

**Barriers and facilitators to the integration of
services for depression in primary care in
Vietnam: the perspective of primary care
providers**

by

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Abstract

Although evidence suggests that depression is one of the leading causes of morbidity and disability in the world, treatment for depression is often unavailable, especially in low and middle-income countries. This gap in treatment has led to momentum to improve and scale-up services through approaches such as task-shifting. These steps, however, must be carefully considered to ensure that such efforts are appropriate, effective and acceptable for populations being served. This dissertation assesses barriers and facilitators to the integration of services for depression in primary care in Vietnam from the perspective of primary care providers (PHPs) by examining sociocultural considerations and individual, organizational and structural factors that might influence the process of service integration. The study has three components. The first, a narrative review, explores considerations for studying depression cross-culturally and the implications for global depression research. The results suggest that although depression is universally experienced, it varies by cultural context, and improved epidemiological methods that account for these cross-cultural variations are needed. The relationship of social determinants of health to depression must also be further explored. The second component, a qualitative study, examined how depression is conceptualized in Vietnam from the perspective of PHPs. Findings indicate that although depression is not widely recognized or seen in primary care, depression in Vietnam is largely understood in psychosocial terms. Along with efforts to improve screening and help-seeking, the introduction of psychosocial depression interventions in primary care is both appropriate and important. The third component used mixed methods to assess barriers and facilitators to the integration of services for depression in primary care. The findings suggest that although PHPs are motivated to build capacity and deliver services for depression for their patients, systemic factors must be addressed to ensure that PHPs are adequately trained and supported to deliver psychosocial interventions. By integrating an approach that examines sociocultural considerations of depression with individual, organizational and structural factors influencing service integration, this study suggests that a balance is both necessary and possible between approaches prioritizing efficient treatment delivery and those emphasizing the need for contextualization and careful sociocultural consideration. A balance of these approaches should be applied when introducing enhanced depression services cross-culturally.

Keywords: Depression; Vietnam; Primary healthcare; Global mental health; Transcultural psychiatry; Mental health services

Dedication

To Mom and Dad, for being endlessly loving and supportive and resisting the urge to ask “how’s your thesis going” (most of the time).

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List of Acronyms

CBS	Culture-bound syndrome
CHS	Commune health station
CHW	Community health worker
CI	Confidence interval
CIT	Contextual Interaction Theory
CMD	Common mental disorder
CMHP	Community Mental Health Programme
CRSS	Culture-related specific syndrome
DALY	Disability Adjusted Life Years
DOH	Department of health
DSM	Diagnostic and Statistical Manual
EM	Explanatory model
HIC	High-income country
ICD	International Classification of Diseases
LMIC	Low and middle-income country
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
NGO	Non-governmental organization
OPC	Outpatient clinic
PHAD	Institute of population, health and development
PHP	Primary healthcare provider
PTSD	Post-traumatic stress disorder
RCT	Randomized control trial
SFU	Simon Fraser University
TVM	Traditional Vietnamese Medicine
USAID	United States Agency for International Development
YLD	Years Lived with Disability

Chapter 1.

Introduction

1.1. Research Objective

Mental health disorders including depression are a significant and growing contributor to the global burden of disease (Murray et al., 2012). Despite the large burden of mental disorders worldwide, mental health services are severely lacking, especially in low and middle-income countries (mhGap, 2008). This gap in services contributes to the unnecessary and prolonged suffering of people with mental health problems, and may lead to economic hardship and to vulnerability to violence and human rights abuses. This treatment gap has been called a “failure of humanity” (Kleinman, 2009)

Governments and international donors have historically neglected mental health, giving it low priority in national health budgets and funding schemes (Becker & Kleinman, 2013; Saraceno et al., 2007). While significant investment was made in important areas such as infectious disease and maternal and child health in the last fifteen years, mental health has been largely overlooked in the global health arena (Thorncroft & Votruba, 2015). The importance of mental health for sustainable development has been established (De Silva, 2015; Thorncroft & Patel, 2014), and the inclusion of mental health in the Sustainable Development Goals in September 2015 indicates that attention to the importance of mental health in a global context is growing (World Health Organization, 2016). Despite this, mental health services remain under-developed and under-resourced in much of the world (Becker & Kleinman, 2013; De Silva, 2015).

Many low and middle-income countries (LMICs) have significant gaps in specialist mental health services and offer limited training in mental health to general practice physicians and nurses (Kakuma et al., 2011). As a response, researchers and advocates for global mental health have recommended task-shifting approaches to improve and

expand the availability of services (Buttorff et al., 2012; Mendenhall et al., 2014; Patel et al., 2007). This approach includes the integration of mental health services into primary health care settings (Patel et al., 2009; Patel et al., 2007). At the same time, proponents of transcultural psychiatry caution that enhanced mental health services in LMICs must be culturally valid and meaningful, and that the direct importation of Western approaches may be ineffective or even harmful (Kirmayer, 2005; Kirmayer & Pedersen, 2014). This balance between improved access and availability of services and ensuring cultural acceptability is a challenge for mental health service provision in LMICs, but one that is not impossible to navigate.

In Vietnam, the government is developing a National Mental Health Strategy on mental disorders for the period of 2015-2020, which includes the prioritization of enhancing community based mental health services (Goldner, Murphy, & Ho, 2015). This includes the enhancement of community-based services for common mental disorders such as depression, which have been largely neglected. In accordance with this policy priority, researchers at Simon Fraser University and the Hanoi-based non-governmental organization (NGO) Institute of Population, Health and Development (PHAD) have been testing an intervention (described below) that integrates services for depression into primary health care settings. This approach will be scaled-up beginning in 2016, marking the first effort to integrate depression services into primary care in Vietnam on a large scale.

The successful integration of mental health services into primary care depends upon a number of important factors, including the identification of evidence-based approaches that are suitable for use in primary care settings and the policy and program support of government and management in the health care sector. Primary care providers (PHPs) are central to the successful integration of services into primary care. The cultural and social settings in which they live and work, the workplace environment, their formal training and informal knowledge may all influence the process of mental health service integration into primary care settings.

This study assesses barriers to and facilitators of the integration of mental health services in primary care by measuring (quantitatively) and understanding (qualitatively) variables related to: attitudes, beliefs, social and cultural norms, policy, training and communication, capacity and control from the perspective of PHPs at the commune level

in Hanoi. The results of this study will inform the ongoing development of enhanced services for depression in primary care in Vietnam, and the scale-up of these services throughout the country. They will also add to the knowledge base about how depression is experienced in the country, informing the enhancement of approaches to training, screening and treatment that are culturally appropriate and relevant to the local context. In this study I use a mixed methods approach that draws on the fields of global mental health and transcultural psychiatry in addition to Contextual Interaction Theory to assess the extent to which numerous contextual variables might act as barriers and facilitators to the integration of services for depression in primary care. I explore the conceptualization of depression in Vietnam in order to understand how enhanced services for depression might be designed and delivered in a way that is culturally meaningful and appropriate for Vietnamese communities. This approach, which combines an exploration of the experience and understanding of depression and the identification of other contextual barriers and facilitators, is novel, as it allows for a comprehensive understanding of context. It responds both to the need for enhanced mental health services and for these services to be valid and appropriate to the local context. The theoretical approaches used in this study are further described below.

In addition to being applicable to the Vietnamese context, this study also contributes to the fields of global mental health and transcultural psychiatry in several ways. The approach used in Vietnam may inform similar studies in other LMIC contexts, contributing to the evidence base about ways in which to assess barriers and facilitators to mental health service integration in a way that comprehensively captures the local context, including culturally based understandings of mental illness. Identifying barriers and facilitators to the integration of mental health services from the perspective of health workers is an important first step in the process of planning for mental health service integration in primary care. Understanding these factors can help policy makers to plan for and avoid possible challenges to integration. It can also help to identify and leverage important opportunities for success. The approach outlined in this study thus makes an important contribution to the evidence base in this field. The integration of the cultural component, informed by transcultural psychiatry, and the identification of barriers and facilitators, which responds to the need to enhance and scale-up services for depression in Vietnam that is central to global mental health, demonstrate that a balance is both necessary and possible between these two approaches. The balance between these two

approaches is a common thread throughout this study. At the core of this study is the exploration of the tension between the need to expand and scale-up mental health services in LMICs in order to fill a critical gap in service availability, and the need to ensure that such approaches are responsive to the local context, culturally valid and appropriate for local needs. This study therefore contributes to an ongoing discussion in the fields of global and transcultural mental health, and provides evidence that is relevant to both approaches, making recommendations about how best to navigate the tensions and challenges that are inherent in the area of mental health services research in a global context.

1.2. Rationale

PHPs are the front-line of the integration of mental health services into primary care. They interact with patients face-to-face, listening, assessing, diagnosing and treating. If health workers are not trained, willing, able and supported to adopt the strategies necessary for integration to be meaningful, then it is very unlikely to succeed. PHPs are also community members, often serving the communities in which they live. They thus have important insight into community illness behaviours and beliefs. Healthcare workers, and the organizational and cultural context in which they work, are key to understanding the variables that lead to successful integration of mental health services into primary care and to understanding any impediments.

Mental health problems, while universally experienced, are often manifested, understood and approached differently across cultures (Kirmayer, 1989; Kleinman, 1988; Simmons, 2007). It is therefore important to understand the culturally based meanings of mental illness in the context in which integration of mental health services are being integrated into primary care. In this dissertation, I argue that understanding local conceptualizations of mental disorder can help to mitigate challenges to successful integration of services into primary care and create opportunities for effective mental health service provision.

Challenges to primary care integration are complex and exist at multiple levels. The WHO (2007b) identified a number of challenges at the individual level including possible discomfort by health workers in dealing with mental illness and “questioning their

role” as mental health workers. In a study examining service quality for mental health in acute care, Baker et. al. (2005) note that “any improvement in service provision is likely to require the analysis of staff perceptions, followed by programmes to address negative attitudes” (Baker et al., 2005).

Challenges may also exist at the organizational level, including the availability of time and overwork of PHPs, who might feel overwhelmed and perceive steps towards the integration of mental health care as adding to their workload (World Health Organization, 2007b). Training of health care workers, both as part of their health professional training and through continuing education, also has implications for quality of care and for health worker motivation (World Health Organization, 2007a).

Structural-level challenges are also important. In Kenya, Jenkins et. al. (2013) found that in order for integration to succeed, national policies must not only be in place, but must also be supported operationally by donors and governments. In a study on the integration of mental health services into primary care in Uganda, Kigozi and Ssebunnya (2009) found that despite strong policy commitment to integration, in practice health workers were reluctant to adopt it in a meaningful way. Many health workers claimed mental health care was already fully integrated into their service delivery despite continuing to show a lack of awareness of mental illnesses beyond those with psychotic symptoms and displaying negative attitudes toward mental illness. This demonstrates that structural level actions may not always transfer effectively into organizational and individual practice.

These findings suggest that understanding barriers and facilitators to the integration of mental health services into primary care from the perspective of PHPs requires multi-level, multiple variable analyses. Policies and priorities, the social and cultural context, the views, experience, capacity and support of health workers are all important variables that may interact to affect successful integration. Understanding these multi-level variables, if and how they interact, and the context in which integration is taking place is important to identify both challenges and windows of opportunity for successful integration of mental health services into primary care.

As described above, services for depression are currently being integrated into primary care in Vietnam. Through a partnership between SFU and PHAD¹ (Principal Investigators Dr. Elliot Goldner and Dr. Vu Cong Nguyen), we² tested the feasibility of implementing a training program and intervention for depression in primary care. In its pilot phase, implemented from 2013-2015, the study developed, validated and tested standardized screening tools for depression, a treatment protocol (Supported Self Management) for depression in primary care and a training program for primary healthcare workers in Hanoi. During the two-year pilot study we tested the feasibility of conducting a full cluster randomized control trial (RCT), bringing the intervention to scale and contributing significantly to the transformation of mental health care in Vietnam. The feasibility study showed very promising results and has since been funded for a full-scale RCT to be implemented in eight provinces in Vietnam with the support of the Vietnamese Ministry of Labour, Invalids and Social Affairs (MOLISA). Throughout the data collection and analysis process, I worked closely with the researchers involved in this feasibility study, including PHAD in Hanoi.

This PhD study was not directly part of the depression feasibility study. I received separate funding support for my research from the International Development Research Centre, MITACS and the Faculty of Graduate Studies at SFU. This study is, however, very relevant to the broader feasibility study and the results will help to inform the ongoing delivery of this intervention through the transition-to-scale phase. My role as a Research Coordinator on the feasibility study provided me with several important opportunities related to developing my research proposal and implementing the research. The partnership with PHAD was instrumental in several respects. Through the development of my research questions and proposal to the implementation of the research and the completion of this dissertation and related manuscripts, partners at PHAD offered invaluable support and guidance by helping me to understand the local context, including priorities, opportunities and challenges related to the enhancement of mental health services in primary care. PHAD hosted me for six months during my field research and offered me unending support and research assistance during that time. My participation in the feasibility study also led to several other opportunities, as the relationship between

¹ Funding is provided by Grand Challenges Canada

² I have been involved in this project as Research Coordinator, a part-time research assistant position, since 2013.

Dr. Goldner and SFU and key partners in Vietnam evolved. Dr. Goldner has been involved in the process of mental health system and policy development in Vietnam and has included me in this process, involving me in the development of an assessment of mental health services delivery in the social services sector (Goldner et al., 2015) and in meetings with key stakeholders involved in the mental health system and policy development process. Through the development of the proposal for the transition-to-scale phase of the Grand Challenges Canada project, I was also able to apply preliminary results of this study to inform the next phase of the project, and to participate in the further development of partnerships between government agencies, NGOs and researchers working in Vietnam. Thus, while this thesis project is not explicitly part of the feasibility study and subsequent transition-to-scale project, it is closely related and will inform the development of enhanced services for depression in Vietnam.

This study also has implications beyond Vietnam. The approach used in this study can help to inform similar processes in other contexts where primary health care integration of mental health services is taking place. Although each country has a unique sociocultural context, many LMICs experience common challenges related to enhancing mental health service provision. These include limited general and mental health budgets, a shortage of trained mental health professionals, high levels of stigma and commonly-held misconceptions about the origins of mental illness (Saraceno et al., 2007) This study also contributes to the fields of global mental health research and transcultural psychiatry. Proponents of a global mental health approach emphasize the universality of mental illnesses worldwide, and call for action to address a critical gap in mental health services and the improvement of the human rights of people living with mental disorders in LMICs (Kleinman, 2009; Lancet Global Mental Health Group, 2007; Patel, 2012). Transcultural psychiatry emphasizes the culturally-based variation in the experience of mental illness, questioning the universal applicability of mental health diagnoses and cautioning against the introduction of invalid and inappropriate approaches to addressing mental health in LMICs (Kirmayer, 1989, 2005; Summerfield, 2008). Throughout this study, the tension between these approaches is explored, and an approach that balances the need to enhance services for depression in LMICs while responding to local contextual factors including unique conceptualizations of depression is advanced.

