai and Dien Bien, recommend the creation of a specific position for a **professional school counsellor**. School administrators from every province expressed concern regarding teacher and medical staff motivation and capacity to take on counsellor roles. Concerns included a lack of teacher time due to teaching demands and poor motivation given that they prefer to teach within their specialty rather than take on a new role. One DOET participant stated that teacher counsellor training has been poor due to lack of training opportunities. When training opportunities are offered, they are often of a poor quality with information shared but no opportunities to actively learn and practice counselling techniques. Additionally, models of training a few staff who are then charged with training additional staff are ineffective.

A principal from a semi-public school in Ha Noi shared, "There are two models at schools. The first one is that there will be no professional counsellor. It's a little effective but it's not very effective. Because it's not [teachers'] specialty, they just do it from experience and from what they observe teaching secondary students. The second model is like the model in our school. We hire a trained counsellor to support students. The effectiveness of this model is much higher than the first one."

While Circular 31 prompted great progress towards establishing private counselling spaces in each school, interviews made it clear that many schools are still lacking these facilities. One administrator from a rural province estimated that 70% of schools in the district lack a specific, private room for counselling.

Many participants suggested the need for a **comprehensive approach** to supporting adolescent student mental health and well-

being. They noted the need for professional counsellors but spoke to the need for other programmes as well. Ideas shared included student, teacher, and parent engagement and training in mental health, systems for screening and assessment of students, improving teacher-student relationships, and offering life skills and well-being classes for students.

- Student engagement in mental health programme. DOET administrators expressed concern that students often lack awareness of their own mental health problems and are reluctant to seek help. A related barrier to student help-seeking is stigma. One DOET participant shared, "Another problem is the lack of students coming for consulting. There needs to be more incentives to encourage students and make them feel welcomed. It [may be] the title of the room, 'mental health consulting.' Why don't we change the room title to 'Communication,' or 'Sharing Room?' It looks intimidating to see the mental health term."

- Teacher training in mental health. Several KI participants reported a need for **general teacher training in adolescent mental health**. As an expert from Ha Noi DOET stated, "My wish is to have a course for teachers that delves into symptoms of mental health, early-stage detection, and how to spot subtle signs of mental issues or traumatic events. Teachers should be able to detect early symptoms of mental health problems in order to notify the family and work out a solution."

- Train and engage parents. Teachers and administrators also noted the need for **improved communication and collaboration with parents** in this effort. Teachers and administrators agree that an important goal is helping parents understand their child's problems and support early intervention efforts. A teacher in Dong Thap noted that a major barrier is parent collaboration and engagement when children are developing problems.

- **Teacher-student relationships.** DOH administrators also noted that these problems are often overlooked by parents and teachers. The administrator from Dong Thap reported that large class sizes are a barrier to teacher identification and support for mental health problems, "There are some students who already finish a school year, and teachers still don't know them because sometimes the class is too crowded up to forty-something students. And… some are mentally-ill, like depressed, but like the passive kind."

For specific ideas on how to develop and enact these positive changes, one DOET administrator suggested that the educational sector look to school counselling models already in place. S/he noted that some private schools, including Olympia, Wellspring, and Vinschool, may have already developed professional school counselling programmes. Semi-public schools including Ngo Si Lien in Hoan Kiem and Nguyen Tat Thanh School may also have made progress in this area.

For students with more severe mental health problems who are in need of expert care, participants discussed a need to develop systems for referrals for outside support, and to overcome family and funding barriers in these situations. A principal from Ha Noi reported that a major barrier is lack of funding to support students who need a higher level of care. Currently the school relies on parents to seek outside support. But, as the principal explained, "I've met families who don't understand. They don't see it as a problem. They think it's kind of a misjudgment by the school or the teacher. They think it is a normal expression of a child in 6th, 7th, 8th or 9th grade. They think there is no need overreact, to intervene with the child's psychological problems. When they don't cooperate, the school still has to support the students, but to a fairly limited extent. That is, we can only use our own teachers. If we invite experts, we have to have funding for that and we do not."

Beyond the counselling programme, many teachers and administrators noted the importance of modifying the educational curriculum or culture in order to be more supportive of adolescent student well-being. In Ha Noi, teachers' suggestions included (a)

reducing academic pressure, (b) increasing art and sport courses/opportunities for students, and (c) teaching more life skills. As one teacher stated, "It's about our programme system, how should we reduce it. We can still value it, but we should not attach too much importance to the academic subjects like Literature, Maths, Chemistry, and English leading to a lot of pressure on those subjects. And we have to strengthen extra-curricular activities, like life skills. Those subjects will help students become more mature and they improve their health, like more sports, physical activities to promote the movement, to help them get stronger. And I also want them not only to study well but to be healthy, then their life in the future will be much more successful… That's what I want to be able to help them. My wish to help them to reduce the pressure and increase the physical activities, the artistic activities."

Funding Gaps

While a full evaluation of the funding structure of adolescent student health is beyond the scope of this study, participants often expressed concern regarding the issue of funding. A DOET administrator from Gia Lai reported that, while Circular 31 development of school counselling services, it does not provide funding for this effort. This administer described how funding must come from already tight school budgets which is very difficult, particularly considering a current teacher shortage.

Access to Community-Based Mental Health Resources

Another area of need regarding support for student mental health and psychosocial support is the availability and access to community-based mental health resources. Students were not aware of any local resources for mental health. Students in Dien Bien were aware of a nearby psychiatric hospital but when asked who received help there they said it was for "crazy people," people with "unstable mind," and people who used drugs. When asked if a student who was depressed and suicidal after a poor exam could go to the psychiatric hospital the students were unsure.

Other participants also noted the lack of community-based services to meet children's mental health needs. A district-level administrator in Dien Bien shared that her son exhibited a variety of problems including hyperactivity, disruptive behaviour at school, and trouble concentrating. She describes taking her child to the Central Pediatric Hospital where he was diagnosed with ADHD based on her report of his behaviours. He was prescribed a medication that resulted in him sleeping all day. She then took him to the Special Education Department at the University of Pedagogy where he was evaluated and it was determined he had a concentration deficit. Treatment with a specialist there would have cost a lot of money and require much expense and time due to travel to Ha Noi. She expressed a hope that quality facilities and specialists could be based in Dien Bien so she and other families could receive quality care for their children.

The facilities that do exist lack human resources. In Dien Bien, a provincial social protection centre was built but reportedly has been vastly underutilized due to a lack in staff and human resources. Also, in Dien Bien, there is an Inclusive Education Resource Center which provides basic services for children with autism. According to administrators in Dien Bien, most families of children with problems are unable to be served at the two facilities and must consider taking their children to Ha Noi, an expensive and time-consuming effort.

Stigma is another barrier for families in need of professional psychological care for their child. Many parents are reluctant to seek out psychiatric care for their children in fear of negative social repercussions if the community learns of the child's problem. As someone from DOLISA Dien Bien noted, "[Parents] could bring their child to medical treatment but they also do not want students at school to gossip about their kids' condition." This fear of stigma is major factor in parents' reluctance to seek help for children suffering from mental health problems.

Challenges regarding Ethnic Minority and LGBTQ student mental health programmes.

Particular challenges in addressing the mental health and well-being needs of ethnic minority students were shared by a DOET administrator

from Dien Bien who reported that school counsellors have difficulties engaging and coordinating with ethnic minority student parents. S/he notes, "The school [counsellors] have only been able to cooperate between parents in urban areas. In the age of technology and information, we can communicate through social media platforms such as Zalo, Facebook, which I think the urban area has taken advantage of pretty well. But in comparison, for the ethnic minorities in the rural areas there is a limitation imposed by the geographical setting and from their understanding of the [Vietnamese] language and information technology familiarity. This is due to the minorities having less phone availability, of which they can call or text but inherently lacking the accommodation in applications and sensory input."

Participants expressed a particular need for mental health programmes for ethnic minority students. The administrator in Dien Bien stated, "I think [mental health programme development] is a very important matter and vital for the development of the educational sector in our country, especially for the minority group. This is because the children we are dealing with are just young students but suffer many impacts and disadvantages in terms of historical economic development and geographical disposition. They have disadvantages in communication capability, sharing capability, and self-expression or problem-solution processing, which can be really negative at times. For instance, many [ethnic minority students] drop out of school due to various issues. Many students just want to graduate the 10th grade and hardly anyone remains until 11th grade after the Tet Holiday. Once we got to ask them for the reason, many had said that they find studying boring. From that, we can see how much pressure these students had to face, but hardly any of them tries to share their thoughts. We have done the encouragement work, students have agreed to keep going to school and for example, we go to the student's house and try to persuade them to go back to school and so they would promise to go back in the next morning. But what happens if they do not show up at school the next morning, and when we call them, no one picks up, right? That makes me think that their students must have something to say for themselves, and that they want to share some kind of pressure, yet they ultimately find it impossible to do. That is why I think this is such a huge limitation for ethnic minority students. And in my mind, these students would have a more secure, healthy spiritual life if they could receive some kind of mental support..." The administrator noted that school support must include helping ethnic minority students and families understand mental health and how they can access help if needed. And s/he expressed a need for more research regarding ethnic minority academic, social and emotional needs and factors related to high rates of school dropout.

LGBTQ students report varying experiences with school psycho-emotional support. Informal support in the form of caring teachers was experienced as highly positive by students. However, LGBTQ students in the FGD did not find formal psychological supports useful. One student reported that their school had a psychology room but did not believe that students went there for help. When asked why not the student speculated, "I think it's probably like, going there won't do anything, or they are afraid of having to deal with teachers since teachers in the psychology room are also teachers in school. So, I feel like she could know everything I have told her and I feel uncomfortable." When asked what else schools could do to support LGBTQ students' mental health and well-being, students in the FGD agreed that schools should provide more formal sex education programmes, including education on sexual orientation and gender diversity. One student stated, "I see that not only schools but the whole country in general, our country is afraid when talking about these problems and feels wrong to talk about these problems. So, we need to put more emphasis on it, making it a real class and treating it like a real subject. For example, firstly education on sex education of men and women, and then on gender equality and LGBTQ so that people see members of the LGBT community as normal people like themselves. Plus, the fact that I feel like we should be able to get rid of sexist issues like gender stereotypes. For example, it doesn't matter if it is a girl with long hair, why do we have ideas that girls can't have short hair or boys can't have long hair. If a boy wants to have long hair or wear a skirt, I feel it's his right [and] he shouldn't be judged for that."

