REPORT: Situation Analysis of the Social Protection Centres for People with Severe Mental Disorders under the Management of the Ministry of Labour Invalids and Social Affairs

EXECUTIVE SUMMARY

This research was a collaboration between the Research and Training Centre for Community Development (RTCCD) and the Bureau of Social Protection (BSP) under the Ministry of Labor, Invalid and Social Affairs (MOLISA) with financial support from the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The aim of the study was to measure the gap between practical needs of mental patients and current response of the MOLISA mental healthcare system. The results can be used to determine future action within the National Mental Healthcare Action Plan of 2011-2020. Data were collected in three specific studies:

1) A review of laws and regulations at both the central level, with the source of information from MOLISA and the Ministry of Health (MOH), and the local level with information obtained from eight selected provinces/cities

2) An assessment of the current status of the MOLISA centers which are in charge of the care and protection of people with severe mental illness in eight surveyed provinces/cities; and

3) An assessment of the provision of community-based services providing care and social support to those affected by mental illness within the areas surveyed.

Data analysis involved a pooled effort from the research team and policy makers who work with social protection and rehabilitation for mentally ill patients at MOLISA. A strong collaboration in research activities and data analysis by policy makers and local researchers facilitated a transfer of research results to policy adjustments in a timely fashion. The research team has been continuously updating the changes in health care policy for mentally ill patients that were issued by MOLISA in 2011 in order to adjust the contents of the report.

The study ended up with five specific conclusions and five recommendations for action to be taken during the period 2012-13, and one in particular was to most strongly benefit WHO and UNICEF.

Conclusions

1. The mental healthcare system managed by the MOLISA consists of seventeen social protection centers in sixteen provinces. It is responsible for making national social protection policies that affect vulnerable populations, including mentally ill patients, in every commune in Vietnam. This system functions parallel to a MOH system which includes the National Institute of Mental Health, two national psychiatric hospitals, 32 provincial psychiatric hospitals, 33 psychiatric departments at provincial general hospitals and 33 psychiatric departments at provincial social disease centers, in addition to a national community-based mental healthcare program that is now functioning in 70% of the communes. The core activity of this program is the distribution of medication to identified schizophrenics and epileptics (diagnosed at either a provincial or a national psychiatric hospital) by communal healthcare centers.

2. There is a lack of a comprehensive mental healthcare national policy. This has resulted in a winding interaction between the MOLISA and the MOH systems, as can be seen in the national standard guideline package and the practical performance at the local level. Projects 32 and 1215 have created a context which invites collaboration amongst various agencies, particularly MOLISA and the MOH.

3. The mental healthcare system managed by MOLISA has the following noticeable features:

    a. The social protection and rehabilitation center for mental patients has acted as a physical institution which takes in patients who live in the street, who were ignored by their family members and relatives, who have no caretakers or who are members of a family that was recognized for its involvement in the struggle for the Independence of Vietnam. The centers exist in only sixteen provinces/cities (approximately 20% of provinces in Vietnam). At present, these centers can provide less than one third of the mental healthcare needs of those residing within those provinces/cities. In the eight surveyed settings, it was discovered that the services that were jointly provided by MOLISA and the MOH has been devoid of professional standards. The network that has been established has provided nothing more then administrative and logistic management which includes referral and the discharge of patients. This situation may exist because of the lack of a regulation of professional activity and standards by the provincial healthcare system. It was found that 18.8% of the mentally ill patients surveyed are at present caged and or fettered at home because their families and communities, who would like to send them to the social protection centers, had their application requests denied.

    b. While healthcare goals have been set by the Vietnam Communist Party (CP) and WHO has made healthcare and rehabilitation recommendations for people who suffer from mental health problems in developing countries in these early decades of the 21st century, the MOLISA system lacks even the basic resources that could meet the mental healthcare needs at either institutions or communities. All seventeen of the provincial centers face a severe shortage of necessary resources. While the human resources are enthusiastic about carry out their duties, they have not been professionally trained and they have not acquired information or skills needed or learned methodologies and they are unable to provide proper healthcare and rehabilitation for those who are mentally ill. The physical environment has not been designed or equipped to function as a mental healthcare rehabilitation facility and it therefore is not operated as such and cannot provide a patient-centered approach which respect their fundamental human rights. None of the surveyed facilities had been supplied with any technical guidelines and none of them were in communication or collaborating with their peers within the mental healthcare system or any other relevant system, and this was particularly the case regarding the MOH. Significantly, their budgets were so limited that they could provide housing services only and not mental health care or rehabilitation of the clients.

    c. For the last five years, the MOLISA system has delivered social protection services as required by Decrees 67/2007/ND-CP issued on April 13, 2007 and 13/2010/ND-CP issued on February 27, 2010. These decrees include the provision of services to the mentally ill patients. By 2011, it was assessed that the system provides the basic services required by Decree 13 to mentally ill patients. However, according to the MOLISA's definition:, "a mentally ill person" is anyone who was treated at a psychiatric hospital. So, anyone who did not receive treatment at a psychiatric hospital is by definition 'not mentally ill'. Consequently, many people who are mentally ill are not a statistic of the MOH system and activities managed by the MOLISA ignore a large proportion of mentally ill people who need assistance.

d. It can be seen that the mental healthcare systems operated by either MOLISA or the MOH have given attention to psychotic disorders but it ignores such things as depression, anxiety, post traumatic stress disorder, disorders due to alcohol abuse or substance abuse, and particularly those mental disorders which are common in pregnant women, breastfeeding mothers, children and adolescents. Such care is not being provided for a number of reasons, the main one being the lack of an IEC program to provide basic information of staff members and citizens on the prevention, treatment and rehabilitation of mentally ill people.