Despite the emergence of global mental health as an important field within global health, the majority of mental health research still takes place in High Income Countries (HICs). Similarly to the 10/90 Gap identified by the Independent Commission on Health Research for Development in 1990, which stated that only 10% of the world's research funds were directed to health issues that affect 90% of the world's population (Commission on Health Research for Development, 1990), in a search of literature published between 1992-2001 Saxena et. al. (2006) found that mental health research from LMIC's accounted for only 6% of mental health studies. Similarly, a review by Patel et. al. (2007), which examines the feasibility of scaling-up mental health services in LMIC's, found that only 1% of studies assessing treatment of schizophrenia, depression, alcohol use disorders and developmental disabilities were from low-income countries, with 10% from LMICs (two thirds of which were from China). It is estimated that up to 75% of people suffering from mental disorders in LMICs receive no treatment (mhGap, 2008), despite the fact that mental illnesses, including CMD, are treatable. This points to a need for increased global mental health research that takes place in LMICs. This study will contribute to the knowledge base of global mental health, in particular in the area of primary healthcare integration.

Finally, in their discussion of the relationship between poverty and CMD in LMICs, Patel and Kleinman (2003) confront the question of whether disorders like depression are simply a result of the conditions and insecurity experienced by many living in resource-poor settings and whether treating depression is worthwhile when these conditions may not be simultaneously addressed:

Just as clinicians must treat tuberculosis even if they cannot get rid of the overcrowding, so, too, must we challenge the despair of clinicians who argue that if their patients are poor they must be depressed and there is little they can do about it. The greatest evidence that this belief is untrue is the fact that the majority of the poor do not suffer from mental illness; they are only at greater risk than the rich (Patel & Kleinman, 2003 612-613).

While some would argue that, in conditions of deprivation, a diagnosis of depression is "pathologizing everyday suffering" (Summerfield, 1999, 2008), I argue that there is a moral imperative to enhance the knowledge base of mental health globally in order to provide appropriate and effective services to those who are suffering from mental health problems in LMICs. While the conditions that act as risk factors for mental distress must certainly be addressed, mental health problems must not be dismissed as inevitable in circumstances

of poverty, deprivation and other forms of human suffering. As Kleinman and Patel argue in the quotation above, people in these circumstances are often most at risk and therefore are most in need of appropriate and accessible services.

Effective and appropriate services for CMD can be offered in LMICs and evidence is needed to improve the accessibility and availability of these services by those who need them (Patel et al., 2009; Patel et al., 2007; Patel & Thornicroft, 2009). This evidence must also explore the sociocultural acceptability and appropriateness of interventions in the context in which they will be implemented (Kirmayer & Pedersen, 2014). This study contributes to this evidence base, making a direct contribution to improving services for CMD in Vietnam. It also contributes to the field of global mental health services implementation an approach that identifies barriers and facilitators to primary care integration in other settings.

1.3. Theoretical Perspectives

This study was informed by theoretical perspectives that 1) guide the analysis of mental health services cross-culturally and, 2) provide a framework for understanding and assessing barriers and facilitators. These theoretical perspectives are briefly introduced below, and are described in more detail in subsequent chapters.

As described above, transcultural psychiatry (Jenkins, Kleinman, & Good, 1991; Kirmayer, 1989, 2005; Kleinman, 1988) and global mental health (Patel et al., 2009; Patel et al., 2011; Patel, Saraceno, & Kleinman, 2006; The Lancet Global Mental Health Group, 2008) perspectives have informed the study. Despite the universality of mental illness, mental disorders like depression are interpreted and experienced very differently across cultures, genders, economic groups etc. Similarly, the treatment needs of people suffering from mental illness are grounded in social and cultural contexts. Wilson (2000) argues that despite “objective clinical findings”, medicine can be practiced in a way that accounts for the context of the patient and practitioner (Wilson, 2000 203). Wilson states: “Recovery from illness will depend on individual beliefs, cultural support systems for the patient, the influence and process of the doctor-patient relationship, and biological factors” (Wilson, 2000 207). In mental health, where there is no gold standard diagnostic tool and where much of the illness experience is socio-culturally grounded (including, e.g., beliefs about

the cause of illness and the impact of stigma), narrative and interpretive processes are perhaps even more important in the treatment environment than in other medical contexts. The fields of transcultural psychiatry and global mental health are particularly helpful for understanding how attitudes towards mental illness and explanatory models for mental illness might influence successful integration of mental health services into primary care in a global context. As described above, however, tensions exist between these perspectives. Both global mental health and transcultural psychiatry perspectives are discussed extensively in Chapter 3. The tension between them, and the implications of this tension are discussed throughout this dissertation.

At the core of the tension between transcultural and global approaches to mental health, and a central aspect of this study, is the concept of culture. It is therefore helpful to explore the meaning of 'culture' and, in particular, how it relates to mental health. Kroeber and Kluckhohn (1952) define culture as:

...patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols...including their embodiment in artefacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, and on the other as conditioning elements of further action." (p.181)

Culture can be understood in terms of shared ethnicity or identity and/ or shared language. It can be embodied in art, music, literature, celebrations and events that are shared by specific groups, and in shared values and beliefs (Guarnaccia & Rodriguez, 1996). Culture can be understood as stemming from an interaction between an individual and the world around them- as an interaction between "the head" and "the world" (Chentsova-Dutton, 2014). Guarnaccia and Rodriguez (1996) note that "culture is both a product of group values, norms and experiences and of individual innovations and life histories" (p.421).

The idea that "culture and the mind mutually constitute each other" (Chentsova-Dutton, 2014 339) is important to the understanding of the importance of culture in the field of mental health. Kleinman (1988) argues that culture is important to psychiatry because the questions that are at the core of psychiatry (e.g. what is considered disordered, how is disordered behaviour experienced, etc.) are at the core of understanding culture as an interaction between the social world and the self and body. He states: "Mental illnesses are real: but like other forms of the real world, they are the

outcome of the creation of experience by physical stuff interacting with symbolic meanings” (Kleinman, 1988 3). The concept of “cultural scripts”, therefore, is very important to the understanding of the interaction between mental health and culture. Cultural scripts help to conceptualize the bridge between culture existing in the mind and in the social/ physical realm by “describing specific sequenced patterns of meaningful ideas leading to observable actions in the world, which in turn reinforces the ideas held by the actor and observers” (Chentsova-Dutton, 2014). In the realm of mental illness, ‘deviant’ cultural scripts are ways in which disordered behaviour is displayed in a way that, despite being considered “abnormal” or disordered, makes sense in that cultural context. This issue of “normative uncertainty”, where there is a question of whether particular behaviours are indicative of illness or are merely “different but normal” within a specific cultural context is a fundamental question in transcultural mental health (Good & Good, 1986). This will be discussed in further detail throughout this dissertation.

While discussing culture and its interaction with mental health and illness, it is important to note that culture is not static or monolithic, but rather is something that is consistently in flux, may be influenced by different factors and may be experienced by individuals and groups differently at different times (Good & Good, 1986). Guarnaccia and Rodriguez describe culture as “a process in which views and practices are dynamically affected by social transformations, social conflicts, power relationships and migrations” (p.421). It is also important to examine how culture interacts with other factors, such as age, gender and social class, in ways that mean cultural experience and understanding might vary within specific populations. Age, for example, does not only represent biological change or development, but is also related to a person’s life experiences, including periods in history and the related political, economic and social conditions that have influenced who they are (Guarnaccia & Rodriguez, 1996). For example, having lived through periods of conflict or deprivation will likely shape the cultural understanding of older adults in a way that might not be true of younger people in the same region or ethnic group. Gender also shapes life experiences, as men and women often occupy different positions or spaces within societies and may have different worldviews, experiences and beliefs. Class is largely related to access to resources, which influences the degree of control and power a person might have in a society, and the types of privileges, oppression or challenges they might experience (Guarnaccia & Rodriguez, 1996). These factors must be considered

when seeking to understand culture and how it influences experiences and understandings of mental health and illness.

As described above, the question of the interaction between culture and mental health, and its meaning for the expansion of mental health services in LMICs, is a fundamental component of this study. This includes the exploration of many challenges, including, as Kleinman (1988) describes, the fact that psychiatric diagnoses are “profoundly influenced by Western cultural premises” (p.4). The centrality of culture to understanding, identifying and treating mental illnesses is clear however. Guarnaccia and Rodriguez (1996) argue that culture is the “web that structures human thought, emotion, and interaction” (p. 437) and that it can provide resources to cope with the challenges of life. In reference to the development of culturally competent mental health services in multicultural societies, they note that placing culture at the core of service delivery is essential “so that people who are in pain and in need can be helped, professionals can experience efficacy and satisfaction, and institutions can provide the services they were designed for” (p. 434). Therefore, the concept of culture and its importance for informing the expansion of mental health services in Vietnam is a core component of this study.

The integration of mental health services into primary care requires changes on several levels- from policy to programs to individual actors in the health system. Contextual Interaction Theory (CIT) (Bressers, 2004) is a useful framework for understanding change at the individual, organizational and structural levels and has informed the design of this study. The theory “assumes that the course and outcome of the policy process depend not only on inputs..., but more crucially on the characteristics of the actors involved, particularly their motivation, information and power” (Bressers, 2004 290). The theory suggests that the variables that influence implementation are interactive, and that their influence depends on “contextual circumstances” (Spratt, 2009 2). The theory was designed to examine how the motivation, information and power of actors, and the nature of their interaction with other actors, might predict the outcomes of the policy process. While this study is concerned with identifying barriers and facilitators to the implementation of an intervention by examining the motivation, information and power of only one group of actors (PHPs), CIT is nonetheless useful for framing the analysis and understanding how these variables may act as barriers or facilitators. The concepts of motivation, information and power are a useful way of framing the numerous variables

(see Chapter 6) that were hypothesised to act as barriers and facilitators to the integration of mental health services into primary care in the context of this study, and for understanding additional variables that emerged during the course of the research and analysis.

1.4. Methods

The theoretical perspectives that are briefly outlined above inform the methodology and design of this study. When discussing research to inform ‘best practice’ for health promotion initiatives among diverse populations, Green (Green, 2001) suggests that perhaps more helpful than emphasizing ‘best practice’ as a fixed end goal, the development of approaches that inform the *process* of identifying best practices is more valuable. These processes might include approaches to community consultation and the assessment of needs and resources. This suggestion is relevant for this study. Drawing on the theoretical perspectives outlined above, this study takes a methodological approach that examines numerous variables to assess barriers and facilitators to the integration of mental health services in primary care. Some variables, including explanatory models of depression and social and cultural norms are informed by transcultural psychiatry (Kleinman, 1988). Others, including resource availability, workload and self-efficacy, are informed by CIT (Bressers, 2004; Owens & Bressers, 2013). The methodological approach thus combines understanding cultural factors with identifying and assessing the importance of contextual factors that might influence the integration of services for depression in primary care. This is depicted in Figure 1 (below). The specific methods used and the variables of interest used in this study are introduced below. The results of this study are outlined in two manuscripts (Chapters 5 and 6), with the study methods outlined extensively in these chapters. Study methods are also briefly described below.

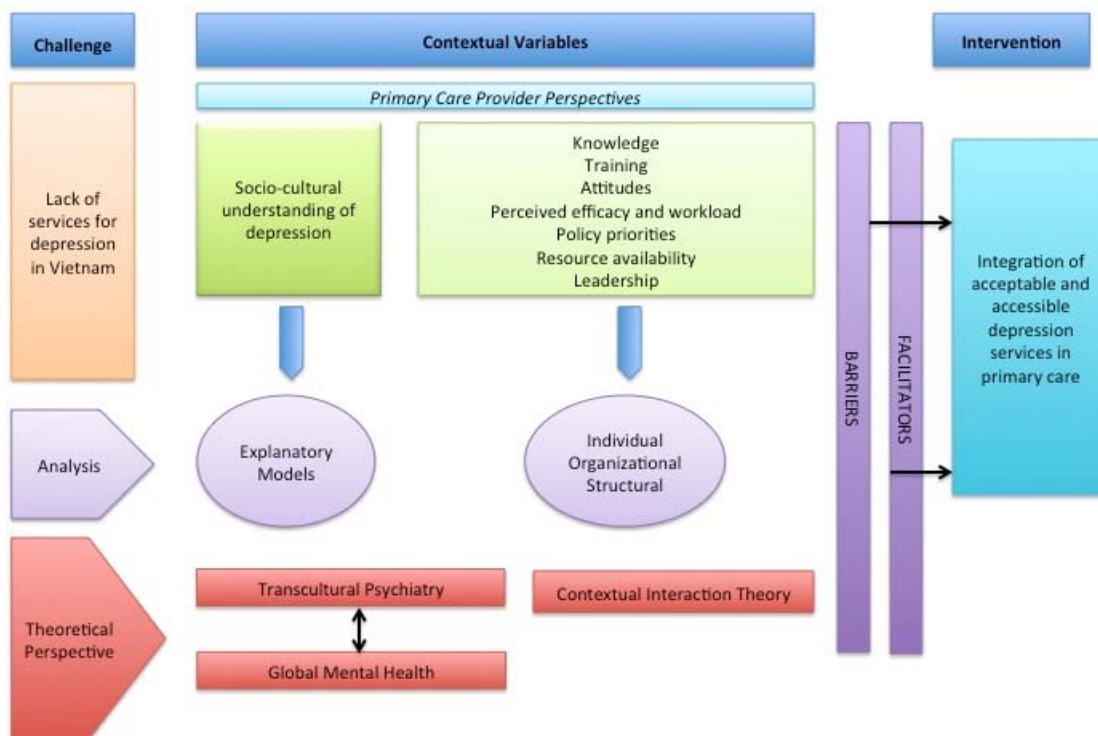


Figure 1: Methodological Approach Logic Model

1.4.1. Research Design

This mixed methods study assesses the barriers and facilitators to the integration of mental health services in primary care from the perspective of primary healthcare workers in Hanoi, Vietnam by examining individual, organizational and structural variables. Semi-structured, in-depth interviews and a survey were used to collect data. Mixed methods are appropriate to triangulate findings and maximize the validity of study results. Quantitative methods (i.e., the survey) are useful for assessing responses from samples of participants in a standardized format, thereby facilitating descriptions of central tendencies as well as comparisons. Survey data also allow identification of associations among variables, e.g., which variables appear to impede or facilitate the ability of health workers to integrate mental health care into their existing roles in primary care. Qualitative methods (i.e., the interviews) allow for a deeper understanding of the study variables within the context of primary care in Vietnam, providing grounded, contextual information

about individual, organizational and structural variables from the perspective of primary care workers (Guba and Lincoln, 1994).