Chapter 8:

Adolescent Student MHPSS Policies and Programmes in Viet Nam: Social and Health Sectors, and Cross-Sector Collaboration

Key Findings

1. Since 2011 MOLISA has established policies providing for the development of community-based mental health care for children and adults.
2. MOLISA experts and administrators report a need for a specific mental health programme for children and adolescents focused on prevention of mental health problems via promotion of safety in the home and through teaching parents, adolescents and community members how to recognize early signs of MH problems and where to go for help.
3. Identified areas of need for MOLISA regarding adolescent student mental health include:
    a. Establishing standards for quality of services and effective M&E procedures for continuous improvement of community services.
    b. Development of community MH human resources.
4. Since 1999 the MOH has been responsible for community-based MH care. Initial focus was on severe mental illness in adults. Since 2005 MOH has expanded focus to common MH disorders, including depression and anxiety, and pediatric MH.
5. The MOH is currently developing policies and programmes focused on common child and adolescent mental health problems including anxiety disorders, depression, and behavioural disorders.
    a. Identified areas of need for MOH regarding adolescent student mental health include:
    b. Training for district administrators and school medical staff in adolescent mental health.
    c. Development of human resources, specifically in the area of adolescent psychiatry.
6. Education and Social Sector collaboration would be improved by:
    a. Systems for sharing information regarding students at-risk and in need of support.
    b. Social sector support for adolescent students via in-school MH literacy programmes and counselling for students.
7. Education and Health sector collaboration would be improved by:
    a. Training for school medical staff in the areas of school-based mental health screening, risk assessment, and mental health care protocols for referral of students in need of professional mental health care.
    b. Health sector support for improving mental health literacy among students, teachers and parents to facilitate early identification of and intervention for student MH problems.
8. Experts agreed that a National Strategy on Mental Health involving collaboration and coordination of health, education and social sectors is needed.

8.1. MOLISA Policies

Prime Minister Decision No. 1215/QD-TTg from July 2011 provides for community-based social assistance and rehabilitation for people with mental illness and mental disorders for the period of 2011 – 2020. This policy sets goals for prevention and care of mental disorders within the community. Activities outlined by the policy include (a) the development of Social Protection Centre facilities, including 20 facilities around the country and at least 3 regional SPCs, (b) increasing provincial capacity to support people with mental disorders, (c) increase human resources for the prevention and treatment of mental disorders via training for social workers and affected families and (d) pilot and scale-up effective models of community-based prevention and treatment of mental disorders. The Circular establishes cross-sector collaboration in this effort. The MOH is directed to support mental health treatment capacity building by integrating research and expertise into training and development. The MOET is directed to integrate life skills education for students into schools, to implement programmes in schools for the prevention and early intervention of students with mental disorders, and to coordinate with the health sector to care for students with mental disorders.

This Decision was followed by Prime Minister **Decision No. 1929/QD-TTg** dated November 25, 2020 approving the community-based social assistance and mental rehabilitation programme, including for children with autism and people with mental disorders, for the period 2021-2030. The subsequent **Decision No. 1069/QD-LDTBXH** dated September 27, 2021 of the Ministry of Labour, Invalids and Social Affairs established the Plan to implement the Programme on social assistance and mental rehabilitation, autistic children and community-based psychosis for the period 2021-2030.

Prime Minister Decision No: 112/QD-TTg in January 2021 established policy to further promote the development of social work during the 2021 – 2030 timeframe by raising public awareness of social work activities and improving the quality of social work services. While this Decision is focused on social work development more broadly, mental health is specifically mentioned in section 2.7.a. which directs MOLISA to "**Communicate and raise the awareness of authorities at different levels and sectors, and communities regarding the role and position of social work and social work service delivery facilities in mental healthcare** and healthcare for people with disabilities, the elderly, children with special circumstances, and other disadvantaged groups." Of specific importance to the development of school-based mental health care is Section IV. Article 2.5 which addresses MOET's role: "Ministry of Education and Training (MOET) shall assume the prime responsibility and collaborate with related Ministries, sectors, and agencies to… **improve the quality of social work trainers and establish the network of social work public employees and workers at schools.**" Additionally, objectives include expansion of social workers in schools, with at least 50% of education facilities providing social work services as planned by 2025 (Objective 2.a.) and to reach at least 60% of education facilities by 2030 in comparison to 2025 (Objective 2.b.). In conclusion, Prime Minister Decision No. 112/QD-TTg sets policy for the intersection of social work and education, and briefly recognizes the role of social work in addressing mental health, although it is contextualized within healthcare for "disadvantaged groups" rather than community groups such as students within schools.

Related policies include **Prime Minister's Decision No. 1437/QD-TTg** (approved October 2018) on approving the 2018 - 2025 scheme on care for the comprehensive development of children in the early years of their family and community life. This policy demonstrates the national effort to promote early childhood development ensuring physical, cognitive, emotional development and equitable access to supporting services for children. However, as it is focused on children under eight it is not directly relevant to adolescent mental health. A MOLISA expert described collaboration with UNICEF in developing and evaluating models of implementation related to the policy. UNICEF supported a learning programme for programme developers and implemented a parenting support model in three provinces. Pilot results will inform next steps including a plan for nationwide programme scale up.

The 2016 **Law on Children** provides a legal foundation for children's rights in Viet Nam and institutionalizes guidelines and policies guaranteeing the enforcement of children's rights in the spirit of the United Nations Convention on the Rights of the Child. The Law on Children provides regulations ensuring various children's rights, including the right of privacy, the right to live with parents, the right to be adopted and the right to be protected from abuse including violence, sexual harassment, labour exploitation, abandonment and kidnapping. While this Law is an important policy related to reducing major risk factors for child mental health problems, it does not specifically address or provide support for adolescent mental health and well-being. Another related policy is Prime Minister Decision 1438 (October 29, 2018) which establishes a National Framework for supporting children with disabilities, including access to community-based protection, care, and education services, for the period 2018-2025.

An expert from MOLISA shared the many general ways that these policies support children's mental health and well-being. However, this expert that MOLISA may need to develop more specific child mental health policies and programmes. As she states, "Honestly speaking, current programmes and projects are available, but we may need to issue a separate programme, a separate mental health project for children. It is necessary to have specific intervention solutions to prevent mental disorders in children, as well as ones to provide timely support for children." According to this expert, prevention programmes should (1) promote safe family environment to prevent trauma, (2) give parents tools to recognize early signs of mental health problems, (3) teach children about mental health and early signs of problems and how to mitigate risk, and (4) provide toolkits for widespread basic mental health literacy, and for improving community capacity to detect early warning signs of problems and make appropriate referrals.

The MOLISA expert also discussed a need for mental health intervention programmes, including policies, regulations, and criteria for ensuring quality services. She notes that, "At the present, psychological or mental health support services for children can be found in hospitals, maybe in educational institutions, and less often in some non-public facilities. But the question is what are the service standards? What are the standards of counsellors, and what are the conditions? We must review it to have something specific. In addition, we need to have monitoring and evaluation, then supervisory agencies for the implementation of programmes and plans in general."

8.2. Social Sector Programmes and Services

MOLISA's service sector includes some school-based services. As the MOLISA expert shared, some schools have incorporated social work providers to provide psychological support for students. However, it was noted that in most schools, medical staff are in charge of children's health, but they are often part-time and not equipped to cover mental health. The social service sector also has child management officers in the community working with a team of social work collaborators in case management. In this capacity they may provide mental health assessment for children, although she acknowledges that the case management officers do not always have sufficient training for high quality service.

MOLISA also supports training of families, students and community members in areas relevant to child health and well-being. For example, a Ha Noi DOLISA administrator shared about a programme for training parents in parenting skills, including parents' ability to recognize and support children's problems. The administrator shared that the programme aims to help parents "have capability to identify problems, including what approach [the children] need, how to work with them in the process of growing up." It is possible that mental health content can be integrated into MOLISA-supported parenting programmes.

The Ha Noi DOLISA offers services via the Ha Noi Social Work Centre. Although these services are focused primarily on young children, a KI from Ha Noi DOLISA reported that the social work centre's goal is to "support children and families in cases where the family encounters difficulties in child rearing or children's problems."

Another MOLISA service provided since 2017 is **Viet Nam's** Department of Child Affairs (DCA) national **child protection hotline (111). This hotline** offers 24 hours telephone support to underage victims of abuse, exploitation and trafficking. DCA has three call centres in the north, central and southern regions of the county to address geographical differences in speaking accent to help children calling from all areas feel comfortable. Reports from the Department of Child Affairs under the MOLISA showed that after nearly 16 years of operating the hotline 111, the department has received over 4 million calls to discuss issues related to children. According to the MOLISA administrator, the hotline staff are all are trained on mental health issues in children.

Human resources are reported to be a concern for social sector service delivery. A MOLISA expert described a lack of training in child mental health; "At the ministry level have some people specialized in mental health. The Department of Children Affairs has a Child Care Room in which there are staff directly assigned to monitor issues related to mental health. But as you move to provincial, district and commune level there are no specialists. Within the DOLISA department you will have one person in charge of all children issues, including mental health."

Child protection officers are training in child abuse and prevention and some topics related to mental health, including detection of early psychological signs that may affect the child, such as anxiety or irritability. An example of how this lack of trained human resources impact child services was shared by a DOLISA administrator from Dong Thap. He explained, "There is the 01 Circular which has just been carried out including the evaluation and review process of autistic children. The Evaluation Council of Disabled Children at Commune Level hasn't been capable of identifying autistic symptoms since the state lacks in-depth medical knowledge. Therefore, the council had to take the results to the central-level hospital for evaluation as the provincial level hospitals are out of touch. By the time the patient was been admitted to the central-level hospital, the symptoms have become severe. Thus, I think the first evaluation and review process needs to be carried out earlier to quickly intervene in the cases of children with signs of depression, autism or hyperactivity." Administrators within the social sector recommended training in child and adolescent mental health for social work centre staff.

Social sector human resources may also be overtaxed. As one DOLISA administrator shared,

social workers at "that grassroots level carry a very hectic workload, I think that is also a huge barrier, a very difficult problem."

Thinking holistically, a participant from Ha Noi DOLISA considered how the community can support positive child and adolescent well-being by providing more opportunities for engagement in positive activities; "in the education sector, in the organizations and unions, such as the Women's Union and the Youth Union, they can do a lot of things related to children, including improving parent-child interactions, improving school environments, and creating teams, activity groups, clubs for children. These activities really promote the children's participation and well-being."

8.3. MOH Policies

MOH support for mental disorders began in 1999 with Prime Minister Decision **Community Based Mental Health Care Project**, entrusting mental health treatment to the health sector. This Decision emphasized the implementation of a community mental health programme. In 2000, the Minister of Health assigned the Mental Health Service to launch the National Targeted Programme on Mental Health, for the entire population. From 2000 to 2006, the Mental Health Care Programme target the care and treatment of schizophrenia. The focus was then expanded to include a programme for epilepsy. The activities of this programme include mental health training of health staff and health collaborators, as well as household surveys to identify depression and epilepsy patients, monthly delivery of medicines for patients, and monitoring and supporting patients through medicine and health education through village media.