4. There exists a plan to upgrade the system by implementing two national projects, one being "National Project 32/QD-TTg in reference to the development of social work," issued on March 25, 2010, and the other being "National Project 1215/QD-TTg in reference to community-based social support and rehabilitation for mentally ill patients and people with mental disorders period 2011-2020," issued on July 22, 2011. The possibility that these projects might be realized is a positive movement by MOLISA and it reflects a strong political determination of the Vietnamese government in the last two years to improve social equity and security in general and for the benefit of the mentally ill people in particular.

5. Due to a severe deficit of resources and cooperation between agencies and two new Projects 32 and 1215 (they are both still in the model establishment phase), there has been no substantial improvement in the provision of mental healthcare since late 2010 when the research team collected the data. It is also obvious that the training bodies of MOLISA, the MOH and the Ministry of Education and Training are now even less able to provide on-the-job training to fill the gaps in profession within the MOLISA system at both community and provincial levels. Therefore, it is believed that the conclusions and recommendations that resulted from this study are pertinent and offer a good opportunity for MOLISA to adjust its priorities and schedule the implementation of Projects 32 and 1215 in the next two years (2012-13).

Recommendations for action

1. Establishing a vision and national action framework for mental healthcare in Vietnam should be given priority status in these next two years. Plans should be made to carry out the activities presented in Projects 32, Project 1215, the mental healthcare project within the National Target Program and Project 930/QD-TTg of June 30, 2009 (which addresses improving and establishing provincial psychiatric hospitals where that kind of hospital does not yet exist), to be run by MOLISA and the MOH. A taskforce group should be created to draw up the draft and introduce a national mental healthcare policy that can function with the existing resources of the nation and approximate WHO recommendations. The policy should facilitate the collaboration of ministries and local agencies to result in the creation of action plans that could function between now and 2020, with a goal being the forming an integrated multi-sectoral mental healthcare system of which the core component is preventative medicine, rehabilitation and community-based support activities for mentally ill people.

2. The National Assembly (NA) is encouraged to issue a resolution to extend the political imperative for MOLISA and the MOH to get together to build and implement one system of community-based mental healthcare at the grassroots level. Meanwhile, it is suggested that MOLISA's Projects 32 and 1215, the national target programs and MOH's Project 930 focus on an overall objective that would renovate the mental healthcare and rehabilitation system for the mentally ill people following WHO recommendations and with a goal of "equity, efficiency, and sustainability" in healthcare as set by the CP. If this direction is taken, each project would concentrate on specific objectives to form both an infrastructure and a management mechanism

of the mental healthcare system in every province. These systems would function with the treatment and rehabilitation facilities and the community-based care regime.

3. Activities on mental healthcare in 2012 should be scheduled as follows:

   - To obtain agreement on the vision and action plan framework for the national mental healthcare policy. This is a high priority activity and every effort should be made to attract the participation of various organizations and multi-sector researchers.

   - To design a mental healthcare model that can function at the provincial level based on the strategies presented in Projects 32, 1215 and 930 and the national community-based mental healthcare program, as well as WHO recommendations. This model is to contain two components: (1) **A basic, community-based component** which is responsible for preventative medicine, early detection, early intervention and treatment and early rehabilitation. It is to be performed and controlled by a multi-sectoral workforce made up of social workers and health workers; (2) **A support component** consisting of care and treatment clinics which involves the cooperation of the psychiatric hospitals with consideration for social protection for mentally ill patients. There should be one clinic in each province that can diagnose, treat, care for and rehabilitate severe psychiatric cases.

   - To plan and introduce an integrated mental healthcare model at the primary level (district or commune), piloted in one district.

4. It is suggested that a technical support group be established containing national experts with experience in multi-sectoral consultancy or those who specialize in mental healthcare, to link and backup the activities run by MOLISA and the MOH. This think tank should be formed and coordinated by VUSTA because its role as assigned by the NA and the Vietnamese government is to provide technical consultancy and critical review for the development of programs and projects.

5. The support of UNICEF and WHO is indispensable and this should be promoted using three approaches:

   - Help relevant ministries to agree on a holistic and community-based approach in mental healthcare and to give priority to models and initiatives which are based on research evidence and are appropriate when considering the existing resources of the country.

   - Foster the establishment and operation of the technical support group while also advocating for the swift creation of political and legislative framework on mental healthcare in Vietnam. Workshops and pilot studies to collect evidence for policy-orientation should be endorsed in 2012-13.

   - Provide consultancy to VUSTA to help them establish and run mental healthcare think tank and ensure its role as a scientific and independent voice that will influence policy review of relevant law makers (the NA Committee for Social Affairs, the Department of Social Affairs of the Commission for Ideology of Communist Party, MOLISA, MOH and Ministry of Finance).

   - Strengthen the involvement of civil society organizations in the area of mental healthcare by providing them with technical and financial aid so that they can establish and pilot policy-oriented models, fund workshops and engage in policy advocacy activities making use of evidence obtained in field studies and human resource training.