1.4.2. Interviews

Commune Health Centre- Human Resource Context

Thirty semi-structured, in-depth interviews were conducted with commune health workers in the public health sector in the rural district of Thach That and the urban district of Dong Da in Hanoi province, Vietnam between August and October 2014. The interviews were conducted by the primary researcher with interpretation into English provided by a bilingual Vietnamese research assistant. Seventeen interviews were conducted in Thach That, and thirteen interviews were conducted in Dong Da. The sample included: physicians (n=8), physician's assistants (n=8), nurses (n=11), and pharmacists (n=3). Of the health workers interviewed, 27 were female and three were male, which is indicative of a predominantly female workforce at the primary care level. Three of the physician's assistants in the sample had specific expertise in Traditional Vietnamese Medicine (TVM) and offer traditional treatments to patients; two have expertise in midwifery and offer antenatal care. Commune health stations (CHSs) are managed by a director who is also a doctor, and is generally the only doctor working at the centre. The additional human resources are comprised of physician's assistants who are responsible for one or more programs, nurses and pharmacists.

Recruitment of Respondents

Interview respondents were recruited in each of ten communes that were included in the "Feasibility Study in Preparation for Randomized Control Trial" study. Due to strict regulations regarding access to government run institutions, including CHSs, formal channels were followed. Permission to conduct the study was obtained from managers at the centre in each district, and then interviews were arranged at each commune with the support of the district manager. For this reason, snowball sampling was not possible and was not necessary.

Sample Size

Semi-structured interviews were conducted with physicians (n=8), physician's assistants (n=8), nurses (n=11), and pharmacists (n=3). Due to the permissions required to conduct interviews at CHCs and OPCs and the unpredictability of the PHPs' schedules, respondents participated in the study based on availability. While the original intention was to interview 10 physicians, the participation of some Dong Da doctors in the training for the feasibility study prior to the interviews contributed to a risk that their responses would be biased. For this reason, only health staff that had not participated in the training program were interviewed in this district. This and other methodological challenges will be further discussed below.

The results of the 30 interviews suggest that thematic saturation has been achieved. Data saturation can be described as "the point in data collection and analysis when new information produces little or no change to the codebook" (Guest, Bunce, & Johnson, 2006). The sample size was also manageable given the study timeframe and resources of the study.

Development and Revision of Instruments

The study instruments were designed prior to beginning the study based on an extensive review of the literature and drawing on Contextual Interaction Theory to capture variables to understand individual, organizational and structural factors related to the integration of services for common mental disorders in primary care. The study instruments were translated to Vietnamese by the research assistant, back translated by an independent translator, and revised for consistency. Two test interviews were conducted with a doctor and a nurse. Revisions were subsequently made to the instrument as the term "Common Mental Disorders" did not seem to be understood by respondents. This is likely due to the association of the term "mental disorder" with psychotic disorders or epilepsy, as discussed in Chapter 5 and 6. Because knowledge about CMD is low in Vietnam, the term did not seem meaningful to PHPs, and risked confusing them. The term was replaced with the term "depression" (*trầm cảm*), which is a specific term that is understood by PHPs. In addition, the term "depression" was not introduced in the interviews until after PHPs had been asked to discuss "severe" and "less severe" mental illnesses. As described below, this approach allowed for both symptoms and terminology

related to specific mental health conditions to emerge unprompted before the specific terminology was introduced by the research team.

The original intention was for the interviews to involve two phases. The first phase was to use vignettes to elicit responses regarding explanatory models of depression. The vignettes were developed based on a literature review about depression in Vietnam and among Vietnamese populations living in other countries, including research on illness beliefs, help-seeking, and symptomology (Nguyen, Hunt, & Scott, 2005; Niemi, Målvist, Giang, Allebeck, & Falkenberg, 2013b; Niemi, Falkenberg, et al., 2010; Phan, Steel, & Silove, 2004; van der Ham, Wright, Van, Doan, & Broerse, 2011; Vuong, Van Ginneken, Morris, Ha, & Busse, 2011). Vignettes had previously been used in Vietnam, including by Neimi et. al. (2010) who used this method to elicit explanatory models for maternal depression among community members and health workers in a community health centre in Ba Vi, in Northern Vietnam. The vignettes, however, were problematic in the context of this study. The intention of the vignettes was to elicit explanatory models for symptoms of common mental disorders and to understand the knowledge of health workers about mental health conditions. Health workers were asked to respond to questions related to three scenarios describing patient symptoms. The intention was that respondents would not have been informed at this stage that the study was interested in mental health so as not to bias the responses and that respondents would be debriefed following this phase of the interview. In reality, however, due to the access issues described above, this became impossible, as interview respondents had already been informed of our interest in mental health. In the early interviews in which the vignettes were used, we also felt that they were causing discomfort in respondents by making them feel as if they were being tested. One respondent, for example, expressed repeated concern that she would fail to answer “correctly” and another repeatedly consulted notes and was visibly preoccupied with providing the “right” answer. This stress was likely exacerbated by my presence as a foreigner who does not speak Vietnamese. My role as a foreign researcher is further discussed below.

Causing discomfort among respondents was a serious concern related to using the vignettes. We were also concerned that responses would be constrained and limited by respondents’ concern with giving “right” answers. In consultation with the research assistant and supervisory committee, the vignettes were discarded and new questions

were introduced that shifted the approach to encourage respondents to generate their own vignettes by describing symptoms, behaviour, words and attitudes related to “severe mental disorders” and “less severe mental disorders”. This approach was successful in allowing respondents to describe their understanding of symptoms, etiology and local beliefs about mental illness. As described above, we asked PHPs to respond to questions on these general terms before introducing the term “depression” to the conversation. We also began each interview by explicitly acknowledging the value of the respondents’ experience both as clinicians and community members, emphasizing the fact that was no “right” answer and that we were interested in hearing about the respondents’ knowledge, expertise and experience.

The interview process involved semi-structured questions that engaged respondents on the variables of interest (Table 1) and allowed for other, unanticipated variables to emerge. Sixteen hypothesised variables of interest were developed based on a review of literature about behaviour and policy change, the CIT theory, attitudes towards mental illness and the integration of mental health services into primary care. The variables may also be identified as individual, organizational, structural or a combination of these. The variables of interest are listed in Table 1 and are described in detail in Chapter 6.

Table 1: Variables of interest

1. MOTIVATION	Level
Internal	
<i>Attitude, Stigma and Discrimination</i>	
Familiarity with people with mental illness (CMD)	Individual
Explanatory models and health beliefs (including aetiological beliefs)	Individual
Perceived need/ perception of mental illness as significant in primary care	Individual
Perceived role or efficacy (could vs. should)	Individual
Perceptions of people with mental disorders (including characterizations of people with mental illness and social distance measures)	Individual
External	
Social/ cultural environment and norms	Structural

National or organizational priorities in the health sector	Structural
2. INFORMATION	
Pre-service training in mental health	Individual/ Structural
In-service training in mental health	Individual/ Organizational
Training of and supervision by management	Organizational
POWER	
Capacity	
Resource availability: medicines and equipment, financial, personnel, space, etc.	Structural
Perceived workload	Individual/ Organizational
Perceived self-efficacy	Individual
Control	
Leadership or champion within org.	Organizational

Questions were drafted using the core categories of Contextual Interaction Theory and hypothesised variables of interest as an outline. Questions intended to elicit perspectives on gender were also included. Using an iterative process, the interview schedule was revised several times throughout the interview process to ensure that the questions were appropriate and effective. A bilingual Vietnamese research assistant provided interpretation during the interviews, allowing for follow-up questions to be asked by the researcher as needed.

Data Collection

The qualitative interviews were conducted in Hanoi from August to October 2014. The interviews included semi-structured questions related to the variables of interest (see Table 1). In the first part of the interviews, respondents were asked to describe the symptoms and behaviour they associate with severe mental health problems and with less severe mental health problems, to describe the words used by patients and families to talk about these symptoms, to identify medical and informal names for these conditions, to describe the potential causes of these problems and to describe how they would approach an appointment with a patient with these symptoms. In the second part of the interviews, respondents were engaged directly on the topic of integrating mental health services into

primary care and their perspectives on individual, organizational, and structural-level variables.

Interviews were conducted with the support of a Vietnamese research assistant who translated questions from English to Vietnamese and responses from Vietnamese to English. Twenty-four and a half of the interviews were recorded (with permission of participants) with five participants refusing to allow the recording and one respondent asking for it to be turned off after the first part of the interview. Extensive notes were taken during the interviews. The recorded interviews were transcribed in Vietnamese by two research assistants and subsequently translated from Vietnamese into English for analysis by a bilingual translator. The researcher and translator had extensive discussions regarding the meaning of language related to mental health, including diagnostic and lay terminology. For example, the translator was able to explain whether terms used were biomedical or colloquial terms. The translator has a Masters of Public Health and speaks excellent English, which allowed for important discussions of context and the nuances of language. This was very helpful during the data collection and analysis processes.

Analysis

The interview data were analysed using a thematic analysis approach (Braun & Clarke, 2006) that is described in detail in Chapters 5 and 6. Coding of the data was conducted using NVivo 10 software (Q. S. R., 2012).

1.4.3. Survey

Sampling and Survey Distribution

A survey was implemented with primary health care workers in Hanoi to assess characteristics of this workforce (including motivation, information, and power variables), perceptions of barriers and facilitators to integrating services for CMD in primary care, and associations among the variables. Health workers surveyed include primary care physicians, physician's assistants and nurses. A list of all the commune health centres in Hanoi was used as the sampling frame.

Probability sampling was used to ensure a representative sample of the population of commune health workers in Hanoi. Commune health stations were selected from a list

of all commune health stations (n=579) in Hanoi, with every fourth commune centre selected for a total of n=150 communes, representing 26% of communes in Hanoi. CHSs that were included in the interviews were excluded from the sampling frame. In partnership with PHAD and through their contacts at the Centre for Preventive Medicine, a list of commune health station contact information, including telephone numbers, was compiled. The research assistant then contacted each CHS in the sample by telephone, requesting that they participate in the survey and that they select a doctor and physician's assistant to take part. Inclusion criteria for the survey include being employed as a physician or physician's assistant in a CHS at the time of the survey.

Confidence intervals are effective in calculating sample size when effect measures (mean or standard deviation) are unavailable, and where prevalence of characteristics (e.g. opinions or beliefs) is being measured in a population (Cocks & Torgerson, 2013; Lenth, 2001; Whitley & Ball, 2002). Confidence intervals allow for sample size to be calculated based on the desired level of precision (Cocks & Torgerson, 2013).

Prior to data collection, the initial sample size was calculated based on information that there were 551 commune health centres in Hanoi, each employing approximately one physician, two to four nurses, two to four physician's assistants, and one pharmacist (Nguyen, Personal Communication, 2013). Physicians and physician's assistants were targeted as respondents for the survey, as they have the responsibility to diagnose, treat and refer patients. Based on the initial figure of 551 communes, the population size of each stratum was estimated to be: physicians (n= 551); and physicians's assistant (n= 1653). The sample size for each stratum was calculated using an 80% confidence interval with a margin of error of +/-5. Based on the estimates above, sample sizes for each population are: physicians (n=130), physician's assistants (n=150). The 80% C.I. was chosen in order to balance accuracy with feasibility, given both time and resource constraints. In the context of choosing an appropriate sample size for a pilot study for a randomized control trial, Cocks and Torgerson (2013) recommend using an 80% C.I., as it "will satisfy the need for reasonable certainty [for trial decision making] but would be small enough to deliver a study with a reasonable budget and timeframe..." (p. 198). Given the budget and time constraints of this study, the recommendation to sample based on an 80% C.I. is appropriate. Despite the slight variation in actual numbers of communes (579 vs. 551), the actual sample remained consistent with the original calculation, with 150

CHSs selected, with a population of 150 doctors and 1737 physician's assistants. The intended sample size for each stratum remained at n=130 doctors and n= 150 physician's assistants.

After the sampling frame had been collected, partners at PHAD recommended that the survey include an incentive for participation, as this is standard practice in Vietnam. In collaboration with PHAD, it was decided that an incentive of 50,000 VND (\$2.50) in mobile phone credit would be offered to respondents. We revised the survey to ask for the respondents' mobile phone number and mobile service provider, and these were collected by the research assistant. While PHPs provided their mobile phone number, they did not give their names. Due to the nature of mobile phone use in Vietnam, where customers "top up" their credit with a card instead of having a plan in their name, there was no risk of associating the phone number with the identify of the PHP. The research assistant then purchased the phone credit and sent an access code by SMS to the respondent. An amendment was made to the ethics protocol before introducing the incentive, with SFU and PHAD's ethics boards approving the amendment.

Responses

The response rate was higher than anticipated, with 331 responses received. We encountered a challenge in some communes, where staff wanted to receive the incentive, meaning that more than two staff members responded in some communes. For this reason, some responses were excluded from communes with inflated response rates in order to reduce bias. The intention was to survey only doctors and physician's assistants, as described above. In practice, however, 20% of respondents indicated that they held "other" roles. The majority of these (n=48) were nurses, n= 7 were midwives, n=1 was a TVM practitioner and n=2 were pharmacists. 28% (n= 91) were doctors and 52% (n= 169) were physician's assistants.

Instrument

A questionnaire using yes/ no answers, Likert scales and numerical fill-in questions was developed to provide a quantitative assessment of the variables of interest. A draft survey was developed prior to conducting field research and was revised based on emerging data from the qualitative interviews. While the original composition was largely maintained, several questions were added or removed based on contextual

appropriateness. The wording was revised to better define mental illness and common mental disorders including depression. This was based on the emerging data from the interviews, which suggested a very low level of awareness of common mental disorders among commune health workers. Questions were also added based on additional contextual knowledge gained from the surveys, such as the role that commune centres play in patient referral, distribution of medications, and offering health promotion and prevention programs. All revisions to the survey were completed before it was conducted.

Anonymous surveys are appropriate for eliciting responses about attitudes towards mental illness. Link et. al. (2004) indicate that in interviews seeking to measure stigma, social desirability bias can be an issue, as respondents might feel that they should display acceptance towards people with mental illness and answer accordingly. A survey allows respondents to anonymously respond to questions about their own perceived capacity and their perceptions about the organizational and structural environment without concern about professional repercussions. A survey is likely to elicit less response bias than an interview.

Data Collection

We distributed the survey using email and SMS text message, which is widely utilized by health workers in Vietnam. Fluid Survey, which allows for the creation of surveys in Vietnamese, was used. The survey included a consent page followed by a declaration of anonymity and confidentiality. Respondents were required to select “yes” or “no” to the survey to declare their consent. Selecting “no” led respondents to the termination page of the survey. Respondents were also informed that they could stop the survey at anytime, and a button allowing them to leave the survey was included on each page. Survey responses were monitored for volume of completion with reminders sent two weeks following the initial distribution. As described above, the number of respondents exceeded expectations.