Since 2015, the programme has begun to focus on common mental health problems, including depression and anxiety, and on pediatric mental health, including autism and ADHD. Major barriers to progress in this area include a lack of medical staff with training and experience in child and adolescent mental health. With the guidance of these policies, considerable progress has been made towards the development of community-based mental health care for severe mental illness. However, screening, care and treatment for depression, anxiety and other common mental health problems is lacking. And human resource development is necessary in order to expand and improve mental health care for children and adolescents (Cuong, 2017).

Recent policies related to mental health include Prime Minister **Decision No. 155/QD-TTg** dated January 29, 2022 by which the government approved the National Plan for prevention and control of non-communicable diseases and mental health disorders for the period 2022-2025. **Decision No. 712/QD-BYT** dated March 21, 2022 issued by the Ministry of Health establishes a plan for the development of social work in the health sector for the period of 2021-2030.

According to a MOH expert, the MOH currently has no specific policies regarding the mental health of students. As the expert described, the community mental health care programme focused on epilepsy, providing free medication and treatment for children with epilepsy. The expert noted that, "However, mental disorders in children that are caused by eco-social development and industrialization are not addressed, like emotional disorders, behaviour disorders, suicide in adolescents or children. To be honest, those problems are not addressed." He shared that the MOH, Department of Preventive Medicine together with the Medical Examination and Treatment Administration are developing an action plan that includes mental health in the non-communicable disease sector. This plan would include child and adolescent mental health problems including anxiety disorders, depression, and behavioural disorders.

8.4. Health Sector Programmes and Services

MOH and provincial health departments do not appear to have school-based programmes regarding student mental health. An administrator from Ha Noi DOH shared that the ministry has a programme to improve reproductive health care for adolescents. The programme involves visiting secondary

and high schools to talk with students about reproductive health, including biological and psychological development. The programme also includes courses to train teachers in adolescent reproductive health so that teachers will have skills to support students with problems. MOH also provides short training courses for medical staff in the area of reproductive health care for adolescents.

In spite of recognition of the importance of adolescent mental health, health experts agree that they lack training about mental health and are ill-equipped to support schools or students in this area. An administrator in charge of the school health department for Dong Thap shared that she has had no training in psychiatry, or anything related to child adolescent MH. She recounted a case where school health staff member consulted with her about a students' concerning behaviours. Without any training, she was only able to suggest monitoring the student and she did not know where to go for further support. A participant from Dien Bien DOH reported that he received no training on mental health in medical school and believes medical schools should include mental health in the curriculum. An administrator from Dong Thap DOH commented, "I want to have knowledge and a procedure so I can instruct the school. But now I don't even know a thing about psychology. So, when it comes to advising [schools] I am not advising. Merely observing. I also want to help but I have no possession to assist them. Like this case of a girl in Sa Dec who tore paper. Without psychological knowledge I just said, 'Well, observe (the student) for now, tell me if something's up.' Because I had not been equipped with psychological knowledge at all, I cannot say anything else. My longing is a longing for knowledge of students' psychology, nothing else, only with that can I do my work." Interviews with provincial health department experts indicate a need for training of the public health sector in child and adolescent mental health, and a need to develop linkages with provincial psychiatric hospital resources.

DOH health administrators report that the school medical staff position lacks capacity to support mental health. A participant from Ha Noi DOH described the role of the medical staff position as addressing student physical health needs and organizing topic discussions for students. They support the school regarding certain health concerns, for example myopia and COVID- 19 prevention. However, health sector participants generally agree that school medical staff are unable to provide mental health support due to "no training provided and the fact that those are not professionals. That also explains why the medical room or channel cannot be suitable for long term mental health checkup or consulting work since they have indisputable limitations."

A major barrier to health sector support for adolescent student mental health is lack of specialized medical experts. According to the MOH expert, "Doctors specialized in mental health are insufficient, not to mention pediatric mental health doctors. There are very few of them trained in pediatric mental health care." Underlying causes of insufficient human resources include stigma from within the medical field where psychiatrists are not respected, and stigma from within the culture and community where mental health is not valued. As described by the MOH expert, "People working in the mental health field have lower status than other medical departments. That's why the mental health specialty is not the priority of students when it comes to choosing a specialty. There are some medical staff that I know, who have to hide from their family the fact that they work in a psychiatric hospital. There are doctors who keep it secret for many years, even when they get married. It's an inequality in the healthcare industry. It attracts few students. The other reason is that, in Viet Nam society, people don't pay much attention to this matter. They care more about other diseases. Parents don't think it's a problem when children have emotional disorders, like, when children get easily upset or cry all the time or have mood swings. They don't think it's a problem. Family, and then society, they don't care about that matter. So, they wouldn't take children to see a doctor. Another reason is **the working environment in psychiatric hospitals**. Infrastructure is not upgraded. Facilities are deteriorating. That's why there are few people choosing this specialty." To address this barrier, MOH plans to submit the Medical Examination and Treatment Law for approval. This law would offer enticements to medical students to study certain specialties, including psychiatry.

Another human resource barrier concerns the lack of a professional employment code for Psychologist. As the MOH participant described, MOH is waiting for finalization of a proposal regarding this issue and plans to then submit the proposal to the Ministry of Home Affairs.

Other concerns include the quality of care provided for adolescent mental health problems. While many hospitals and health clinics have expanded services for autism, the quality of services for other types of mental health problems is inconsistent.

8.5. Cross-Sector Collaboration in Adolescent Student Mental Health

8.5.1. Education and Social Sector Collaboration

Evidence for cross-sector collaboration between MOET and MOLISA includes programmes to support implementation the 2016 Children's Law regarding children's rights in schools. This programme includes a general procedure for supporting children, including case management from DOLISA, and coordination with school and health agencies around individual child needs.

Participants reported other existing collaboration at the commune or district level. For example, an administrator for DOLISA in Dien Bien reported that DOLISA was supporting DOET in the area of training for teachers on disability assessment and evaluation. There is also some coordination in the area of autism. As autism is now included in Government Decision 1438's policies on support for children with disabilities, MOLISA is working with MOET and MOH to review policies and programmes regarding coordination of early detection and care for children with autism.

While these efforts are promising, there is evidence that coordination and collaboration between education and social sectors is lacking and the majority of coordination efforts have focused on younger children rather than adolescents. This was confirmed by a MOLISA expert who reported that coordination between the two sectors remains "very fragmented."

One area in need of improved collaboration is sharing of relevant information and data. A DOET administrator from Ha Noi expressed concern about the coordination between education and social sectors. S/he understood that DOLISA had activities regarding adolescent mental health, but has not seen data regarding this work. S/he would like to see more sharing of data in order to have a clearer picture of adolescent mental health needs and potential interventions. A MOLISA expert also emphasized the need for systems for sharing information about at-risk students who could then refer students in need of higher-level care to social work centres. This expert stressed that a particular focus for collaboration should be around adolescent suicide where data sharing could inform cross-sector prevention programmes.

An expert from MOLISA shared about an opportunity to expand MOET-MOLISA collaboration for adolescent student mental health. Recently, MOET worked with MOLISA on the National School Health Project for the period 2021-2025 which was approved by the Prime **Minister in Decision #1660** dated October 2, 2021 and launched on February 10, 2022. Areas of focus include assessment of risk factors for student mental health problems, improving students' knowledge about mental health, and providing developmentally appropriate counselling on psychophysiology and mental health in schools. The plan is for these areas to be developed via collaboration between MOET and MOLISA.

8.5.2. Education and Health Sector Collaboration

Education and health sectors have had some collaboration in the area of adolescent student mental health. An administrator from Ha Noi DOH shared examples of collaboration including DOH providing training to teachers regarding student development and reproductive health. Furthermore, schools "invited experts to talk with parents so that parents could understand more about the biological and psychological state of their children."

However, coordination and collaboration between the two sectors is generally lacking. Administrators from both sectors agreed

that very little coordination occurs. DOET administrators from Gia Lai and Dien Bien shared that school medical staff are not trained in counselling and there is no connection with district or provincial psychiatric hospitals or departments.

A MOH expert affirmed the lack of formal coordination between MOH, MOET and MOLISA in the area of student mental health. S/he reported that the three ministries proposed areas of cooperation in the implementation of the National Strategy on Mental Health but that the government restructured the strategy to focus on one strategy per Ministry. The MOH expert asserted that MOH would like to cooperate with MOET regarding adolescent mental health but "the problem is that there is no protocol to maintain that kind of cooperation, to keep it frequent. There is no communication. So, we just do our jobs. If there is a protocol indicating that we should have meetings regularly, to exchange information, then the cooperation between two departments to do task A, task B would happen naturally."

Education and health participants expressed enthusiasm for collaboration and shared many ideas for how the two sectors can work together to benefit adolescent mental health. An administrator from Gia Lai DOH was eager to consider opportunities to work with schools and noted that the health sector could raise mental health awareness among teachers and students and promote referrals to the hospital for serious problems. An administrator from Gia Lai DOET shared this enthusiasm and suggested an annual meeting between school leadership and psychiatric departments or hospitals. This meeting would be an opportunity for the medical sector to share with the educational sector about common mental health problems in students, signs of adolescent problems, available mental health services, and how to refer students in need of higher-level support.

Collaboration between MOH and MOET would be optimized by clear roles regarding adolescent student mental health efforts. Experts noted areas for collaboration, including screening, risk assessment, mental health care protocols, and action plans. Clear responsibilities for relevant Ministry departments will maximize the likelihood of successful implementation.

The MOH expert affirmed the significant need for adolescent mental health care. The expert shared that MOH should first focus on improving the mental health knowledge of adolescent students and their parents; "If we just support students without changes from the living environment or family, it would be really hard. There must be a synchronization, from family environment to society to schools." The expert also recommended that MOH work with MOET to develop teacher and counsellor training programmes for the purpose of early identification of student mental health problems. School-based screening would allow for early intervention, and referrals for children in need of expert treatment to medical centres or hospitals.

A participant from Ha Noi DOH reinforced the importance of teacher training for early identification of student mental health problems. He suggested that, "Teachers should be trained and provided with basic knowledge about adolescent mental health. They need to be equipped with tools to screen, to evaluate common disorders. For instance, they should have a short checklist for symptoms. When a student shows symptoms, teachers can use that checklist to identify [students at-risk] and then invite psychiatrists to work with that student. There should be cooperation among psychiatric hospitals and schools in the matter of students' mental health."

An administrator from Dong Thap discussed collaboration needs and suggested that health, social and education sectors jointly receive training and work on a joint policy for collaboration and MH service provision. She reflected this this was done in the area of nutrition and thought the process for nutrition could serve as a useful model for building cross-sector collaboration in adolescent mental health. The expert in Dien Bien agreed, stating "In terms of official written documents, I would support the proposal for a special policy development and implementation coordination between institutions, especially in the Education Ministry. They can work together to develop vital mental impact techniques for adolescent children."

Chapter 9

Conclusions and Recommendations

Conclusions

UNICEF has collaborated with the Ministry of Education to study the relationship between school-related factors and the mental health and well-being of adolescent girls and boys. Results of this research will inform development of school-based interventions targeting adolescent mental health and well-being. The research integrates data from various geographical regions of Viet Nam, across relevant sectors (education, health, and social sectors), and levels of the system (student, family, school, local and national governance). Study findings provide international and national context for these issues, and include results from primary quantitative and qualitative research into adolescent student mental health, school based factors including school climate, academic pressure and bullying, perceptions of needs, existing policies, programmes and services from all stakeholders, and opportunities for improving support for adolescent students as they strive to become healthy adults capable of making a positive impact on the world.

Adolescent students in Viet Nam are bright young people with big dreams. They love to learn new things, care about their family and friends, and strive to be active and successful at school and at home. Adolescent students report a range of mental health problems, including emotional problems, peer problems, hyperactivity and conduct problems. About 26% of students report current symptoms associated with moderate- or high-risk for mental health problems. Girls are at higher risk for emotional problems compared to boys, and high school students are at higher risk compared to secondary school students.

All stakeholders recognize the importance of adolescent mental health and well-being. Teachers, principals and administrators from educational, social and health sectors all agree that adolescent mental health is an area of concern. While parents struggle to understand and support their teenagers, parents demonstrated less knowledge of student mental health symptoms and risk-factors, and expressed less concern about the issue. Ethnic minority students and LGBTQ students may be at particular risk for mental health and well-

being problems due to a variety of risk factors.

A number of school-related factors place students at risk for mental health problems. School climate factors were moderately related to student mental health problems, with student perceptions of school safety, student engagement in school, and the school environment all associated with student mental health. Academic pressure was strongly associated with student mental health. Student experiences of study pressure, worries about grades, despondency related to academics, self-expectations, and workload were all significantly related to mental health problems. Girls are at higher risk for academic pressure than boys. Student lack of sleep and experiences with bullying were concerning for students and stakeholders alike.

Results found widespread concern among participants regarding academic pressure. There was general agreement that pressure from teachers and parents, high workload, and stress related to grades and exams have a negative impact on student mental health, harming students' emotional, social, and academic development and placing some students at risk for negative life trajectories. Underlying causes of academic pressure were explored, and recommendations made for how to improve student emotional support and learning at school.

Educational policies and programmes regarding adolescent student mental health aim to establish basic counselling services in secondary and high schools, including facilities and trained human resources. While progress has been made, evidence indicated gaps between policy and implementation. Many schools lack designated counselling rooms and adequately trained counsellors. Most schools put poorly trained teachers or administrators in the role of counsellor, leading to a variety of problems. The school community, including students, teachers and parents, lack mental health knowledge contributing to missed opportunities for student support and early identification of student mental health problems. Prevention efforts must include mental health literacy training and systemic efforts to bolster student-teacher relationships.

Social sector policies directly provide for development of social work for mental health care, including care in the context of schools. Social sector policies provide for parent training programmes and community mental health services, both of which are relevant to adolescent student mental health. However, these programmes are not always available or sufficient in practice. Specific programmes addressing adolescent mental health in schools are lacking, and currently there is little direct social work service provision in schools. Collaboration between social and education sectors must be strengthened to benefit adolescent students.

Health sector policies entrust mental health treatment to the health sector, but do not directly address adolescent student mental health. Health sector programmes within schools address mental health indirectly. Medical staff in schools lack training and capacity for mental health care support. And there is a lack of coordination between schools and psychiatric service providers. Collaboration between health and education sectors must be strengthened to benefit adolescent students.

Systemic strengths include widespread understanding of the importance of adolescent student mental health on developmental outcomes, and a strong commitment to improving policies, programme and service provided to support students. Participants from all sectors are committed to working together and shared ideas for progress that reflect shared understanding of barriers and paths forward.

Although not directly assessed in the current research, there is significant evidence that COVID-19 has caused significant stress for children and families around the world, and in Viet Nam. Stakeholders shared concern regarding the impact of the pandemic on student health and well-being. Pandemic-related stress and associated risks remain a compelling reason for urgently addressing issues of adolescent student mental health.

Recommendations

The following recommendations are offered for consideration by MOET and partner agencies, MOH and MOLISA, and UNICEF as they work to promote adolescent student mental health and well-being.

A. EDUCATION SECTOR RECOMMENDATIONS

1. Holistic and whole school-based approaches to improving student well-being and building student resiliency. School climate is the context for child and adolescent learning and development at school. This context includes fundamental factors such as student relationships with teachers and peers, the school environment, student, parent, and teacher engagement, and students' experiences of safety at school. A positive, supportive school climate is essential for student learning and well-being. Specific recommendations regarding school climate include:

b. **Promote positive teacher-student relationships.** Universal school-based mental health promotion programmes see that the quality of teacher-student relationships predict outcomes. Stakeholders shared models for improving teacher-student relationships, including restructuring class schedules so that students meet with certain teachers twice/day; integrating time for student-teacher sharing and support into the standard curriculum; prioritizing teacher-student relationships such that teachers receive recognition or are evaluated based on quality of relationships; and reducing class sizes.

c. **Prohibit the use of physical discipline in schools.** Related to the issue of adolescent student well-being is the critical need to eliminate physical discipline in schools. Policies and practices must clearly communicate that physical discipline is not tolerated in classrooms. Importantly, teachers must be equipped with the skills to motivate students and implement positive, non-violent discipline. Teacher training programmes and in-service professional development opportunities can train and support teachers' use of these skills.

d. **Promote student engagement and connection to school.** Student well-being is improved by engagement with peers in cocurricular and **extracurricular activities**, including arts, sports, clubs, etc. Activities provide students with valuable opportunities for developing skills for problem solving, communication, relationship building, and emotional resilience. Activities provide opportunities for students to "shine," increasing their motivation and engagement in school and life. Inclusion of activities into students' day will teach students to value health, relationships, and balance in life. Most stakeholders believe that the current educational system does not value or support extracurricular activities enough.

e. **Promote kindness and positive peer relationships.** Student experiences of bullying represent one of their biggest challenges and there is strong evidence that bullying puts students at risk for mental health problems and negative life outcomes. Schools can reduce bullying by

celebrating kindness and positive peer relationships as deeply held school value, recognizing and honouring students who demonstrate kindness, and having clear expectations for student behaviour with consequences for bullying. Specific bullying prevention programmes exist and may be adapted when needed.

f. **Reduce academic pressure.** All stakeholders agree that students are under significant academic pressure and students experiences of academic pressure, including study pressure, worries about grades, despondency related to academics, self-expectations, and workload, were all significantly related to student mental health problems. Girls are particularly vulnerable to academic pressure. It is clear that reducing academic pressure will be a significant challenge as many systemic, underlying factors contribute to this problem. Teacher training and evaluation, examination schedules and focus, beliefs about learning objectives and outcomes, etc. all contribute to the current culture of high pressure. MOET may consider a path forward, such as a task force designated to addressing this issue, and inclusion of an academic pressure evaluation process within each department and activity. Prioritizing student approaches to learning, including skills for communication, collaboration, problem-solving, creativity, and reflection, may be empathized over subject content to enhance learning objectives while reducing academic pressure.

2. Universal approaches directly targeting mental health and well-being.

a. **Improve teacher, parent and student mental health literacy.** Stakeholders did not have a shared understanding of student mental health. The whole school community must be more knowledgeable about common mental health problems and symptoms, the prevalence of these problems among students, factors that place students at risk for problems, and strategies for reducing risk. Teachers and parents especially need to recognize symptoms of serious mental health problems, and know when and how to seek professional help for their students/children. A large-scale campaign to promote mental health literacy will provide a strong foundation for further prevention and intervention efforts. **Outreach to ethnic minority parents and students must be a high priority.**

b. **Teach students skills necessary for positive mental health and well-being**. The acquisition of social and emotional skills is associated with positive youth development, academic achievement, healthy lifestyle behaviours, and reductions in depression and anxiety, violence, bullying, conflict, and anger. Crucial life skills for adolescents include emotion regulation, problem-solving, communication, conflict resolution, and maintaining healthy relationships. School-based programmes aimed to enhance these skills go beyond a problem-focused approach to embrace a more positive view of health. Life skills programmes should be integrated into the school curriculum.

   i. Sexual education may be provided in partnership with education on mental health and well-being. Many students, teachers and parents express concern regarding sexual relationships. Skills for healthy and respectful (non-violent) romantic relationships and sexual health are necessary for promoting adolescent health and resiliency. These programmes should also include inclusive, non-judgmental information about sexual orientation and gender identity to reduce LGBTQ student discrimination and improve LGBTQ student mental health. UNICEF's Comprehensive Sexuality Education Framework offers guidance on how this type of program can best be developed and implemented.

3. Targeted stepped-care approach to early identification and intervention for students with mental health problems. All stakeholders agree on the need to improve capacity to identify children with problems early and provide them with the support they need to reduce mental health symptoms and regain full health and functioning. Currently, very few schools have the capacity for early identification of student mental health problems. And while some schools have highly

capable counsellors to support students in need, the vast majority of schools do not. Currently, most schools offering counselling assign teachers to the counselling role. There are numerous, clear limitations to this model and most participants agreed that professional counselling services are needed.

a. **Provide for early identification of student mental health problems.** This begins with improved mental health literacy among teachers and parents, however knowledge alone is not sufficient. A screening programme is recommended to more consistently identify students at-risk for problems. Participants shared models for screening, including charging school medical or counselling staff with student screening. Brief screening of all students or those deemed at-risk must occur within the context of available school counselling support, parent engagement in the programme, and access to specialized psychiatric and psychological services. Screening programmes must prioritize student and parent consent and confidentiality of personal mental health information.

    i. The recently established School Health Programme for the period 2021-2025 (Prime Minister Decision No. 1660/QD-TTg, October 2, 2021 and Prime Minister Decision No. 85/QD-TTg, January 17, 2022) may offer policy support for expanding the role of school health workers to include screening for the early detection of mental health problems in adolescent students.

    ii. With MOET guidance, DOETs will need to identify local resources for professional mental health treatment (e.g., psychiatric hospitals or departments, psychological clinics, social protection centres offering adolescent counselling services). Referral pathways for each district should be developed and shared with all secondary and high schools in the district.

b. **Provide professional school-based counselling for students with moderate-level mental health problems.** An official position for School Counsellor must be established. School counsellors should have training in adolescent development, adolescent mental health, basic mental health assessment and treatment planning, group and individual evidenced-based interventions for common mental health problems, coordination with teachers and parents in supporting students, and referrals for students with severe problems for expert medical and psychological treatment. School counsellors should have clear roles and responsibilities and be empowered to facilitate teacher and parent support for students.