Analysis

Descriptive statistics were used to capture demographic data about the survey respondents, including professional role (e.g. physician, physician’s assistant, other), location of health centre (e.g. rural or urban) and gender of PHP. Descriptive statistics were also used to capture the extent to which the variables of interest may act as barriers

or facilitators to the integration of services for depression in primary care. Chi-square tests were used to measure the association between demographic variables (provider role, gender and location) and variables of interest.

1.5. Reflections on the Challenges of Global Health Research and my role as the researcher

Conducting global health research is a rich and rewarding experience that involves many learning opportunities but may also include numerous challenges. All research with human participants involves distinctions between researcher and study participants that must be recognized and navigated. In global health research, where a researcher may collect data in a country or community that is not native to them, the researcher's language, culture, socioeconomic status and ethnicity may influence or affect the interaction with study participants and the collection of data. What the researcher brings with them to the field is unavoidable and is not neutral; it is important to be aware of the role of the researcher in global health research and to explicitly acknowledge the challenges it brings.

Critical reflection is important foster an understanding of the ways in which these influences and interactions might impact the research process. Hickson (2011) states:

Reflexivity means understanding and recognizing our own influence on our practice and accepting that what we see is influenced by what we are looking for, including being aware of the context, framework and our own knowledge as we analyse and interpret our experiences, interactions and responses (Hickson, 2011 832)

Drawing on Kondrat (1999), Heron (2005) recommends that critical reflectivity involve asking questions about 'the world', 'my world' and "the correspondence and contradictions between these worlds" (Heron, 2005 345). In this section I reflect on my experience with conducting this study as a Canadian in Vietnam. These reflections are introduced in this section and are woven throughout this dissertation.

At all times during my field research experience in Vietnam, I was very obviously a "foreigner". This was evident in my appearance, my name and my linguistic limitations.

At the core of my study is the recognition that concepts such as mental health and depression are not culturally neutral. One of my primary research objectives was to understand how mental illness and depression are understood in Vietnam. The exploration of cross-cultural differences was an explicit aim of my research, and one that I stated openly to the research participants. This meant that at the outset of data collection my position as an outsider was acknowledged, and I made no pretence of being an “expert” about depression in Vietnam. Despite this fact, my role as a foreign researcher may well have influenced how study participants felt and acted during interviews. As described above, I felt that participants were uncomfortable with the initial vignette approach to interviews, where they felt they were being tested and felt pressure to offer the “right” answer. Changing the approach to interviews and stating explicitly that there is “no right answer” and that my goal was to learn from their expertise and experience seemed to reduce this discomfort and clarify my role and purpose. Asking participants to position themselves as ‘experts’ enabled me to shift the dynamic somewhat, whereby they were able to share their knowledge with me and I was able to listen and learn from them.

Language was also a significant challenge throughout the research process, including preparation of materials, data collection and analysis. As a researcher, especially when conducting qualitative research, having little knowledge of the language is an extreme limitation. Because I had limited language ability in Vietnamese, I was at a disadvantage in several respects; I was entirely dependant on Vietnamese colleagues for every aspect of the research process, unable to finalize documents, make arrangements for interviews, or conduct interviews alone. My language limitation also likely created a wedge between me, as a foreign researcher, and the study participants. My ability to develop a rapport with participants, or to put them at ease through pleasant conversation, was limited. My use of English was a definitive sign of my “foreignness”.

Because of these limitations, I had to rely of on several strategies to mitigate the challenges of the language barrier. It was essential to work closely with high quality interpreters and translators who not only helped to translate the language but also to explain the nuances of language, the meaning of lay terminology, metaphors and slang, and who could help me to interpret body language and other non-verbal cues. The partnership with PHAD was essential to my success in this respect. PHAD designated staff members (Dang Thuy Linh and Pham Thi Oanh) who were familiar with the

depression feasibility study to work as my research assistants and interpreters. Working with these interpreters, I was able to successfully conduct semi-structured interviews in which I could ask essential follow-up questions based on simultaneous interpretation of participants' responses. I was also able to debrief with the research assistants, asking their impression of responses, asking for clarification about terminology and statements made by participants. Because I worked with both research assistants closely on the depression feasibility study, we developed a friendly and collegial relationship, which made working together easy and pleasant. I trusted their skills in interpretation and knowledge about the context in which we were working. They provided wonderful support and their contribution to the success of this project cannot be overstated.

Excellent translation was equally important. I hired a translator (Le Mai) who has graduate-level education in public health, with whom I was able to discuss the meaning of mental health terminology both during the data collection phase and during the process of analysis. I was able to ask Mai about the nuances of the language emerging from the research, and she reflected thoughtfully and was generous with her insight. For example, the term "mental illness" may be used in general or to refer to schizophrenia, or may be used in a neutral, clinical way or be used in a somewhat derogatory manner. Mai helped me to distinguish the meaning behind the use of such terms and to understand how they were used in the context of the interview discussion.

While I did not become proficient in Vietnamese, I did learn proper greetings so as to develop a rapport and show respect to study participants. I also learned key terminology related to mental health in Vietnam. This enabled me to recognize when, for example, participants were explicitly discussing depression. I also took extensive field notes during interviews, which I reviewed during the analysis phase, and made written reflections following each interview that included observations about body language or non-verbal cues (e.g. laughter) and overall impressions of the interviews. Despite having excellent resources to support my research, not speaking the Vietnamese language is a factor that was certainly challenging. I am fortunate to have had the support of skilled and generous colleagues. While I did take many steps to try to minimize the challenges related to language, the fact that my study was conducted in a language in which I am not proficient is an important factor. I have relied on interpretation and translation and, although I trust that the quality of these supports is high, this is a "filter" through which this study should

be viewed. My PHAD colleagues, however, have also been included as co-authors on the manuscripts included in this dissertation, and have provided important insight into the findings. Both research assistants, for example, have contributed as co-authors for Chapter 5 and have found the analysis to be consistent with their participation in the interviews, helping to validate the findings.

I was also reliant on Vietnamese colleagues in several other ways. Working in Vietnam, the structure and management of the health system meant that my access to CHSs and PHPs was heavily dependent on PHAD and their relationship with the appropriate governing bodies. I was dependent on PHAD to obtain permission to conduct the study and to make all arrangements for interviews and the distribution of the survey. Because of the top-down nature of the bureaucracy in Vietnam, PHPs who participated in the study did so at the direction of their superiors. This might have had implications in terms of their consent to participate in the study, the nature of the study was such that risk was minimal. To minimize this risk I followed all informed consent procedures to ensure participants knew their participation was optional.

While I made numerous attempts to mitigate the challenges of conducting research in Vietnam, I am very aware of the limitations created by my status as a foreign researcher. The linguistic limitation, for example, has implications for more than understanding the responses of participants and communication. The requirement of interpretations and translation is very resource-intensive and costly. This means I am limited in my ability to verify findings with participants through the analysis process, as the funding I have for translation and interpretation was limited to the field research process. Despite this limitation, I plan to seek funding to prepare and translate a summary of my findings for distribution to participants following the completion of the analysis.

I am also aware of the ethical implications of conducting research in Vietnam in terms of the likelihood that the research will benefit the study participants and the communities in which my research is conducted. I am lucky to be involved with the depression pilot study and the transition-to-scale phase, as well as broader efforts to enhance mental health service delivery in the social services sector, and hope that my findings will inform the ongoing scale-up of services for depression in Vietnam.

1.6. Dissertation Outline

Chapter 2 provides background for the study by discussing depression as a diagnostic category, reviewing the global burden of depression, the global gap in treatment of depression and recommendations for addressing this gap. Chapter 2 also provides an overview of the Vietnamese context by introducing existing evidence on the burden of mental illness and reviewing the structure of the mental health system and mental health service delivery in the country. Finally, Chapter 2 discusses gender and stigma as they relate to mental health and mental health service delivery in Vietnam.

Chapter 3 describes key theoretical perspectives and approaches to studying mental health from a global perspective. It provides a detailed overview of the transcultural psychiatry and global mental health perspectives, interrogating the differences and similarities between the approaches and their implications for studying the improvement of mental health service delivery in LMICs.

Chapter 4 is a narrative review that, building on Chapter 3, provides an overview of important considerations for studying depression cross-culturally, introducing key concepts and questions that are at the core of this study. In Chapter 4 I outline three major considerations for studying depression cross-culturally and describe the implications for depression research and practice in a global context.

Chapter 5 is the first of two manuscripts that describe the findings of the study. It examines the “social/ cultural and environmental norms” variable of interest, with an emphasis on PHPs’ ‘explanatory models’ of depression. This component of the study elicits the ways in which PHPs conceptualize depression, including the symptoms, cause and prognosis, and the ways in which PHPs currently approach care for patients with depression. It also reports findings related to community perceptions of and help seeking for depression from the perspective of PHPs. Based on the findings, implications for the integration of services for depression into primary care are discussed.

Chapter 6 is the second manuscript that describes the finding of this study. It takes a mixed methods approach that includes the results of the semi-structured interviews and survey. Drawing on Contextual Interaction Theory (CIT), Chapter 6 describes the barriers and facilitators to the integration of services for depression in primary care, taking into

account individual, organizational and structural factors. Based on these findings, I offer recommendations for the enhancement of services for depression in primary care in Vietnam.

Chapter 7 discusses the findings of this study, first outlining their implications for the expansion of services for depression in primary care in Vietnam, and subsequently describing their relevance to the fields of global and transcultural mental health. This chapter provides conclusions and recommendations that are relevant for both Vietnam, and for the broader context of global and transcultural mental health. I summarize the implications of this study and identify important next steps.

Factors influencing the success of integrating mental health services into primary care are complex. Few mental health studies in LMICs have addressed individual, organizational and structural factors together, pointing to the need for research that crosses disciplinary boundaries to address the complexities of primary care integration and health worker perspectives. This study yields results relevant to Vietnam, and will contribute to a body of knowledge that will be relevant to other contexts and to the growing field of global and transcultural mental health service research and implementation.

Chapter 2.

Setting the Context

In this chapter, I broadly review the concept of depression and describe the current knowledge about depression within the global context. I also describe the recommended approaches to addressing the gap in treatment for depression in LMICs. I provide an overview of the context of Vietnam, including the existing epidemiological on the burden of mental illness, the composition of the mental health system and the challenges related to service delivery. Finally, I describe the importance of gender and stigma in the study of depression service delivery.

2.1. What is Depression?

While the term “depression” might evoke an image of sadness and despair in countries where the dominant medical paradigm is informed by Western or Eurocentric biomedicine, the nature of depression as a diagnosable condition is far more complex and warrants discussion. Evidence suggests that forms of what those in Western society now refer to as depression have existed across history and across cultures (Jenkins et al., 1991; Paykel, 2008). Despite its seeming universality, conclusive evidence about what depression “is” remains elusive. An overview of what is known about depression is provided in this section, drawing, due to the availability of evidence, largely from research that is embedded in Western approaches. While this section makes reference to the importance of culture in understanding depression it does not fully explore this area. Because the interaction of culture and mental illness is a fundamental thread throughout this dissertation, it warrants specific consideration. To this end, an extensive discussion of depression cross-culturally is found in Chapter 4.

A condition referred to as ‘melancholia’ was recognized in the time of Hippocrates and through medieval times, when it was associated broadly with all forms of “quiet insanity” (Paykel, 2008), or what today might be referred to as ‘internalizing disorders’. The concept of melancholy was first associated with despair during the Renaissance, with the term “depression” first appearing in reference to sadness in the 19th century. Paykel

(2008) notes that the word “depression” is an analogy to reflect ‘feeling low’. This is interesting in terms of both linguistic and conceptual equivalence in other languages and cultures.

While depression is often referred to as one discrete condition, it is in fact a syndrome that is made up of a number of possible clinical features. While, as Paykel describes, ‘syndrome’ might imply “a cluster of symptoms and signs which tend to occur together, which are assumed to reflect a common pathophysiology...”, syndromes are in fact not equivalent to diseases and therefore may have differing aetiologies and clinical manifestations. The current concept of depression is of a “clinical syndrome, defined by a number of clinical features, but not requiring specific aetiology, and acknowledging the possibility of both psychological and biological causative factors” (Paykel, 2008). Research is inconclusive about the aetiology of depression, with theories evolving and changing over time. In early Western depression research, two competing theories of depression emerged; one suggesting that the disease had organic origins while the other related it to psychological stress (Paykel, 2008). Currently, no conclusive evidence about depression aetiology exists, although the illness is understood to be the result of a combination of organic, psychological and social factors. Chentsova-Dutton et. al. (2014) state: “depression is distinct from many other medical conditions because it is not only a neurological phenomenon, but also a psychological and cultural one, and therefore cannot be explained without referencing all of these levels” (Chentsova-Dutton, 2014 338) .

Paykel describes the identification of depression in modern psychiatry as a process that takes place “by committee agreement, based sometimes on quite limited empirical research” (Paykel, 2008 281) and is defined by lists of symptom criteria, duration of course, exclusions, etc. Official classification systems include the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2014), now in its 5th edition and the World Health Organization’s International Classification of Disease- Mental and Behavioural Disorders (ICD-10), now in its 10th revision, with an 11th revision forthcoming (World Health Organization, 2015a). The core symptoms of depression as identified by these classification systems are depressed mood and anhedonia, or loss of interest or pleasure. The ICD-10 also includes fatigue as a core symptom. Both the DSM and the ICD-10 classify depression as an affect disorder. Paykel notes that the association of depression with lowered mood is in fact a

Western concept, and one that was introduced, even in the Western context, fairly recently. He notes that anhedonia was introduced to English-speaking psychiatry in the DSM-III (published in 1980), and that previously depression was more associated with changes in behaviour. Other symptoms associated with depression in the DSM and ICD-10 include: weight loss or gain, insomnia or hypersomnia, agitation or retardation, loss of energy or fatigue, loss of confidence or self-esteem, feeling worthless or guilty, reduced concentration, indecisiveness, and suicidal ideation (Paykel, 2008).

Depression is further classified as unipolar (major depressive disorder, disruptive mood dysregulation disorder, unspecified depressive disorders) and bipolar depressive disorder (this study is primarily concerned with unipolar depressive disorders and will thus not discuss bipolar disorders extensively). Unipolar depressive disorders are further classified in the ICD-10 as mild, moderate or severe. Paykel notes that a general misunderstanding exists that people who meet the criteria for 'mild depression' according to the ICD-10 have a minor condition, but states that "the definitions for individual symptoms and the absence of some symptoms from the list means that subjects who fit these criteria usually have sufficient depression also to qualify as DSM-IV major depressives" (Paykel, 2008 285).

The question of threshold is also important and contentious for depression classification, in terms of the clinical distinction between general low mood and a qualification of clinical depression. 'Sub-threshold' or 'sub-syndromal' depression are increasingly studied and are found to be common in community-based populations. Paykel suggests that the inclusion of sub-threshold depression in classification schemes would be useful for primary care. Efforts have also been made to sub-classify depression into "melancholic symptoms" (e.g. weight loss, inability to sleep, loss of appetite) and "atypical symptoms" (e.g. weight gain, sleeping too much, increase in appetite), although a meta-analysis did not support the need to subtype depression in such a way (van Loo, de Jonge, Romeijn, Kessler, & Schoevers, 2012).