4. Consider specific needs of ethnic minority students, girls and LGBTQ students in policy and programme development. These groups are at higher risk for mental health problems. Programmes may tailor outreach, engagement and implementation approaches to students of different ethnicities, genders and sexual/gender identities in order to maximize programme success with these vulnerable groups.

5. Build human resources. Human resources for adolescent student mental health are lacking in all sectors. MOET can consider human resource needs and develop policies to build capacity within the education sector.

a. Build **human resources with specialized student mental health expertise** to guide programme developments and oversee progress in this area.

b. **Integrate adolescent student mental health and well-being training into the general university teacher training curriculum.**

B. HEALTH SECTOR RECOMMENDATIONS

1. Build human resources. The medical system has very few doctors and nurses specialized in child and adolescent mental health.

a. Improve knowledge and skills for all health care workers by including course content related to child and adolescent mental health in the **general medical school curriculum**.

b. Develop **specialized child and adolescent mental health human resource**s. Significant challenges contribute to the lack of psychiatric specialists in Viet Nam. MOH leadership should directly addresses these barriers with clear policies and programmes designed to improve health sector capacity to care for all people suffering from mental illness, including children and adolescents.

Train school medical staff in basic adolescent mental health. The scope of this training will depend on the cross-sector collaborative models developed by the Ministries for addressing student mental health needs. However, at a minimum it is recommended that school medical staff have basic mental health knowledge, screening capacity for common mental health problems, and the ability to coordinate with school counsellors support students and to access local psychiatric and other mental health care and treatment.

Build DOH-DOET collaboration. Formal collaboration between DOH and DOET is necessary to address adolescent student mental health. Leadership from both ministries must prioritize this effort and establish policies to guide collaboration. Potential models for collaboration include:

Establish **formal partnerships between DOET and DOH** including structures for regular sharing of data and experiences to support ongoing programme and service development.

Develop **systems for referral of students** to psychiatric hospitals or medical centres when in need of higher-level care for severe mental health problems.

Have local **medical specialists participate in mental health literacy programmes** for teachers, students and parents and support building teacher capacity to recognize signs and symptoms of emerging mental health problems.

C. SOCIAL SECTOR RECOMMENDATIONS

1. Build human resources. MOLISA has made significant progress in developing social work capacity for community-based mental health care. However, human resources remain the biggest barrier to expanding social work capacity in the area of adolescent student mental health.

a. Improve knowledge and skills for all social workers by including course content related to child and adolescent mental health in the **general social work curriculum**.

b. Develop **specialized adolescent and family mental health human resource**s. Significant challenges contribute to the lack of clinical social workers specialized in child and adolescent mental health. MOLISA leadership should develop clear policies and programmes designed to improve social sector capacity to support children, families and schools in the area of student mental health and well-being.

2. Build DOLISA-DOET collaboration. Formal collaboration between DOLISA and DOET is necessary to address adolescent student mental health. Leadership from both ministries must prioritize this effort and establish policies to guide collaboration. Potential models for collaboration include:

a. Establish **formal partnerships between DOLISA and DOET** for regular communication and sharing of data regarding adolescent mental health problem prevalence and potential interventions. This communication and data sharing should inform cross-sector programmes.

b. **Integrate adolescent mental health training content into existing MOLISA/DOLISA parent training** and support programmes.

c. DOLISA collaboration with DOET to **provide school-based life-skills courses for students**.

d. Co-develop **pathways of care for students with mental health problems referral to Social Work Centres** for child and family counselling.

D. UNICEF RECOMMENDATIONS

UNICEF has supported research and development regarding children's mental health in Viet Nam for many years and is in an excellent position to support policy and programmatic developments related to this research moving forward. Specific recommendations for UNICEF include:

1. Public advocacy and awareness raising. UNICEF is in a key position to utilize study findings to raise awareness of the importance of adolescent mental health in Viet Nam. There is a serious need for public advocacy at the community level and across education, social and health sectors. Raising awareness of the serious impact of mental health problems on adolescent health, learning, functioning and well-being is a fundamental step towards developing essential systems of support for students.

a. Specifically, UNCIEF may support dissemination of study findings and recommendations to leaders in education, health and social sectors and all stakeholders. A dissemination workshop with all key stakeholders is recommended. Additional dissemination sessions with specific sectors or stakeholders may be a useful way to share study findings and raise awareness.

2. Facilitate cross-sector collaboration regarding adolescent student policy and programme development. As noted at the beginning of the Recommendations, participant administrators and ministry experts from all three sectors identified the lack of cross-sector coordination as a significant barrier to progress, and identified a specific need for a cross-sector conference or meeting on this subject. UNICEF may be in a key position to facilitate a high-level learning and planning conference, bringing cross-sector leaders and stakeholders together to share knowledge related to adolescent student mental health, consider sector roles and challenges, and develop action plans for policy and programme development. Conference objectives may include sector sharing of relevant data and experiences, establishment of goals for adolescent student mental health, documentation of models of cross-sector coordination, and consideration of policy implications, pilot programmes, and associated research needs.

3. Advocate for and support further research. Specific areas identified include risk factors for vulnerable groups of adolescent students, including girls, ethnic minority, and LGBTQ students. While some data exists regarding effective prevention, screening, and support programmes in Viet Nam, much remains to be studied. Pilot programmes should be developed with robust monitoring and evaluation processes, and results documented and shared with relevant stakeholders. This process would be best supported by MOET for the collection and distribution of research as local and national programmes are piloted and disseminated.

4. Support alignment of child protection and adolescent mental health issues. UNICEF has great expertise and experience with child protection in Viet Nam. Child protection and adolescent

mental health issues share some common risk factors and pathways. It is recommended that UNICEF support MOET and MOLISA to consider how to align policies and programmes for identification and referral for both child protection and adolescent mental health concerns. This will ensure a holistic approach to students' needs.

5. Integrate adolescent mental health issues into related UNICEF programmes. For example, a participant from MOLISA, Department of Children Affairs, expressed hope that UNICEF will continue to work with them on programmes related to child protection, integrating child mental health support into these programmes. A specific goal shared was the development of toolkits for supporting children with mental health problems.

E. RECOMMENDATIONS FOR FURTHER RESEARCH

There is sufficient evidence regarding Vietnamese adolescent student mental health needs, limitations of the current systems of support, and promising programmes for improving students' mental health and well-being. Policy and programmatic planning should move forward. However, models of collaboration and programmes should be piloted within schools, districts or providences before scaling up to the national level. Research should evaluate these pilot programmes and guide subsequent expansion efforts. Research on both the efficacy and effectiveness of models and programmes must be included in the process. Studying (a) what programmes have a significant impact on student well-being, and (b) what implementation factors are associated with successful uptake and implementation will be necessary.

Research on the specific mental health needs of adolescent students from vulnerable groups is lacking. Studies of ethnic minority and LGBTQ students are needed to more clearly understand the problems these students experience, the barriers they face, and how schools and communities can best support their health and well-being.

F. PANDEMIC SUPPORT

Students around the world have suffered during the COVID-19 pandemic. School closures and social restrictions have deprived students of social relationships essential to healthy development. Financial stress on families has impacted students' mental health. Disengagement and stress have led to increased rates of depression and anxiety in young people globally. Viet Nam is no exception and all stakeholders express concern regarding the impact of the pandemic on adolescent health and development.

While these recommendations primarily focus on longer-term policy and programmatic developments, it is clear that adolescent students require mental health and well-being support now. **MOET and all stakeholders must consider timely interventions to support students impacted by the pandemic.**

Appendix 1

Focus Group Guidelines and Questions

Guidelines for Focus Groups with Students

** We really appreciate your participation in this group. Today we just want to have a discussion about your life, school and some things that can be stressful for kids. We are talking with kids like you from 5 different provinces in VN. In this way we can learn more about the life of adolescents like you, and be able to support students better at school. This discussion is being recorded just so we don't miss anything you say. We will keep everything said anonymous – that means that we will never use your name or identity when we share things we learn from this discussion. I hope you can speak freely about your experiences since then we can truly understand what life is like for you and try to improve things that may be difficult. Any questions?

** Assent form.

1. How do you like school? What do you like and what do you not like?
2. What causes you stress in life? (if not mentioned, ask specifically about academic stress, stress about peer relationships, stress about family problems or circumstances, internet/social media/cyberbullying)
3. How does stress affect your life? (Helps you? Causes problems for you? Does it help you with your school work or make it hard for you academically?)
4. What do you do after school? What do you do on weekends? (understand if they have any time to relax or engage in sports, hobbies or fun activities)
5. What do you do to help yourself when you are stressed?
6. If students are having a hard time emotionally, because of stress or other problems, do your teachers or school help in some way?
7. What do you think your school could do to better support students emotionally?

Guidelines for Focus Groups with LGBTQ Students

**** We really appreciate** your participation in this group. Today we just want to have a discussion about your life, school and some things that can be stressful for kids. We are talking with kids from 5 different provinces in VN. In this way we can learn more about the life of adolescents, and be able to support students better at school. We know that LGBTQ kids may have specific stressors or challenges so it's really helpful to talk with your group today. We hope that the things we learn from this discussion can help Hanoi DOET, and the national MOET, be able to provide more support for LGBTQ students so that all students can feel supported and successful at school. This discussion is being recorded just so we don't miss anything you say. We will keep everything said anonymous – that means that we will never use your name or identity when we share things we learn from this discussion. I hope you can speak freely about your experiences since then we can truly understand what life is like for you and try to improve things that may be difficult. Any questions?

**** Assent form.**

1. How do you like school? What do you like and what do you not like?
2. How does being LGBTQ affect your life as a teenager? (Positive identity? Fear of stigma or discrimination? Worry about family reaction? Experience pressure or negative reactions from family?)
3. How does being LGBTQ affect your life as a student? (Worry about peer reaction? Experience discrimination and/or bullying from peers? Worry about teacher reaction? Experience discrimination from teachers? Academic impact does it make it harder to study or have success in school in some way?)
4. How do you feel when you think about the future? (Positive? Worried or pessimistic?)
5. How does stress in your life affect you? (Helps you? Causes problems for you? Trouble sleeping, eating, socializing, etc.? Does it help you with your schoolwork or make it hard for you academically?)
6. What do you do to help yourself when you are stressed?
7. If you or your friends are having a hard time emotionally, because of stress or other problems, do your teachers or your school help in some way?
8. What do you think your school could do to better support you and other LGBTQ students emotionally and academically?