Existing epidemiological evidence from around the world suggests that depression is frequently chronic and often relapsing, with between one half and one third of people with lifetime depressive disorder likely to be "in an episode" in a given year for the remainder of their lives (Kessler, 2014). Depression is believed to be most common in women, with ratios of women to men affected by depression of 2:1 in HICs and variable

ratios (usually 3:1 or 4:1) in LMICs (Culbertson, 1997). Studies suggest, however, that depression prevalence in men may be underestimated due to factors including underdiagnosis and lower levels of help seeking among men (Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012; Kilmartin, 2005). Gender differences in depression rates have been associated not just with biological factors but gender inequity. Other determinants of depression include socioeconomic status and education, with evidence pointing to decreased rates of depression with increased levels of education (Patel et al., 2010). Although definitive conclusions about the mechanisms of these associations are difficult to establish, they include: stress and stigma due to low socioeconomic status, disempowerment and marginalization, experiences of violence, economic insecurity and reduced access to health services (Patel et al., 2010).

Depression can be devastating for those affected, their families, and their communities. Depression ranks high in terms of disability adjusted life years (DALYS), due to a combination of lifetime prevalence, early age of onset, chronicity and impairment caused by the disorder (Kessler, 2014). In addition to the suffering caused directly by depression, it is associated with numerous comorbidities (Kessler, 2014; Prince et al., 2007). There is evidence of comorbidity between depression and other mental disorders, such as anxiety disorders, impulse control disorders and substance use disorders (Kessler, 2014). Depression is also associated with many chronic physical illnesses, including cardiovascular disease, diabetes, and HIV-AIDS (Kessler, 2014; Prince et al., 2007). Depression is shown to be predictive of many chronic diseases. It is also a consequence of these illnesses and is associated with worsened outcomes of chronic illnesses. Depression is associated with early death. While depression is often associated with suicide, the majority of people with depression will not display suicidal behaviour. The lifetime risk of suicide among people with affective disorders is estimated to be 4% (Bostwick & Pankratz, 2000), with the risk of suicidal behaviour increasing with psychiatric comorbidity including alcohol use and psychotic disorders (Cavanagh, Carson, Sharpe, & Lawrie, 2003). Early mortality rates and depression are also due to a higher mortality risk from certain chronic conditions (Carney, Freedland, Miller, & Jaffe, 2002).

Depression has substantial socioeconomic consequences. It is shown to have a negative impact on marriage and to be associated both with perpetration of and victimization by intimate partner violence (Kessler, 2014). Depression is also associated

with increased absenteeism from work and decreased productivity. Research conducted in 24 countries found that depression is the 4th highest attributable cause of days out of role (Alonso et al., 2011). Depression is highly disabling, with research based on the World Mental Health surveys finding that unipolar and bipolar depression were most frequently rated as causing severe impairment compared to physical conditions in both HICs and LMICs (Ormel et al., 2008).

Mental illness also has implications for sustainable development in LMICs, as it is associated with loss of income, lower levels of educational attainment, and increased risk of violence and insecurity (Patel & Kleinman, 2003). A report by the World Economic Forum suggests that the economic burden of mental illness is higher than that of each of the four other categories of non-communicable diseases: diabetes, cardiovascular disease, chronic respiratory disease, and cancer (Bloom et al., 2011). Becker and Kleinman (2013) speak of the numerous costs of untreated mental illness, which include stigma and discrimination, human rights violations, lack of access to education and employment, and results in "...entry into a pernicious cycle of social disenfranchisement and poverty..." (Becker & Kleinman, 2013 66).

2.2. Depression in the Global Context

According to the 2010 Global Burden of Disease Study, mental health disorders make a significant contribution to the global burden of disease, comprising 7.4% of global disability adjusted life years (DALY's) (Murray et al., 2012). Depressive disorders in particular have emerged as a major contributor to the global burden of disease and are growing in significance. The WHO estimates that by 2030 depression will become the leading contributor to DALY's worldwide (World Health Organization, 2008), while in low-income countries depression is expected to be the third most significant contributor to DALY's, after HIV/AIDS and perinatal conditions (Mathers & Loncar, 2006). The 2010 Global Burden of Disease Study (Murray et al., 2012) indicates that major depressive disorder is the second highest cause of years lived with disability (YLDs) worldwide.

Point prevalence for depression varies, with community surveys indicating that up to 20% of adults and 50% of children and adolescents report "depressive symptoms" with a recall period of between one week and six months (Kessler, 2014). When applying the

DSM criteria for major depressive disorder, however, point prevalence falls to 2-4% of adults, 1% of children and 6% of adolescents. Kessler et. al. (2014) state that this discrepancy is attributable to the existence of sub-syndromal, or sub-threshold, depression. Despite the discrepancy in the classification of depression, they note that sub-syndromal depression is a “powerful predictor” of major depressive disorder, that it is very common around the world, has similar risk factors to major depressive disorder, and has a negative impact on health (Kessler, 2014). Bjelland et. al. (2009) note that sub-threshold depression has “significant clinical relevance in terms of functional impairment, mortality, treatment and prognosis” (Bjelland et al., 2009 129). As described above, sub-syndromal depression appears to be important for primary care settings due to high prevalence in community populations. People with sub-threshold depression are also frequent users of health care systems, have high medical costs and make up a large number of patients who are prescribed antidepressants in primary care settings (Bjelland et al., 2009).

Global epidemiological evidence on the prevalence of depression is relatively recent and somewhat limited. The WHO World Mental Health Surveys, conducted in 18 countries among almost 90,000 respondents, found a 12-month prevalence of major depressive disorder of 5.5% in the 10 HICs included in the study, and of 5.9% in the 8 included LMICs. Vietnam was not included in the surveys. The World Mental Health Surveys found a lifetime prevalence of 14.6% in HICs and 11.1% in LMICs. The WHO World Health Survey, which was conducted in 70 countries and included approximately 245,000 respondents, found a 12-month prevalence for major depressive disorder of 3.2%. Vietnam was included in this World Health Surveys (Harvard Medical School, 2005). While the numbers point to a substantial burden of depression worldwide, the use of global burden of disease data on depression must be accompanied by a discussion of the challenge of accurately classifying, identifying and measuring depression cross-culturally. This is discussed in detail in Chapters 3 and 4.

Despite the high global burden and devastating impact of mental disorders like depression, there is a significant gap in formal treatment, especially in low and middle-income countries (LMIC's). There has been little progress in reducing the burden of mental illness in the last two decades. The combined number of YLD's resulting from mental and behavioural disorders (22.7%) has remained the same as it was in 1990, indicating that despite improved knowledge about mental health globally, major gaps in treatment have

persisted (Becker & Kleinman, 2013). The WHO's mhGAP program estimates that in many LMIC's up to 75% of people suffering from mental disorders are untreated (mhGap, 2008). There are critical shortages of human resources for mental health in almost all LMIC's, with an estimated deficit of 1.18 million mental health workers in 144 LMIC's (Kakuma et al., 2011). The median number of psychiatrists in HIC's is 172 times that in LMIC's, and only 55% of low-income and 69% of lower-middle income countries have psychiatry training programs (Kakuma et al., 2011). In many LMICs, there is only one psychiatrist per 100,000 population, with limited allied professionals and scarce availability of medications (McKenzie, Patel, & Araya, 2004). As described below, recommendations are in place to improve mental health service delivery and access in LMICs.

2.3. Responses to the Treatment Gap: Scale up and Integrating Mental Health Services into Primary Care

Given the gap in specialist mental health human resources, proponents of a global mental health approach recommend 'scaling up' services that have proven effective. In 2007, the *Lancet* Global Mental Health Group called scaling up services the "most important priority for global mental health" (Lancet Global Mental Health Group, 2007). The WHO defines scale up as "deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis" (Simmons, 2007 viii). Eaton et. al. (2011) state that scale up is a process involving several components. This first is an increase in the availability of services, or coverage. The range of services offered may also be increased. Scale-up usually involves evidence-based interventions that have "a service model that has been shown to be effective in a similar context" (Eaton et al., 2011 1592). Finally, scale up may involve strengthened health systems, including financing, policy development and implementation.

The call to prioritize the scale up of mental health services, especially in LMICs, is based upon the argument that evidence exists to support the affordability and cost-effectiveness of interventions in LMICs. The Global Mental Health call to action was directed at numerous stakeholders, including national governments, donors, multilateral organizations, mental health professionals and consumer groups. It is based upon the recommended expansion of a "core package" of interventions for mental health. The

recommended core package for depression is described below. In practice, proponents of mental health service scale up argue that it must involve a number of shifts and steps in the way health and mental health systems are currently organized in many countries. Eaton et. al. state that “most services should be delivered in decentralized locations, with deinstitutionalisation and integration between the community and hospitals, and appropriate referral systems incorporating secondary and tertiary care” (Eaton et al., 2011 1596). In practice, decentralized services may be delivered by a range of facilities, including psychiatric outpatient clinics for acute cases, primary health care centres, and community-based care including residential and day programs (Lancet Global Mental Health Group, 2007). Achieving scale up of services requires a number of initiatives and commitments, including: improved mental health financing by governments and donors, the establishment of mental health policy and guidelines at national and international levels, investment in infrastructure and resources, including the training of both specialist and non-specialist providers, and awareness raising among populations (Eaton et al., 2011; Lancet Global Mental Health Group, 2007).

The call to scale up services includes the acknowledgment of the need to change practice in terms of how mental health intervention research is conducted. Too often, interventions that are piloted in LMICs never become sustainable or reach scale, meaning that there is a fundamental gap in evidence and practice (Eaton et al., 2011; Lancet Global Mental Health Group, 2007). Also of concern is the emphasis by many existing funding priorities on the development of new mental health interventions, with little support for enhancing existing and evidence-based services. The rigorous evaluation of scale up initiatives is also essential, and is often lacking. Evaluation is essential in order to establish evidence to support the scale up of interventions.

Patel et. al. (2009) propose two “packages of care” for depression in primary care based on the availability of mental health specialist resources. For low resource settings, they recommend: routine screening for depression, psychoeducation, where patients and their families are provided information about depression as a means by which to help them to manage their condition, generic anti-depressants, and problem solving. For high resource settings they recommend: both routine and high-risk screening with a diagnosis confirmed by a specialist, psychoeducation, a choice of antidepressant medications, a choice of psychosocial interventions and electroconvulsive therapy (ECT) in severe cases

(Patel et al., 2009). Patel et. al. further identify a number of steps to depression care delivery. They recommend improving help seeking for depression by raising awareness and addressing stigma in communities, with interventions taking place in schools, through public channels, in primary care and professional educational settings. They also advise increasing the capacity of health workers by training primary care workers and non-professionals (including village health teams/ community health workers) and improving recognition of depression by training for both practice-based and community-based screening using validated instruments. Also included is the adaptation of interventions for both cultural or contextual acceptability and affordability. Examples of this might include offering group psychosocial therapies instead of individual models to reflect the sociocentric context of some cultures. Also involved are the development of both practice-based care (e.g. collaborative care, stepped care) in primary care settings and community-based interventions (e.g., peer support programs, community health worker visits). Finally, steps must be put in place to address the effects of depression on other social or health factors. These might include support for perinatal depression to support the health of both mothers and babies or suicide prevention programs. Overall, they note that: “the delivery of the treatments should ideally be carried out through an integration of depression programs into existing health services or community settings with task-shifting to non-specialist health workers to deliver front-line care and a supervisory framework of appropriately skilled mental health workers” (Patel et al., 2009 5).

Task-shifting refers to the use of non-specialist providers who have received specific training in particular mental health interventions to deliver services (WHO, 2008). Eaton et. al., (2011) argue that task-shifting is “the means to most efficiently use low numbers of trained personnel” (Eaton et al., 2011 1601). Task-shifting has been used in LMICs in areas ranging from obstetrical care to HIV/AIDS and management of chronic illness (Fulton et al., 2011), with evidence about task shifting for depression care in LMICs also growing (Araya et al., 2003; Chibanda et al., 2011; Petersen, Lund, & Stein, 2011). Using task-shifting within a stepped care model, in which care is tailored to individual patient needs and more intensive treatments are recommended for patients not responding to usual care are employed, is recommended as both beneficial to the patient and efficient for health systems (Gilbody, Whitty, Grimshaw, & Thomas, 2003; Petersen et al., 2011; World Health Organization & World Organization of Family Doctors, 2008). Task-shifting may also be referred to as “task-sharing”, which calls attention to the

continued need for specialist supervision within these models of care to maintain quality control and motivation of providers (Eaton et al., 2011).

The WHO and WONCA define primary care for mental health as “mental health services that are integrated into general health care at a primary care level” which includes offering “first line interventions” as part of general health services provided by skilled practitioners who are capable and are supported (World Health Organization & World Organization of Family Doctors, 2008 9-10). Primary care workers may deal with all types of mental disorders, including depression. WHO and WONCA state that “essential” mental health services in primary care include: early identification, treatment of common mental disorders (CMDs), management of stable psychiatric patients, referrals when needed, monitoring the mental health requirements of patients with physical health problems, and mental health promotion and prevention” (World Health Organization & World Organization of Family Doctors, 2008 17). Benefits of the integration of mental health services into primary care include: reduction of stigma, improved access to services, improved prevention and detection of mental illness, improved treatment and follow-up, more holistic treatment of both mental and physical illness, reduction in the chronicity of mental illness and improved outcomes, human rights protection, and reduced social and economic disruption (Funk, Saraceno, Drew, & Faydi, 2008; World Health Organization, 2007b; World Health Organization & World Organization of Family Doctors, 2008).

In practice, integrating mental health services into primary care can involve a number of approaches, including active case management (Dietrich et al., 2004; Gilbody et al., 2003), practice-based quality improvement (Gilbody et al., 2003; Patel & Thornicroft, 2009), and guideline implementation and educational strategies (Gilbody et al., 2003). Collaborative care models are frequently recommended, in which numerous types of practitioners and approaches are involved in patient care (Gilbody et al., 2003; Patel & Thornicroft, 2009; World Health Organization & World Organization of Family Doctors, 2008). The WHO and the World Organization of Family Doctors (2008) draw on the WHO’s Service Organization Pyramid for an Optimal Mix of Services for Mental Health (see Figure 1), which sees patient self-care as the foundation of improved mental health care and is based on the “principle that no single service setting can meet all population mental health needs” (World Health Organization & World Organization of Family Doctors, 2008 15):

Figure 1.1 WHO service organization pyramid for an optimal mix of services for mental health

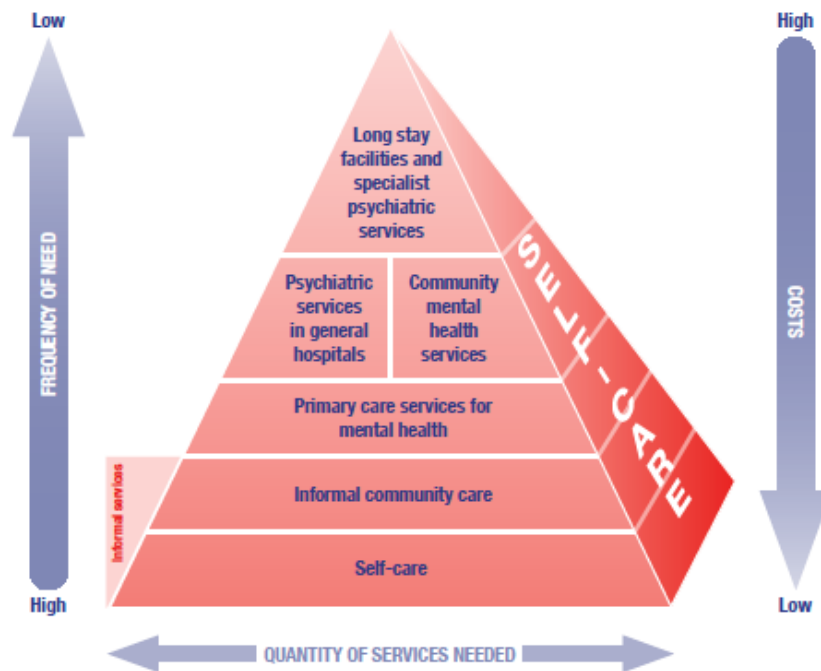


Figure 2: WHO Service organization pyramid for an optimal mix of services for mental health

Evidence has shown that given the proper training and ongoing monitoring and supervision, non-specialist health workers can successfully engage in mental health promotion, education and follow-up, while primary care physicians with mental health training can identify, diagnose and treat mental disorders and are able to appropriately refer complex cases (Kakuma et al., 2011). Requirements for successful primary care integration include: inclusion of mental health in policy and programs; pre-service mental health training for health workers complemented with regular in-service training; adequate supervision and support by specialist mental health workers; effective referral systems; the reallocation of human and financial resources away from tertiary level mental health facilities and to primary care; available and accessible medications; and collaboration with community-based services and resources (Funk et al., 2008; World Health Organization & World Organization of Family Doctors, 2008). Patel et. al. (2009) note that “collaborative care models that incorporate systematic identification of patients, active case management by competent staff, and specialist supervision are effective for the integration of depression treatment into primary care” but caution that LMICs might have to alter collaborative care models due to scarcity of resources, including mental health specialists.

The integration of mental health services in primary care is not without challenges. Health workers may have low levels of mental health knowledge and require extensive training. The availability of specialist providers to train and supervise primary care staff may be limited. Primary care providers are often overburdened already and may be challenged to integrate further skills and duties into their workload. For this reason, Eaton et. al. (2011) recommend integrating mental health services into other areas of health care, including long term care for chronic illness and perinatal care, and into other sectors, including education and social services. Finally, the integration of mental health services into primary care does not replace the need for mental health specialists who are accessible to patients with more complex conditions and who can play a training and supervisory role in collaborative care models. Investment by mental health systems in both non-specialist and specialist providers is recommended to improve mental health services (Lancet Global Mental Health Group, 2007).

Despite the promise of these approaches for improving the gap in treatment, “their potential to be scaled up and delivered in a sustained way remains untested and uncertain” (Becker & Kleinman, 2013 69). Systematic monitoring, greater input of local knowledge, and country-specific health system considerations are all needed to ensure the positive impact of the integration of mental health services into primary healthcare (Becker & Kleinman, 2013).

The call to scale up services is based upon the claim that evidence about mental health services delivery in LMICs is “now good” (Lancet Global Mental Health Group, 2007). In their review of evidence for approaches to care models for depression, Patel et. al. (2009) note that evidence remains limited from LMICs. For this reason they draw on systematic reviews and meta-analyses “based on global evidence and key trials from HICs where appropriate” (Patel et al., 2009 1). It is clear that efforts to scale up services, and further recommendations regarding ideal service models in LMICs would benefit greatly from enhanced evidence from LMICs. Similarly, the question of cultural appropriateness, while addressed by most proponents of scale-up to a degree, is not discussed in any depth. The Lancet Global Mental Health group does recognize the need to enhance research originating from LMICs. When describing the 10/90 Gap in research (see Chapter 1), the group states: “ the adverse effect of this gap is potentially greater for mental health, which is heavily influenced by sociocultural factors and for which current

practice and evidence is dependent on cultural norms from HICs, especially Europe and the USA (Lancet Global Mental Health Group, 2007 1245). When calling for rigorous evaluation of scale-up initiatives Eaton states that: “although contextually appropriate services will always differ, effective models will be those that show the best performance for relevant outcomes” (Eaton et al., 2011 1601). There is no mention, however, of how to ensure that scale up initiatives account for and respond to cultural variation. The importance of cultural variables to inform the enhancement of mental health services in primary care, and the scale up of these services, is an important theme in this study.

2.4. Vietnam Context

Vietnam is a lower middle-income country (The World Bank, 2015a) with a total population of 91,680,000 with 32% living in urban areas (World Health Organization, 2015b) The combined life expectancy at birth was 76 years in 2013, with an under five mortality rate of 24 per 1000 live births and a maternal mortality rate of 49 per 100,000 live births. Both indicators have improved since 1990, when under five mortality was 51 per 1000 live birth and the maternal mortality rate was 140 per 100,000 live births (World Health Organization, 2015b). Vietnam’s GDP per capita in 2014 was US \$2052.3, up from \$1333.6 in 2010 (The World Bank, 2015b).

There is limited epidemiological data on mental illness in Vietnam. The mhGAP country profile on Vietnam states that neuropsychiatric conditions are estimated to make up 16.3% of the burden of disease, while suicide rates are unavailable (mhGap, 2008). Vuong et. al. (2011) cite an unpublished nationally representative epidemiological survey that shows a combined prevalence of mental disorders of 14.9%, with a prevalence of depression of 2.8% and of anxiety of 2.6%. One study on maternal mental health in Ho Chi Minh City (Fisher, Morrow, Nhu Ngoc, & Hoang Anh, 2004) found high rates of depression (33%) and suicidal ideation (19%) in women accessing general health clinics. A national survey, using a diagnostic instrument validated for Vietnam, found a prevalence rate of depression or anxiety of 20% among 2000 women with one-year old children (Tuan, Harpham, & Huong, 2004). The same study found poor mental health in 20% of children, and Harpham, da Silva and Tuan (2006) cite unpublished, community-based research that showed a high prevalence of sadness and helplessness affecting daily functioning among youth (Harpham et al., 2006). No extensive epidemiological studies have been conducted

on depression among adult men, although there is evidence of high rates of alcohol use among men, especially those under the age of 44 years (Vuong et al., 2011). In a sample of informal male labourers in Hanoi, Van Huy et. al. (2015) found a high prevalence of depressive symptoms, with social isolation acting as a contributor to depression in this demographic. While there is clearly a need for more epidemiological research at the population level on the prevalence of mental illness in Vietnam, these studies suggest that there is a significant burden of CMD in the country. Vietnam has undergone rapid industrialization as well as economic and state reorganization. The country has experienced fast economic development, accelerated urbanization, and has undergone reunification and recovery from conflict, all of which have been identified as risk factors for an increased burden of mental health problems (Lee et al., 2015). The *doi moi* (meaning 'renovation') economic reforms, introduced in 1986, led to success in poverty reduction and economic growth in Vietnam but have also been associated with broader disparities in access to social and health services for people living in different geographical areas and from differing socioeconomic groups (Vuong et al., 2011).

There are a number of important determinants of mental health that are relevant to the Vietnam context. While there is no study directly identifying the determinants of mental health in Vietnam, many of the conditions that increase the risk of mental health disorders in populations are present in the country. Vietnam experienced three wars within a century. The experience of violent conflict has been associated with both direct mental health effects and with negative impacts on the social structures that promote mentally healthy societies (Lee et al., 2015; World Health Organization, 2001). Evidence from other LMICs shows a high burden of mental health disorders in populations undergoing rapid political, economic and social change (Dzator, 2013; Phillips, Liu, & Zhang, 1999). Beginning with the introduction of the *doi moi* reforms in 1986, Vietnam has undergone a transition from a centrally planned to a market economy. This has led to profound social change, including changes that increase pressure on families and social support structures (Lee et al., 2015). Social and economic change has increased levels of urban to rural migration and participation in informal and precarious labour, which may be detrimental to mental health (Van Huy et al., 2015). With the reforms has also come a widening gap in access to health and social services, especially among economically marginalized groups, and an increase in the use of drugs and alcohol (Vuong et al., 2011).

Mental health services in Vietnam have been increasingly decentralized, with a diffusion of service delivery across the country's four main administrative levels of governance (Central, Provincial, District, and Commune) under the mandate of Ministry of Health and increasingly MOLISA (LaFortune, 2014). There is no specific mental health legislation in Vietnam. The Law of People with Disability identifies people with mental and intellectual disabilities as a subgroup, granting them certain rights and access to services. This law, however, only identifies people with severe disabilities as eligible for social assistance benefits (Goldner et al., 2015). There is concern that this law therefore does not adequately protect people living with less severe mental health conditions (Niemi, Thanh, Tuan, & Falkenberg, 2010). Beginning with the 1998 introduction of the first National Health Target Program, the central government has emphasized the need to provide community based mental health support. Decision No. 1215 was introduced to enhance mental health service provision in Vietnam by expanding the mental health workforce, specifically in the social services sector through the training of a new cadre of social workers. Decision 1215 also includes a mandate to improve and expand a network of "social protection centres" for people living with severe mental illnesses, and to expand mental health services in the community (Goldner et al., 2015). Despite these existing policies, adherence varies and violations occur (Goldner et al., 2015; Minas, 2009). In practice, mental health services remain focused on institutionalization and pharmacotherapy, with community-based psychosocial interventions remaining largely unavailable (Vuong et al., 2011).

Mental health services in Vietnam have been largely concentrated in tertiary psychiatric facilities and focused on schizophrenia and epilepsy (Niemi, Thanh, et al., 2010; Vuong et al., 2011; World Health Organization-AIMS, 2006). There are 5000 psychiatric beds in Vietnam (6.08/ 100,000 population) with a 2004 occupancy rate of 122.9% (Vuong et al., 2011). Vuong et al. (2011) indicate that there are 700 outpatient mental health facilities operating in 64% of communes. An estimated 5% of community-based facilities offer psychosocial interventions, although data are limited (Niemi, Thanh, et al., 2010). There are no mental health consumer or family support groups in Vietnam and there is no mental health human rights policy (Niemi et al., 2010). The health system in Vietnam has become increasingly two-tiered, marked by the increased growth of the private health sector. The private mental health sector is largely dominated by multinational pharmaceutical corporations, with a very underdeveloped domestic

pharmaceutical industry (Lee et al., 2015). Private mental health services mainly consist of the provision of psychotropic medication, with very few psychosocial private support services offered.

Evidence about the treatment of CMD including depression is limited, implying that little has been done to build capacity for treatment, especially at the community level. Niemi et. al. state: “The lack of focus on depression treatment mirrors the situation found in most low-income countries, where this illness receives little programmatic and research attention” (Niemi, Thanh, et al., 2010).

There is a significant shortage of mental health human resources in Vietnam. In a study of the prevalence of three types of mental health workers (psychiatrists, nurses and psychosocial care providers) in 144 LMIC's, Vietnam had the largest shortage of psychiatrists and psychosocial care providers, with 1.70 psychiatrists and 11.52 psychosocial care providers per 100,000 (Kakuma et al., 2011). The proportion of nurses working in mental health facilities was 2.1/100,000 vs. 81.9/100,000 in all healthcare fields (Vuong et al., 2011). Vuong et. al. (Vuong et al., 2011) also indicate that in recent training programs there have been no graduates in mental health professions, with none of the 2500 medical graduates in 2004 studying psychiatry. In 2014, 6.9% of physicians had specialized in psychiatry, meaning there were approximately 173 new psychiatrists among 2500 medical graduates (Hòa, 2014). Psychiatry continues to be unpopular among medical trainees in Vietnam (Goldner et al., 2015).

Community-based mental health services are increasing in Vietnam, and are offered at approximately 700 outpatient facilities (Vuong et al., 2011). There are 37,5000 physician-based primary care clinics in Vietnam (7500 in the public sector and 30,000 in the private sector) and 3000 non-physician-based public primary health care clinics (World Health Organization-AIMS, 2006). General practice physicians in Vietnam receive 2% of their training in psychiatry, while nurses receive 1% of their training in mental health (World Health Organization-AIMS, 2006). The level of training and capacity in mental health among non-specialist health workers has implications for the successful integration of mental health services into primary care.

The basic structure of primary care in Vietnam is the 6278 commune health stations, which operate on a catchment area system and act as the gatekeeper to the

health system (Vuong et al., 2011). Hanoi has 579 commune health stations and centres, each with approximately five or six staff working at a given time, with a total of approximately 4065 health workers. These include one physician/ manager, physician's assistants, nurses, and one pharmacist. It is common for at least one physician's assistant to specialize in Traditional Vietnamese Medicine (TVM). Commune health stations administer specific health programs that are mandated by the provincial and national government. The largest programs managed by these centres are immunization programs for children and pregnant women (Ngo & Hill, 2011).

Commune health stations play a role in community-based mental health service delivery, and are involved in implementing the community-based mental health program (CMHP), which, as of 2011 had been implemented in 64% of communes and all provinces (van der Ham et al., 2011). As part of the CMHP, commune health stations largely provide screening and referrals and dispense medications based on the prescription provided by a specialist. The CMHP provides people living in participation communes with free access to prioritized psychotropic medicines for schizophrenia, epilepsy and, in some cases, depression (Niemi, Thanh, et al., 2010; Vuong et al., 2011). Access to medications for depression, however, remains very low.

Studies demonstrate low levels of help seeking for mental illness, with the exception of schizophrenia, in Vietnam (Niemi, Thanh, et al., 2010; van der Ham et al., 2011). van der Ham (2011) found low levels of disease recognition for all mental illness, while Niemi et. al. (2013a) found low levels of disease recognition and diagnosis of depression in primary care. Do et. al. (2014) found low levels of formal knowledge about mental illness among Vietnamese nationals and among Vietnamese immigrants to the United States. They found that mental illness was often attributed to the experience of "shocks" or adverse life events.