Guidelines for Focus Groups with Parents

** We really appreciate your participation in this group. Today we just want to have a discussion about your children's life, school and some things that can be stressful for kids. We are talking with parents like you from 5 different provinces in VN. In this way we can learn more about the life of adolescent students, in order to better support students at school. This discussion is being recorded just so we don't miss anything you say. We will keep everything said anonymous – that means that we will never use your name or identity when we share things we learn from this discussion. I hope you can speak freely about your experiences since then we can truly understand what life is like for your child and try to improve things that may be difficult. Any questions?

**** Consent form.**

1. How are your children doing emotionally? How is their well-being?
2. Do your children experience stress? How much stress/how often?
3. What causes your child stress in life? (if not mentioned, ask specifically about academic stress, stress about peer relationships, stress about family problems or circumstances, internet/social media/cyberbullying)
4. How does stress affect your child's life? (Helps him/her? Causes problems for him/her? Does it help you with his/her school work or make it hard for him/her academically?)
5. What does your child do after school? What does she/he do on weekends? (learn if they have any time to relax or engage in sports, hobbies or fun activities)
6. Do you think the children spend too much time on school work and studying?
7. What should the school and society do to reduce student stress and support students better?

Guidelines for Focus Groups with Teachers

** We really appreciate your participation in this group. Today we just want to have a discussion about your students and some things that can be stressful for kids. We are talking with teachers like you from 5 different provinces in VN. In this way we can learn more about the life of adolescent students, in order to better support you and your students at school. This discussion is being recorded just so we don't miss anything you say. We will keep everything said anonymous – that means that we will never use your name or identity when we share things we learn from this discussion. I hope you can speak freely about your experiences since then we can truly understand what life is like for the students you teach. The results of this project will be shared with help and try to improve things that may be difficult. Any questions?

**** Consent form.**

1. How are your students doing emotionally? How is their well-being?
2. Do your students experience stress? How much stress/how often?
3. What causes your students to have stress in life? (if not mentioned, ask specifically about academic stress, stress about peer relationships, stress about family problems or circumstances, internet/social media/cyberbullying)
4. How does stress affect your students in life? (Helps him/her? Causes problems for him/her?)
5. Does stress help students with school work or make it harder for them to succeed academically?
6. How much school work do students usually do outside of school hours?
7. How many of your students take extra classes or have tutors after school or on weekends?
8. What do you think about parents' expectations of their children's academic performance?
9. What do you think about students' expectations of themselves?
10. Do you think the children spend too much time on school work and studying?
11. Does the school have any programmes or services to support students suffering from stress or mental health problems?
12. What else do you think the school and society could do to reduce student stress and support students better?

Appendix 2

Key Informant Interview Guidelines and Questions

Ministry of Health KII Guidelines	
Participants:	**MOH, DOH Key Informants (45-60 minutes each).**
Goals:	Explore perceptions of student mental health needs and risk factors, understanding of relevant policies, and knowledge and understanding of existing MHPSS programmes.
Introduction to the study and this interview	
Key Informant Information:	
Name:	
Date:	
Job Title:	

Years of Experience with Adolescent Education, Health or Social Support:

Semi-Structured Interview Questions:

1. What is your experience with the topic of adolescent student mental health and well-being?
2. How important is the issue of adolescent student mental health and well-being?
3. What are common mental health problems or needs in adolescent students in Viet Nam?
4. What are major factors that put kids at risk for mental health problems? (consider academic pressure, study burden, school climate, home situation, substance abuse, poverty, illness, systemic issues in education, health, social support)
5. Are there ways that the health sector (MOH, DOH) supports kids' mental health and well-being?
    a. What MOH/DOH policies exist regarding adolescent mental health and well-being?
    b. What specific services or interventions exist for students' emotional and mental health?
    c. Are these services / interventions effective?

6. Is there any coordination between the health sector and the educational sector? Please describe.

7. What types of coordination between the health system and the school system would improve support for adolescent mental health?

MOLISA KII Guidelines	
Participants:	**MOLISA, DOLISA Key Informants (45-60 minutes each).**
Goals:	Explore perceptions of student mental health needs and risk factors, understanding of relevant policies, and knowledge and understanding of existing MHPSS programmes.
<u>Introduction to the study and this interview</u>	
<u>Key Informant Information:</u>	
Name:	
Date:	
Job Title:	

Years of Experience with Adolescent Education, Health or Social Support:

Semi-Structured Interview Questions:

1. What is your experience with the topic of adolescent student mental health and well-being?

2. How important is the issue of adolescent student mental health and well-being?

3. What are common mental health problems or needs in adolescent students in Viet Nam?

4. What are major factors that put kids at risk for mental health problems? (consider academic pressure, study burden, school climate, home situation, substance abuse, poverty, systemic issues in education, health, social support)

5. Are there ways that the social services sector (MOLISA, DOLISA) supports kids' mental health and well-being?

   a. What MOLISA/DOLISA policies exist regarding adolescent mental health and well-being?

   b. What specific services or interventions exist for students' emotional and mental health?

   c. Are these services / interventions effective?

6. Is there any coordination with the educational sector? Please describe.

7. What types of coordination with the school system would improve support for adolescent mental health?

Education Sector KII Guidelines	
Participants:	**Principles, DOET, and MOET Key Informants (45-60 minutes each).**
Goals:	Explore perceptions of student mental health needs and School-Related risk factors, understanding of relevant policies, and knowledge and understanding of existing MHPSS programmes.
Introduction to the study and this interview	
Key Informant Information:	
Name:	
Date:	
Job Title:	

Years of Experience with Adolescent Education, Health or Social Support:

Semi-Structured Interview Questions:

1. What is your experience with the topic of adolescent student mental health and well-being?
2. How important is the issue of adolescent student mental health and well-being?
3. What are common mental health problems or needs in adolescent students in Viet Nam?
4. Are there ways that schools and/or the educational system put kids at risk for mental health problems? What specific aspects of school contribute to students' social, emotional and psychological problems? (consider academic pressure, study burden, school climate, home situation, systemic issues in education, health, social support)
5. Are there ways that schools and/or the educational system support kids' mental health and well-being?
   a. What school policies exist regarding student mental health and well-being?
   b. What specific services or interventions do schools have for students' emotional and mental health?
   c. Are these services / interventions effective?
6. What else could schools do to support kids' mental health and well-being?

Appendix 3

Quantitative Data Results

DESCRIPTIVE DATA: STUDENT PARTICIPANTS

Age:

Mean **14.23,** median = **14,** SD = 1.9

Range: 11 years – 18 years

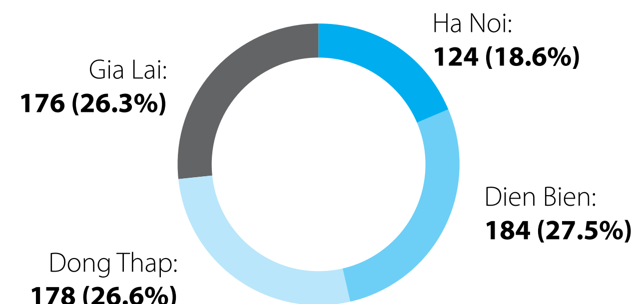
Gender:

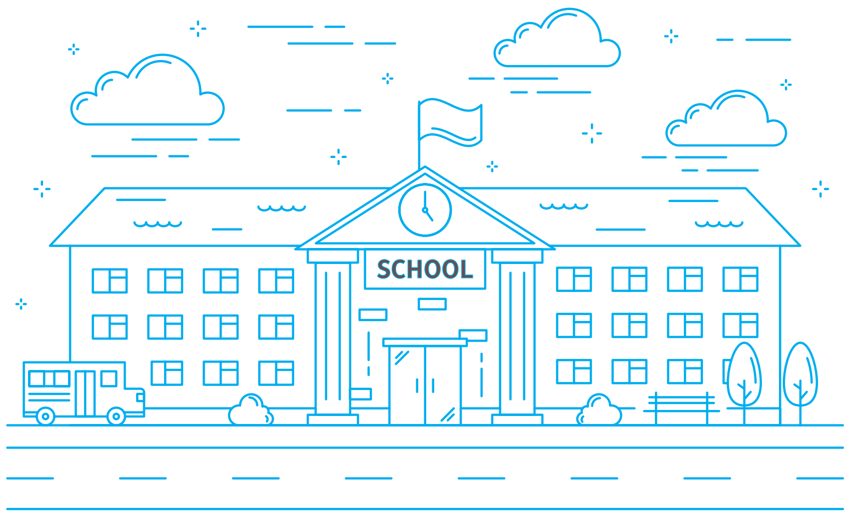
Male: **228 (34%)**
Female: **439 (66%)**

Ethnicity:

Kinh: **307 (45.9%)**	Jrai: **110 (16.5%)**	Thái: **98 (14.7%)**
Mông: **22 (3.3%)**	Ba Na: **13 (1.9%)**	Mường: **5 (.7%)**
Khơ Mú: **5 (.7%)**	Khác: **24** (bao gồm Cống, Dao, Ê đê, Hàn Quốc, Lào, Nhắng, Nùng, Phù Lá, Sơ rá, Tày, và Xơ đăng)	"N/A": **85 (12.7%)**

Province:





School level:

secondary school: **425 (63.6%)** # high school **242 (36.2%)**

Grade level: ranges from 7-12th grades

in 6th	in 7th	in 8th	in 9th	in 10th	in 11th
18.6%	25.7%	19.3%	15%	16.5%	10, 4.9%

School Type:

Public: **608** # Semi-public: **60**

Quantitative Data Regarding Mental Health, Academic Pressure and Bullying

Quantitative Data was collected from secondary school and high school students in Ha Noi, Dien Bien, Gia Lai and Dong Thap provinces. Students completed questionnaires regarding their mental health, school climate (safety, engagement, and school environment), academic pressure, and cyberbullying experiences. Participants came from three schools in each province (668 total students). Surveys in Dien Bien, Gia Lai, and Dong Thap were administered in April – May 2021. Data collection in Ha Noi was delayed in September 2021.

Mental Health Symptoms (Strengths and Difficulties Questionnaire-25).

1. Overall student mental health. Percent of students reporting normal, moderate-risk and high-risk levels of symptoms on self-report measure (SDQ-25 Total Problems and Sub-Scales). 26.1% of adolescent students reported symptoms associated with moderate or high risk for mental health problems. The most common types of problems reported were peer problems (32%) and emotional problems (30.9%). Hyperactivity symptoms were reported by 14.4% of students and conduct problems were found in 11% of students.