Patients with CMD may present with somatic symptoms such as insomnia or headaches. Do et. al. (2014) found that mental illness was often described in physical terms, including the inability to sleep and loss of appetite. In a study on explanatory models for post-partum depression among a small sample of patients and health workers, Niemi et. al. (2010) found that both patients and health workers largely explained depression in terms of relational factors such as marital problems. They also found that health workers attributed factors such as physical ailments or failure to conceive a son as causes of

depression. Understanding health workers' explanatory models for depression has implications for assessing facilitators and barriers to primary care integration. Niemi et. al. state that: "by studying practitioner explanatory models, one can understand how they understand and treat sickness" (Niemi, Falkenberg, et al., 2010 30). This is discussed in detail in Chapter 5.

2.5. Gender

Risk factors for depression may vary by gender. Despite limited evidence about gender and depression in Vietnam, evidence suggests that there are high rates of depression among new mothers (Fisher et al., 2004) and high prevalence of depressive symptoms among men in the informal labour sector (Van Huy et al., 2015). Poverty, lack of education, marital problems, poor social support and violence have been identified as risk factors for postnatal depression (Niemi, Falkenberg, et al., 2010). When asked to elicit explanatory models of postnatal depression (Niemi, Falkenberg, et al., 2010), mothers and health workers in a northern Vietnam community identified relational issues as the most prominent cause of depression. Among these, problems with the husband (e.g. violence, gambling) were identified as the most important cause. Other relational factors included problems with children, parents or in-laws. The failure to conceive a son was also identified as a cause of depression, pointing to pressures related to male preference in Vietnamese society and the expectations placed on women (Niemi, Falkenberg, et al., 2010).

Van Huy et. al.'s (Van Huy et al., 2015) study on depression among male informal labourers suggests risk factors for depression among this population include financial strain, separation from family and social networks, poor treatment by bosses, and poor living conditions. The nature of informal labour, which involves financial insecurity and separation from families who are often left behind in rural areas, challenges traditional male roles. Men are expected to be breadwinners and heads of the household, and the inability to meet these expectations may increase stress and increase vulnerability to mental health problems like depression (Van Huy et al., 2015)

Health services provision for mental disorders is not neutral, and can be influenced by social norms and structures. The gender of both physicians and patients may influence

the nature of primary care consultation, especially in terms of discussing topics that are considered sensitive. A study in the US (Henderson & Weisman, 2001) found that female gender of a physician significantly improved likelihood of receiving counselling on sensitive topics for both male and female patients in primary care. In a study examining decreased help-seeking behaviour for tuberculosis among women in Hanoi, Thorson and Johansson (2004) found that women are more reluctant to be forthcoming about symptoms and health concerns. This was associated with the female role within society and within the household (specifically in a rural context), where women held a lower status and were expected to be shy and self-sacrificing. This study, as opposed to the US study, found that sensitivity among health workers to gender differences among patients seemed to vary according to practitioner personality rather than gender. The authors suggest that the emphasis by Vietnam's government on gender equality might be creating gender blindness in healthcare, wherein women's specific needs are being neglected. They recommend emphasising an equity approach in public health. While female gender is associated with an increased prevalence of depression in much of the world, a global study found no difference in detection rates for men and women in primary care (Gater et al., 1998). This study was based on data from the WHO Collaborative Study on Psychological Problems in General Health Care and included data from just fifteen countries, not including Vietnam. The limited scope may mean that the results are not generalizable to other settings. This study takes into account both health care worker gender and the perceptions of health workers about women and men in relation to depression and its treatment.

2.6. Stigma

Also extremely important when assessing barriers and facilitators to the integration of mental health services is the issue of stigma. Mental illness is highly stigmatized globally, leading to discrimination and lack of opportunities for employment, education and housing (Lauber & Rössler, 2007). Stigma can affect health service delivery and health worker attitudes (Abiodun, 1991; Arvaniti et al., 2009; Foster, Usher, Baker, Gadal, & Ali, 2008; Jorm & Reavley, 2013; Muga & Jenkins, 2008), with stigma identified as a “significant obstacle to development of mental health care and to ensuring quality of life of those suffering from mental illness” (Lauber & Rössler, 2007 158). Stigma can exist at both individual and structural levels, with discriminatory policies or neglect of mental health

in organizational or government budgets impacting the potential for intervention implementation to succeed (Yang et al., 2007).

Although mental illness stigma seems to be experienced universally, its manifestation and impact are culturally determined (Lauber & Rössler, 2007). Stigma is believed to influence help-seeking for depression as well as how the disease is explained. In Asian countries, help-seeking for mental illness is influenced by “the lack of mind-body distinction, the tendency for somatization, and the shame shared by the patient and their families” (Lauber & Rössler, 2007 162). Niemi et. al. (2010) (2010) found that “depression” was often described as “thinking”, which may be a term that is less stigmatizing. van der Ham (2011), Vuong et. al. (2011), and Niemi et. al. (Niemi et al., 2013b; Niemi, Falkenberg, et al., 2010) acknowledge the role that stigma plays in discouraging help-seeking and treatment for depression in Vietnam. In their study comparing perceptions of mental illness and stigma among Vietnamese nationals in Ninh Binh province and Vietnamese migrants in New Orleans, Do et. al. (2014) found that study participants who had experienced mental illness were reluctant to discuss it openly, including in health professional settings. They quote one respondent from the New Orleans sample:

“I have much sadness... I very much want to speak out. But I still keep it to myself; I still endure and do not share it with other[s]... That is why when the doctors investigate; they find that very few Vietnamese have mental illness. For example, I am depressed, but it takes many people to come to find that out” (Do et al., 2014 1295)

The authors suggest that this reluctance to talk about mental health problems might be a result of stigmatizing attitudes towards mental illness, as well as a reluctance to revisit or remember adverse or traumatic experiences. They note that the New Orleans sample was more likely to describe mental illness as something that should be kept quiet however, speculating that the American culture of privacy and individuality might have influenced this group to view mental illness as an issue to be kept to oneself. Although research on mental health stigma in Vietnam is very limited, it is possible that in the sociocentric society of Vietnam keeping mental illness a “personal issue” might not be customary or possible. In Asian societies, stigma is also experienced by the family as well as by the patient. This can result in families losing social status or in patients and their siblings losing marriage prospects (Lauber & Rössler, 2007; Park & Park, 2014). The issue of family stigma may be important to explore further in the Vietnam context

Understanding attitudes of health workers towards mental illness is an important component of assessing the potential for effective integration of mental health services into primary healthcare. Stigma towards people with mental illness on the part of health workers can affect the interaction of health care providers with patients by “hindering trust and rapport between health professionals and their patients” (Park & Park, 2014 165).

The experiences and meaning of depression and factors, including gender and stigma, which influence the experience, identification and treatment of depression, may vary cross-culturally. While mental illnesses like depression may be universally experienced, understanding them within the cultural context in which they exist is essential. The next chapter explores mental illness from a transcultural perspective and the implications of this approach for global mental health research.

Chapter 3.

Transcultural Psychiatry and Global Mental

3.1. Overview

As illustrated above, mental health has been described as both a significant contributor to the global burden of disease and as having been neglected in global health. The emergence, less than a decade ago, of a cohesive community for global mental health research and advocacy has been accompanied by a call to close the mental health gap globally and to prioritize mental health within the field of global public health. Since the 1980's, however, proponents of transcultural approaches to mental health have cautioned against the increased biomedical and universalist approaches to mental health in diverse settings. Exploring both these perspectives and understanding how they converge and diverge is important as a backdrop for research on mental health in a global context. This chapter helps to situate this study within the broader context of global and transcultural approaches to mental health and the tensions and commonalities between them. This chapter includes several components: 1) a review key concepts in transcultural mental health; 2) an examination of the literature emerging from the field of global mental health; 3) an exploration the ways in which the two fields diverge and intersect; and, a discussion the implications for this research study.

This chapter distinguishes transcultural psychiatry from global mental health literature, exploring how the two are divergent or complementary. Despite the fact that both bodies of literature are concerned with improving mental health globally, with particular focus on populations residing in or originating from LMICs, they take a distinct approach. Transcultural psychiatry takes a culturally relativist perspective, arguing that there is no universal way of understanding, diagnosing and treating mental illness. Several of its proponents caution against what they see as the importation or imposition of North American and European understandings and approaches to mental health. While proponents of global mental health also recognize the importance of cultural variation in mental health, they advocate for increased global attention to mental health based on its universality. They advocate based on the high global prevalence of mental illness, calling attention to similarities rather than differences as a way of making the case for increased

investment in research and services. As is described below, the two bodies of literature are often complementary, but fundamental differences do exist.

3.2. Transcultural Psychiatry and Cross- Cultural Perspectives on Mental Health

3.2.1. Putting Transcultural Approaches to Mental Health in Context

The belief that mental ill health is not solely the result of biological factors but is also influenced by social and cultural determinants is the foundation of transcultural approaches in the fields of psychiatry, anthropology and other disciplines interested in mental health across cultures. The belief that mental ill health can be experienced differently in different contexts has implications for understanding what signs and symptoms constitute mental disorders across cultures, how to identify and classify these disorders, what the course of illness might be, and how best to diagnose and treat those who are affected.

A leader in the field of transcultural psychiatry, Kleinman situates his influential 1988 volume, *Rethinking Psychiatry: From Cultural Category to Personal Experience*, in the context of an increasing trend in psychiatry of approaching mental illness from an exclusively biomedical perspective, both in terms of diagnosis and treatment. He argues that this singular concern with biomedicine in the field of psychiatry risks ignoring not only the cross-cultural variations in mental illness, but also a significant dimension of illness as experienced by psychiatric patients in all societies. He argues that this has implications for diagnosis, prevention and treatment of mental illness worldwide, and that this reductionism fails to fully understand that which is unique about mental disorders. Mental disorders, he argues, are unique in that that they are only partially the result of purely “biological” factors and are also influenced by other determinants, such as the social, cultural, political and economic factors that may “lead to human misery” (Kleinman, 1988 8) To make his case he draws on examples of the ways in which mental illness is understood, experienced and treated across many different cultures.

Kleinman argues that mental health disorders are both universally and uniquely experienced across cultures. This means that while every society and culture experiences mental disorders, many of which are the same or at least similar, many variations exist in the manifestation, understanding and treatment of these disorders. He argues that it is these variations that are at the core of the disease experience and therefore should not be minimized but deeply understood. Similarly, Kirmayer (1989, 2005) Summerfield (1999, 2001, 2008) and a number of other authors have made the case for deep cultural awareness in psychiatry and mental health practice.

Below, a number of contributions to the fields of transcultural psychiatry and cross-cultural mental health are reviewed. The discussion will focus on several interrelated topics: the issue of identifying disordered or ‘abnormal’ behaviour (behaviour that is recognized to be outside of a cultural norm, is demonstrative of some type of health or spiritual ‘condition’ and may lead to social exclusion) cross-culturally; the classification of mental disorders across cultures; psychiatric diagnosis cross-culturally; and cross-cultural perspectives on the treatment of mental disorders. Notably, two key concepts- *validity* and *meaning*- stand out throughout the discussion of cross-cultural perspectives on mental health. These will be further discussed below.

3.2.2. How is “Disordered” Behaviour Defined Cross-Culturally?

It is evident that the question of what is perceived within a cultural or medical context to be “normal” and what is “abnormal” or ‘disordered’, and, more importantly, how this is identified and dealt with by patients, their families, practitioners and societies is at the heart of transcultural psychiatry and cross-cultural approaches to mental health. “Abnormal”, while it is a term that is certainly alienating, is used because it is sufficiently general to capture the fact that manifestations of mental illness and expectations regarding the norms of behaviour vary somewhat across cultural contexts. The term refers to behaviour that is outside of the “norm” of what is culturally acceptable in a specific context and that will likely prevent those who are suffering from meeting the expectation or requirements of daily living. Chentsova-Dutton et. al. (2014) described “normative and deviant cultural scripts” as ways in which an experience is “flagged” as abnormal, and thus pathological. These scripts help to make sense of this deviant behaviour or experience and “turn experiences that are alarming and confusing... into experiences that are

troubling, but comprehensible and meaningful, with a label, acceptable explanations for the distress and specific ways to address it” (Chentsova-Dutton, 2014 342). Kleinman argues that understanding “abnormal” behaviours cross-culturally depends on understanding “idioms of distress”, which refers the ways “in which biological and cultural processes dialectically interact” and signal disorder or illness (Kleinman, 1988 25) ‘Disordered’ behaviour is also used to refer to the behavioural manifestations that might point to a mental illness or condition and not simply to an expression of personality, standard human emotion (e.g. sadness) or experience (e.g. grief). Good and Good (1986) describe the “normative uncertainty” which involves determining what is “normal” and what is “disordered” in a particular culture. They describe the challenge of how to “determine whether particular behaviours or forms of experience are abnormal and therefore a symptom of illness or simply different but normal within the patient’s own cultural context (p. 37).

Primarily, cultures differ in how they define and pathologize abnormal or disordered behaviour and interpret signs of distress. These differences in turn have significant and universal implications for both the diagnosis and treatment of mental disorders. The idea of what is “normal” and what is “abnormal” seems to influence how disorders themselves are classified in terms of dominant psychiatric nosology. Disorders that do not fit into the dominant model of Western psychiatric classification are labelled “culture-bound syndromes” or “culture- related specific syndromes” and are grouped separately and, as in the case of the DSM-IV where they are found in an appendix, are even situated outside of the domain of the “normal” mental disorders. The culture-bound syndromes will be further discussed below.

As a background to understanding the exploration of if and how “abnormal” behavioural patterns differ cross-culturally, Draguns (1997) provides a history of the emergence of both culturally-relativist and universalist perspectives in mental health. He describes the “new transcultural psychiatry”, such as that advocated by Kleinman, as a combination of both etic (understanding that there are universal characteristics of mental disorders) and emic (recognizing that mental disorders must be understood in cultural and social context) approaches. Thus, while mental distress exists in all societies and many recognized mental disorders (such as schizophrenia) are prevalent across the world, the experiences of mental distress and understandings of mental disorder do vary cross-

culturally. Kirmayer (2005) also describes this tension between universalist approaches which he says dominate “world psychiatry” and the more culturally relativist approaches advocated by transcultural psychiatry. He states that in “world psychiatry” the trend has been to “view culture as a distraction” to a “core of universal human experiences” (Kirmayer, 2005 192). He argues that all psychiatric classification and diagnosis is influenced by culture and that all humans are cultural beings. He cautions against the “reductionist” approach that ignores the fundamental role culture plays in all areas of mental health, including the recognition of certain behaviours as “abnormal” and the classification and diagnosis of these behaviours as specific disorders.

Discussions of cultural variation in mental illness might lead to questions of the actual global burden of mental disorder. Regarding the prevalence of mental illness cross-culturally, Kleinman argues that epidemiology cannot be separated from ethnography. He states that understanding the culturally-based determinants of mental illness are essential for understanding if, how and to what extent mental disorders exist in certain cultural contexts. For example he argues that prevalence and incidence data cannot be validated without understanding the existence of stigma in a given society, which may cause significant underreporting and under-diagnosis. He also describes how the social setting of research (e.g. whether interviews take place in clinical settings, in family homes, etc.) may influence response rates.