	Students Risk Level (N=668)		
	Normal N (%)	Moderate-Risk N (%)	High-Risk N (%)
Total Mental Health Problems	439 (65.7%)	112 (16.8%)	62 (9.3%)
Conduct Problems	581 (87%)	47 (7%)	27 (4%)
Emotional Problems	446 (66.8%)	104 (15.6%)	102 (15.3%)
Hyperactivity	552 (82.6%)	66 (9.9%)	30 (4.5%)
Peer Problems	436 (65.3%)	167 (25.0%)	47 (7.0%)

2. Student mental health and gender. See similar rates of problems among boys and girls except for Emotional Problems (symptoms of depression and anxiety) where we see significantly higher rates of emotional problem symptoms in girls compared to boys.

	Gender	N	Mean
Conduct Problems	male	226	1.85
	female	428	1.76
Hyperactivity	male	223	3.88
	female	424	3.77
Emotional Problems**	male	224	4.24
	female	427	4.92
Peer Problems	male	226	2.91
	female	423	2.99
Total Difficulties	male	216	12.88
	female	396	13.45

***Highly significant, p<.01.*
**Significant, p<.05.*

3. Student mental health and school level. See significant differences with high school students having more conduct problems, hyperactivity, emotional and total problems compared to students in secondary schools.

		N	Mean
Conduct Problems*	secondary school	414	1.68
	high school	240	1.98
Hyperactivity**	secondary school	412	3.63
	high school	235	4.12
Emotional Problems**	secondary school	413	4.46
	high school	238	5.07
Peer Problems	secondary school	413	2.91
	high school	236	3.05
Total Problems**	secondary school	387	12.62
	high school	225	14.27

***Highly significant, p<.01.*
**Significant, p<.05.*

School Climate (Adapted Maryland Safe and Supportive Schools Climate Survey; MDS3). 56 items assess 3 dimensions of school climate, including **safety** (perceived safety, bullying and aggression, general drug use), **Engagement** (connection to teachers, student connectedness, academic engagement, whole school connectedness, culture of equity, parent engagement), and **school environment** (rules and consequences, physical comfort, support, disorder). All answer choices are scored on a 4 point Likert scale from strongly agree to strongly disagree, whereby higher scores represent a more favourable school climate.

School Climate and Student Mental Health. See a weak-to-moderate relationship between student reports of school climate factors and student mental health. Student perceptions of school safety, student engagement in school and the school environment are all significantly correlated with all mental health problems. There is a moderately strong relationship between Total Mental Health Difficulties and student perceived school engagement and school environment. As correlational analyses cannot prove the direction of the relationship, it may be that (a) school climate may influence student mental health, (b) student mental health may influence their perceptions of school, (c) they both may influence each other or (d) something else may influence both school climate and student mental health.

Pearson correlation table. Cell N ranges from 570 – 643.

	School Climate		
	Student Safety	Student Engagement	School Environment
Conduct Problems	-.15**	-.18**	-.19**
Hyperactivity	-.12**	-.11**	-13**
Emotional Problems	-.08*	-.21**	-.18**
Peer Problems	-.10**	-.11**	-.15**
Total Difficulties	-.16**	-.22**	-.22**

***Highly significant, p<.01.*
**Significant, p<.05.*

School Climate and Gender. Girls and boys report similar perceptions of school safety and the school environment. Boys rate their experiences with school engagement more positively than girls.

	Gender	N	Mean
Safety	male	222	14.36
	female	416	14.03
Engagement*	male	218	68.16
	female	397	66.24
School Environment	male	220	38.28
	female	412	37.29

***Highly significant, p<.01.*
**Significant, p<.05.*

School Climate and School Level. See that high schoolers perceive school to be safer, while secondary school students report greater school engagement compared to high school students (including greater student connectedness, academic engagement and parent engagement). Students report higher rates of bullying in secondary school. Students report higher rates of drug and alcohol use in high school.

		N	Mean
Safety**	secondary school	404	13.56
	high school	233	15.14
Engagement**	secondary school	387	67.84
	high school	227	65.33
School Environment	secondary school	403	37.80
	high school	228	37.32
Perceived Safety*	secondary school	414	6.74
	high school	235	6.49
Bullying**	secondary school	418	3.80
	high school	239	4.77
Drug Use**	secondary school	419	2.91
	high school	240	4.00
Connection to Teachers	secondary school	415	14.80
	high school	238	14.49
Student Connectedness**	secondary school	421	11.76
	high school	240	10.91
Academic Engagement**	secondary school	421	9.80
	high school	241	9.45
Whole School Connectedness	secondary school	422	10.05
	high school	240	9.99
Culture of Equity	secondary school	411	9.83
	high school	236	9.76
Parent Engagement**	secondary school	417	11.49
	high school	236	10.91
Rules and Consequences	secondary school	414	12.44
	high school	239	12.25
Physical Comfort*	secondary school	424	9.04
	high school	241	8.59
Support	secondary school	421	7.04
	high school	236	7.06
Disorder	secondary school	418	9.23
	high school	238	9.52
Total School Climate	secondary school	354	120.18
	high school	211	117.46

***Highly significant, p<.01.*

**Significant, p<.05.*

School Climate and Province

See differences on perceived safety of students in Ha Noi vs. all other provinces. Students in Ha Noi feel significantly safer than students in each other province. Also see students in Gia Lai feel significantly less safe than students in each other province. Students in Dien Bien report the least school engagement in school while students in Dong Thap are the most engaged.

		N	Mean
Ha Noi	Safety**	124	17.86
	Engagement*	124	66.88
	Environment	124	38.35
DT	Safety	176	15.14
	Engagement	169	68.98
	Environment	172	37.39
DB	Safety	170	13.38
	Engagement	162	65.75
	Environment	170	37.31
GL	Safety	162	11.19
	Engagement	154	66.20
	Environment	161	37.76

***Highly significant, p<.01.*

**Significant, p<.05.*

Academic Pressure (Educational Stress Scale for Adolescents; ESSA) and Gender. The ESSA includes 16 items rated by students on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree) with higher scores indicating greater stress. The scale covers five dimensions of educational stress including study pressure (4 items), worry about grades (3 items), despondency (3 items), self-expectation (3 items), and workload (3 items).

Academic Pressure and Mental Health. Correlational analyses indicate a moderate-to-strong relationship between student experiences of academic pressure and student reported mental health. Study pressure, worry about grades, despondency related to academics, self-expectations, and workload were all significantly related to all mental health problems (excluding workload x peer problems). There is a strong relationship between total academic pressure and total mental health difficulties. As correlational analyses cannot prove the direction of the relationship, it may be that (a) academic pressure may influence student mental health, (b) student mental health may influence student experiences of academic pressure, (c) they both may influence each other or (d) something else may influence both academic pressure and student mental health.

Pearson correlation table. Cell N ranges from 571 – 650.

	Academic Pressure					
Student Mental Health	Total Academic Pressure	Study Pressure	Worry About Grades	Despondency	Self-Expectation	Workload
Conduct Problems	.33**	.30**	.15**	.31**	.24**	.19**
Hyperactivity	.36**	.34**	.14**	.36**	.26**	.22**
Emotional Problems	.35**	.30**	.18**	.36**	.32**	.13**
Peer Problems	.14**	.13**	.10**	.10**	.13**	.05
Total Difficulties	.42**	.38**	.20**	.40**	.35**	.21**

***Highly significant, p<.01.*

**Significant, p<.05.*

Academic Pressure and Gender

See the girls experience significantly higher levels of academic pressure including pressure to study, worries about grades, self-expectations, and despondency regarding academics. This is in spite of similar perceptions of academic workload among boys and girls.

	Gender	N	Mean
Pressure to study**	male	224	10.17
	female	429	11.11
Worry about grades**	male	222	9.51
	female	429	10.33
Self-expectation**	male	220	8.60
	female	423	9.75
Workload	male	219	7.92
	female	435	8.03
Despondency**	male	225	8.13
	female	436	8.85
Total Pressure**	male	211	44.27
	female	407	48.11

***Highly significant, p<.01.*

**Significant, p<.05.*

Academic Pressure and School Level. See that high school students report significantly more academic pressure compared to secondary school students. The academic stress comes from pressure to study, self-expectations, workload, and their experience of greater despondency.

		N	Mean
Pressure to study**	secondary school	414	10.15
	high school	239	11.86
Worry about grades	secondary school	412	9.91
	high school	239	10.26
Self-expectation**	secondary school	415	8.90
	high school	237	10.12
Workload**	secondary school	416	7.75
	high school	238	8.40
Despondency**	secondary school	419	8.24
	high school	242	9.22
Total Pressure**	secondary school	389	44.93
	high school	229	49.82

***Highly significant, p<.01.*
**Significant, p<.05.*

Total Academic Pressure and Province. See higher levels of academic pressure in Gia Lai and Ha Noi compared to Dong Thap and Dien Bien provinces.

	N	Mean
Ha Noi	124	47.61
DT	166	45.40
DB	164	45.73
GL	160	48.71
Total	615	46.76

Time Spent Studying After School. See that over 50% of students are studying more than 2 hours with 28% reporting more than 3 hours of study each night.

a. Almost none – 24 (3.6%)

b. less than one hour – 60 (9.0%)

c. 1–2 hours – 225 (33.7%)

d. 2–3 hours – 169 (25.3%)

e. more than 3 hours – 188 (28.1%)

Time for Private Tutoring and Extra Classes. See half of students with 2 or fewer hours of extra classes or tutoring per week. And see half with more than 3 hours per week, including 15% with more than 9 hours a week of extra classes/tutoring.

a. Almost none – 213 (31.9%)

b. 1–2 hours – 138 (20.7%)

c. 3-5 hours – 130 (19.5%)

d. 6-8 hours – 83 (12.4%)

e. 9-12 hours – 50 (7.5%)

f. more than 12 hours – 51 (7.6%)

g. Academic Performance.

Student Reported GPA. No significant gender differences were detected.

	Maths N (%)	VietnameseN (%)	Overall GPAN(%)
Below 5	53 (7.9%)	19 (2.8%)	10 (1.5%)
5-6.9	199 (29.8%)	172 (25.7%)	108 (16.2%)
6-7.9	152 (22.8%)	252 (37.7%)	229 (34.3%)
8-10	261 (39.1%)	223 (33.4%)	315 (47.2%)

Cyberbullying frequency. A total of 668 student responses to the question, "Have you ever been cyberbullied?" No significant gender differences or providence differences were detected.

Have you ever been cyberbullied?"	
Never	316 (47.3%)
Rarely	200 (29.9%)
Sometimes	135 (20.2%)
Often	14 (2.1%)

Cyberbullying Frequency and Distress. Adapted from the Revised Cyberbullying Inventory. The Revised Cyber Bullying Inventory, Viet Nam includes 18 items regarding student experiences on the internet during the previous 6 months, including frequency of experiences and distress regarding the experiences. Higher scores on the scale reflect greater frequency of cybervictimization and greater associated stress.

Cyberbullying and School Level. High schoolers are significantly more likely to experience cyberbullying and report significantly more distress related to cyberbullying compared to students in secondary schools.

		N	Mean
Cyberbullying frequency**	secondary school	395	2.35
	high school	237	3.35
Cyberbullying distress**	secondary school	363	14.90
	high school	221	19.13

Cyberbullying and Gender. No significant gender differences were detected for student reported cyberbullying frequency and distress.

		N	Mean
Cyberbullying frequency	male	217	2.68
	female	415	2.74
Cyberbullying distress	male	201	14.89
	female	383	17.39

Teacher Survey Results

Teacher participants include 66 teachers who completed a survey.

Descriptive Data

Province:

Ha Noi = 12

Dien Bien 18

Dong Thap 17

Gia Lai 18

School level:

secondary school - 40 (60.6%)

high school - 24 (36.4%)

Grade level teach:

Grade 7 - 23

Grade 8 - 15

Grade 9 - 15

Grade 10 - 16

Grade 11 - 16

Grade 12 - 15

School Type:

Public: 64 (97%)

Semi-public: 1 (1.5%)

Age: Mean=39.61, Median=40, SD=6.23 (ages 55 – 25)

Gender:

Male: 10 (15.2%)

Female: 56 (84.8%)

Ethnicity:

54 (81.8%) Kinh

3 (4.5%) Thái

1 (1.5%) Thổ

Highest educational level achieved:

HS

some college

college – 5 (7.6%)

college - extra training – 48 (72.7%)

Masters – 13 (19.7%)

Years teaching experience: Mean=16.86; median=18, SD=6.43 (range 1 -29)

Teaching specialty: # of each

[1] Sciences - 17

[2] Math - 12

[3] Literature-Vietnamese - 10

[4] History - 7

[5] Foreign Language - 9

[6] Other social sciences subject - 6

[7] Supplemental subject - 6

Average class size: Most teachers have 30 – 40 students in a class, and 38% have 40 – 50 students in a class.

a. # less than 30 students: No – 64 (97%); Yes – 2 (3%)

b. # 30-40 students: No 23 (34.8%); Yes – 43 (65.2%)

c. # 40-50 students: No 41 (62.1%); Yes 25 (37.9%)

d. #50-60 students: No 66 (100%)

e. # more than 60 students: No 66 (100%)

1. **How concerned are you about your students' stress and well-being?** Almost all teachers are concerned about their students' stress and well-being (91%) with 53% of teachers reporting they are "Very concerned."

	N (%)
Not at all concerned	1 (1.5%)
A little concerned	4 (6.1%)
Somewhat concerned	25 (37.9%)
Very concerned	35 (53%)

2. **How concerned are you about your students' mental health?** Almost all teachers are concerned about their students' mental health (95%) with 54% of teachers reporting they are "Very concerned."

	N (%)
Not at all concerned	0
A little concerned	3 (4.5%)
Somewhat concerned	27 (40.9%)
Very concerned	36 (54.5%)

3. **Approximately how many of your students suffer from stress problems in the past month?**

   a. 0-10% - 34

   b. 10-20% - 15

   c. 20-30% - 3

   d. 30-40% - 7

   e. 40-50% - 2

   f. 50-60% - 2

   g. 60-70% - 1

   h. 70-80% - 2

   i. 80-90%- 0

   j. 90-100%- 0

4. **Approximately how many of your students suffer from mental health problems in the past month?**

   a. 0-10% - 50

   b. 10-20% - 10

   c. 20-30% - 3

   d. 30-40% -3

   e. >40% = 0

5. What are mental health problems that you see in your students?

	N (%)
Anxiety	34 (51.5%)
Poor attention	61 (92.4%)
Low-energy/tired	40 (60.6%)
Sad/depressed	10 (15.2%)
Lack of confidence	46 (69.7%)
Angry/aggressive	12 (18.2%)
Disruptive behaviour in classroom	13 (19.7%)
Oppositional or defiant behaviour in the classroom	7 (10.6%)
Alcohol/substance abuse	3 (4.5%)
Serious peer conflicts	6 (9.1%)

6. Does student stress impact student academic success?

	N (%)
Stress improves student academic performance	2 (3%)
Stress does not affect academic performance.	3 (4.5%)
Stress negatively affects academic performance	61 (92.4%)

7. What are the contributing factors to why students may develop a mental health problem?

	Not a Factor	Minor Factor	Moderate Factor	Major Factor
Bad behaviour	**10 (15.2%)**	**28 (42.4%)**	**18 (27.3%)**	**4 (6.1%)**
Genetics	**17 (25.8%)**	**25 (37.9%)**	**16 (24.2%)**	**6 (9.1%)**
Family problems	4 (6.1%)	6 (9.1%)	**25 (37.9%)**	**28 (42.4%)**
Academic pressure	6 (9.1%)	20 (30.3%)	**27 (40.9%)**	**11 (16.7%)**
Life stress	4 (6.1%)	9 (13.6%)	**36 (54.5%)**	**15 (22.7%)**
Personality	**14 (21.2%)**	**23 (34.8%)**	**19 (28.8%)**	**5 (7.6%)**
Environments	6 (9.1%)	8 (12.1%)	**30 (45.5%)**	**17 (25.8%)**
Trauma	9 (13.6%)	14 (21.2%)	**31 (47%)**	**8 (12.1%)**
Parenting	1 (1.5%)	7 (10.6%)	28 (42.4%)	**26 (39.4%)**
Karma	**48 (72.7%)**	10 (15.2%)	5 (7.6%)	0
Spiritual failing	**45 (68.2%)**	16 (24.2%)	1 (1.5%)	**1 (1.5%)**

8. About what percentage of children in Viet Nam suffer from a mental health problem? See that most teachers underestimate rates of mental health problems in children.

a. **Less than 5% - 13 (19.7%)**

b. **5-15% - 29 (43.9%)**

c. 15-25% - 17 (25.8%)

d. 25-50% - 4 (6.1%)

e. 50-75% - 1 (1.5%)

f. More than 75% - 0

Perceptions of Teacher and School Roles, Barriers and Needs Regarding Student Mental Health

9. Teachers' perceptions of personal competency and role to support children with psychosocial problems. Most teachers feel confident in their basic knowledge about student mental health, although a sizeable group (about 36%) do not have enough information about mental health. Teachers also largely agree that identifying and supporting students with mental health problems is part of their role.

10.

	Completely disagree	Disagree	Agree	Completely agree
I have enough information about risk factors for student mental health problems.	7 (10.6%)	16 (24.2%)	**39 (59.1%)**	**4 (6.1%)**
I have enough information about the causes of mental health problems.	5 (7.6%)	17 (25.8%)	**42 (63.6%)**	**2 (3.0%)**
I have enough information about school psychosocial services available to students.	1 (1.5%)	10 (15.2%)	**48 (72.7%)**	**7 (10.6%)**
I have enough information about psychosocial services in the community.	4 (6.1%)	20 (30.3%)	**40 (60.6%)**	**2 (3.0%)**
I am confident in my ability to identify students with mental health or well-bring problems.	3 (4.5%)	12 (18.2%)	**44 (66.7%)**	**7 (10.6%)**
I am confident in my ability to support students with mental health or well-being problems.	1 (1.5%)	17 (25.8%)	**43 (65.2%)**	**5 (7.6%)**
What do you think is your role for supporting students with mental health problems?	Completely disagree	Disagree	Agree	Completely agree
It is not my role to support students with mental health problems.	**28 (42%)**	**26 (39.4%)**	10 (15.2%)	2 (3%)
I should help identify students with mental health problems. (informally or with screening)	0	0	52 (78.8%)	14 (21.2%)
I should help link students with problems to a doctor or services like counselling.	0	4 (6.1%)	50 (75.8%)	12 (18.2%)
I should work with school counsellors or other professionals to know how best to support students with problems in the classroom.	0	1 (1.5%)	49 (74.2%)	16 (24.2%)
I should teach social skills or life skills as part of the curriculum.	0	0	45 (68.2%)	21 (31.8%)
I should provide supportive counselling to my students with mental health problems.	0	1 (1.5%)	43 (65.2%)	22 (33.3%)

11. **What are barriers to providing more services for children with mental health problems at school?** Teachers identified several major barriers to providing more services for children with mental health problems at school, including lack of human resources (like counsellors), lack of interest / concern from parents, lack of training opportunities for school staff, and lack of policy to guide services.

	Not a Barrier	Minor Barrier	Moderate Barrier	Major Barrier
Lack of human resources (like counsellors)	4 (6.1%)	11 (16.7%)	24 (36.4%)	27 (40.9%)
Lack of funding	11 (16.7%)	17 (25.8%)	23 (34.8%)	14 (21.2%)
Lack of interest/concern from leadership	19 (28.8%)	12 (18.2%)	18 (27.3)	17 (25.8)
Lack of interest/concern from parents	3 (4.5%)	5 (7.6%)	11 (16.7%)	47 (71.2%)
Lack of interest/concern from teachers	9 (13.6%)	18 (27.3%)	15 (22.7%)	24 (36.4%)
Lack of training opportunities for school staff	4 (6.1%)	9 (13.6%)	39 (59.1%)	14 (21.2%)
Lack of policy to guide services	4 (6.1%)	8 (12.1%)	37 (56.1%)	16 (24.2%)

12. Does your school have any policies in place for student mental health and well-being?

1. No. 12 (18.2%)
2. Yes. 53 (80.3%) Most identify the school counselling room and counselling service, and note a nurse at school.

13. Does your school have any resources or programmes in place for supporting student mental health and well-being?

1. No - 12 (18.2%)
2. Yes - 54 (81.8%) Many teachers report private doner scholarships for poor students. Also report that NGOs and social enterprises have provided help for students with financial or social difficulties, and have supported the school with sexual reproductive health or social skills education for students.
3. If yes, are the resources and programmes adequate for supporting students?
   i. No - 38 (57.6%)
   ii. Yes - 17 (25.8%)

14. Have you had any training in understanding and supporting student mental health and well-being?

a. No - 57 (86.4%)

b. Yes – 9 (13.6%) These teachers report receiving training from MOET and DOET. One reported attending a MOET training on general adolescent health. Another attended a MOET training on school counselling including adolescent mental health risk factors and some solutions to support students. Another teacher reported attending a DOET training on adolescent sexual reproductive health.

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