Kleinman gives an overview of epidemiological findings (based on the very limited evidence available at the time) related to psychotic disorders, depression and suicide cross-culturally. The evidence shows the universal but varying prevalence of each type of mental disorder studied. When discussing the epidemiological evidence, Kleinman raises the need to understand the different and changing idioms of distress across cultures. For example, he suggests that the evidence pointing to an increasing incidence of depression in China is actually confounded by significant changes in the expression of depressive symptoms so that they are more in line with Western diagnostic criteria. This, he argues, may in fact point not to an increased occurrence of depressive disorders but to an increase in diagnosis as the changing idioms of distress more closely mirror the symptoms as listed in Western diagnostic guidelines. Again, he points to the differential presentation of mental disorders, or differing idioms of distress, which make universal

diagnostic criteria inappropriate and may therefore impact the validity of epidemiological evidence. This will be further discussed below in relation to depression.

Important concepts related to the cross-cultural diversity of the experience of mental illness include “illness behaviours” and “illness beliefs”. Kleinman defines “illness behaviour” as: “meaningful experience of symptoms and patterns of coping and help seeking” (Kleinman, 1988 45). He argues that culturally different illness behaviours can shape the course and the outcome of a disease, and argues that more research is needed about differing disease outcomes cross-culturally.

Related to illness behaviour is illness belief. Kleinman describes how understandings of body and self, in addition to categories of illness, lead to differences in beliefs about what constitutes “normal” and “abnormal” behaviour. He describes how “personal experiences” of mental disorder become “cultural categories” through shared understandings of distress, “normal” and “abnormal” behaviour and illness. He argues that this leads to cross-cultural differences in the experience of mental illness, while limiting the diversity of experience for individuals from a shared cultural context. Both illness behaviour and belief have implications for the classification of mental disorder and therefore for our understanding of the burden of mental disorder worldwide. The burden of mental disorder will be discussed below in relation to the literature on global mental health and depression.

Kirmayer (1989) also contributed to the discussion of the cross-cultural variation in what is understood to be “abnormal” or disordered behaviour. He advocates an approach to transcultural psychiatry that combines emic and etic approaches and describes the differences across cultures in responding to mental disorders. He points to variations cross-culturally in both the expression of psychiatric distress and the classification of mental disorders. Like Kleinman, he uses an “illness behaviour model” as a means of understanding how people across different cultures express signs of “abnormality” or distress, and how they respond to these signs. He states that an illness behaviour model: “...emphasizes that symptom expression and help-seeking are the outcome of psychosocial processes rather than a direct expression of pathobiology or the natural history of disease” (Kirmayer, 1989 329). For example, in reference to somatization, he states that people often experience both physical and emotional distress simultaneously, and which of these experiences the patient emphasizes as being

symptomatic of distress may be determined by culturally-influenced illness behaviour. Further to this, Kirmayer states that psychological distress can be understood in terms of "...modes of expression that explicitly refer to indigenous theories of mind, self and emotion" (Kirmayer, 1989 330). Cultural patterns of emotional expression, he states, influence the expression of everyday emotion and therefore also influence what is deemed to be "abnormal" in this respect. Similarly, the concept of the person and a person's place in a broader social structure also influences what is considered to be "normal" or "abnormal". For example, while in Western society distress may be understood in terms of individual experience, in many cultures distress may be understood as a "disruption of the social or moral order" (Kirmayer, 1989 331). Kirmayer's illness behaviour model is an important framework for understanding how cultural factors can influence the ways in which "abnormal" behavioural patterns are understood, expressed and acted upon, which in turn has implications for psychiatric diagnosis and treatment cross-culturally and for the social impact of psychiatric diagnosis across cultures. This will be revisited below.

3.2.3. Classification of Mental Disorders Cross-Culturally

In addition to expressions of distress cross-culturally, Kirmayer draws on labelling theory to discuss the variations in the classification of disordered behaviour across cultures and their socio-cultural implications. He states that labelling theory "in its strong form argues that the social identification of deviance and distress creates the disorders it aims to describe and control" (Kirmayer, 1989 332). He argues for the application of a softer form of this theory that examines "how the social recognition or diagnosis of deviance may shape symptomology, amplify or reduce distress, and influence the course and outcome of illness" (Kirmayer, 1989 332). As described above, Kirmayer argues that cultural norms of emotional expression are a determinant of deviance or distress. He also argues that the cultural implications of classification as "abnormal" may not always be positive for the patient. He thus calls for a balance between the positive effects of labelling (e.g. treatment) and the negative effects (e.g. stigma and social exclusion). Chronicity, he explains, is an important factor in this balance. If a patient is understood to be chronically ill (as are schizophrenics in Western society) their identity and role in the community often shifts. This means that psychiatry must understand these cultural nuances in order to fully grasp the meaning of mental distress for the lives of patients.

Banks (1992) also calls attention to the meaning of symptoms cross-culturally in determining both whether a person will assume a “sick role” in society and what this might mean for individuals, families and communities. She describes the role of Christian religious fundamentalism in anorexia nervosa in the United States, and describes how some patients view their anorexia not as “starving” but as “fasting” and thus refuse to assume the role of “sick person”. The implications for psychiatric diagnosis will further be discussed below.

A discussion of the classification of mental disorders cross-culturally is further illuminated by an examination of the category of “culture-bound syndromes” (CBS’s). The most striking issue when reading about this particular classification of mental disorders is that they are clearly determined in reference to Western psychiatric nosology, which is seen as the benchmark for understanding mental disorders. Western classified mental disorders, in fact, seem to be generally recognized as being ‘normal’ or ‘mainstream’ mental disorders. Hughes (1998) and Tseng (2006) both provide useful discussions of CBS’s and their place in the world of psychiatric classification. Hughes describes the process leading to the inclusion of CBS’s in the appendix of the DSM-IV and is critical of both its placement as an appendix and in the separation of “culture” into a specialized and relegated category. He states that although the DSM-IV in general advised “taking culture into account” it provided no guidance on how to do this in practice. He is further critical of the term “culture-bound syndrome”, arguing that everything is, in fact, culture-bound. He states that referring to a “culture-bound” mental health disorder is similar to referring to a “culture-bound language” (Hughes, 1998 418). He argues that culture should not be treated as a side bar but should be recognized as being fundamental to psychiatric understanding. He states that, given the placement of the CBS’s in the DSM-IV and the treatment of the word “culture” as an extra consideration, the word is being used in the DSM-IV in a way that makes “culture” refer to the other and presents CBS’s as exotic descriptions that seem less important than the ‘mainstream’ mental disorders listed in the manual.

Tseng is also critical of the treatment of “culture” in dominant psychiatric classification but argues in favour of the value of understanding different cultural manifestations of mental disorder as described by the CBS’s. He begins by providing a history of the evolution of the study of CBS’s, and advances a more up-to-date term:

Culture-Related Specific Syndromes (CRSS's). He defines CRSS's as: "a collection of signs and symptoms that is restricted to a limited number of cultures, primarily by reason of certain of the psychosocial features" (Tseng, 2006 561) He argues that CRSS's are useful in terms of their potential for understanding how all forms of psychopathology relate to culture. Above all, he argues for their importance in helping to develop culturally competent and culturally relevant treatment for mental disorders across cultures.

Both Hughes and Tseng make the case for the role of culture in successful diagnosis and treatment of mental disorders. They also point to the danger of assuming that culture only plays a role in shaping mental disorders that are deemed "exotic" by Western psychiatry and in turn consigning those disorders to an appendix in highly influential manuals such as the DSM. Similarly, Kleinman (1988) argues that 'idioms of distress' is a more useful framework for regarding disordered behaviour than CBS's, as the latter reduces culturally specific experiences of distress and mental disorder to "exotic versions" of disorders that are listed in Western diagnostic manuals. The important role of understanding culture for diagnostic success is displayed in Banks' previously mentioned ethnographic study of anorexia nervosa, in which an understanding of the religious narrative of her case-study subjects would be essential to both their diagnosis and treatment.

3.2.4. Diagnosing Mental Disorders Cross-Culturally

As mentioned above, the concept of validity is very important throughout the discussion of cultural approaches to mental health. When discussing the diagnosis of mental illness cross-culturally, Kleinman focuses on the issue of validity, which he argues is highly contextual. He argues that a diagnostic technique or set of criteria (e.g. the DSM), although proven reliable through its use in a specific (in this case Western) cultural context, may prove to be invalid in other contexts. He introduces the term "category fallacy" which is defined as: "the reification of one culture's diagnostic categories and their projection onto patients in another culture, where those categories lack coherence and their validity has not been established" (Kleinman, 1988 14-15).

Kleinman also discusses the (then limited) cross-cultural research on psychiatric conditions, including the Determinants of Outcome Study on schizophrenia. He argues that these studies, through both their design and analysis, focused on the similarities that

exist across cultures, demonstrating, for example, that schizophrenia is universally experienced. Kleinman argues that these studies in fact minimize essential variations in the presentation of schizophrenia cross-culturally. He further argues for the importance of anthropology in understanding these cross-cultural nuances in the experience of mental disorders, stating that while similarities are the business of psychiatry, it is the differences that are of interest to anthropologists. Anthropology, he argues, can enrich the understanding of mental disorders across cultures; while biology “determines the forms of mental illness”, culture “shapes the content of these disorders” (Kleinman, 1988 24). Anthropology can therefore help increase the validity of diagnoses, he states, arguing that validity involves “the verification of concepts, not observations” (Kleinman, 1988 24). He argues for the need to understand the interaction between biology and culture, which he says is in opposition to the dominant approach of stripping away cultural influences in order to understand the “real” biological explanations for disordered behaviour. Diagnostic tools, he argues, cannot be valid unless they take into account contextually and culturally appropriate idioms of distress and exclude those that may be inappropriate or irrelevant.

Hughes (1998) cites Rogler (1993) when describing three ways in which culture plays a role in assessment and diagnosis:

- The ways that culture influences the experience of distress must be understood, in addition to the impact of culture on the “willingness of respondents to divulge symptoms” (Hughes, 1998 419);
- Culture plays an important role in the translation of symptoms into syndromes;
- Culture plays a role in the diagnostic relationship and in the development of understanding, trust and buy-in between patient and practitioner.

Clearly, these three ways in which culture interacts with diagnosis have major implications for validity, understood in this context as the ability of patients to access diagnostic services that will properly interpret their own experiences of distress, and that are acceptable and legitimate to them as patients. It presumably also has a significant impact on subsequent course of action to support the patient to heal and/or to manage symptoms of distress.

Unfortunately, the recognition of the importance of culture in psychiatric diagnosis does not always translate to practice. In a review of depression measures validated and

used in Vietnam and among the Vietnamese diaspora, we (Murphy et al., 2015) found that few studies using Western-derived measures adequately tested for construct and content validity. The majority of the studies defined “validity” as the ability of a measure to identify caseness against a standard Western psychiatric interview, which itself had not been validated for use in this population. This indicates that even when measures are ‘validated’, the methods may be insufficient to identify whether measures are in fact culturally appropriate. When validating psychiatric measures for use in diverse populations it is essential to balance criterion validity and reliability assessment with extensive testing for construct and content validity. While this review examines the use of screening measures for one psychiatric condition in one country, it raises concerns about the use of such measures in the broader global context.

The concept of meaning is also very important in cross-cultural approaches to mental health as identified by Kirmayer (2005) in his discussion of diagnosis. Kirmayer calls attention to the far-reaching impact of diagnosis by describing both the explicit and implicit functions of a diagnostic system. The explicit role of a diagnostic system, he states, includes “guid[ing] clinical intervention” including prognosis and course of treatment, in addition to influencing research and policy agendas. He also describes implicit functions, which affect the clinician, the patient and society. For the clinician, he states that diagnosis has the role of “nam[ing] and contain[ing]” the suffering of a patient. For the patient, the implicit function of a diagnostic system is to define or redefine personal identity in relation to a particular disorder or disability. Finally, the function of a diagnostic system in social context is to assign a “sick role” to people experiencing distress and thus help to legitimize their distress or disability. This may, however, also lead to their stigmatization and social exclusion. Therefore the impact of a psychiatric diagnosis is broad. Kirmayer argues that psychiatric classification and diagnosis does not just outline categories that explain natural occurrences, but “constitutes a map and charter of a social world” (Kirmayer, 2005 193).

Kirmayer’s discussion of the far-reaching impact of psychiatric diagnosis and the variation of this impact cross-culturally is very important. It demonstrates that not only do patients and practitioners assign meaning to signs and symptoms that are influenced by culture, but that the actual diagnosis has implications for how the patient will exist in the broader social context. In 1989 Kirmayer stated:

“Even when purely biological theories are tendered in psychiatry, the fact that the symptoms and signs of illness are directly related to the everyday expression and confirmation of personhood ensures that neither patient nor physician will find it easy to ignore the moral dimension to diagnosis” (Kirmayer, 1989 335).

Taking culture into account in diagnosis, he argues, is essential for understanding the many implications of diagnosis. In 2005 he further argues that understanding of cultural diversity is increasingly relevant across the world due to increased migration and the effects of globalization. He calls for further research to enrich psychiatric classification and diagnosis, stating: “this diversity cannot be addressed with a nosology based on research conducted in only one or a few cultural contexts” (Kirmayer, 2005 196).

3.2.5. Treating Mental Disorders Cross-Culturally

Validity and meaning are also very important concepts for the treatment of mental disorders cross-culturally. When discussing healing and mental illness cross-culturally, Kleinman explores how psychiatrists (mostly referring to psychotherapists) and other practitioners heal. Interestingly, he provides a comparison of psychiatry and various types of “folk” healing and draws on evidence that suggests: “local indigenous systems of symbolic healing have rates of successful outcome similar to those found in general medical care” (Kleinman, 1988 130) He describes the healing process as a symbolic process to which both patient and practitioner must attach meaning in order to succeed. He states that for healing to take place both the patient and the practitioner must be “committed to a shared symbolic order” (Kleinman, 1988 137). He describes the process of symbolic healing as being essential to its success- that is, that the patient and practitioner must both commit to and believe in the symbolic process that is taking place.

The difference between ‘healing’ and ‘fixing’ and the implications of these approaches is also relevant for effectiveness of treatments for mental disorders. Returning to the discussion of the increasing biomedical dominance in psychiatry, Kleinman describes what he refers to as a “postmodern paradox”: “healing has become increasingly marginal to the West’s dominant healing system” (Kleinman, 1988 139). He says that although understanding pathologies of the brain and prescribing appropriate medication is certainly important, “the psychiatrist’s work is chiefly about people’s life stories” (Kleinman, 1988 139). He further argues that the most significant contribution of psychiatry

to medicine and health care is that it has made legitimate understanding the patient's personal experience and the meanings behind the patient's illness (Kleinman, 1988 140).

Kleinman also makes the case for the importance of anthropological approaches to enhancing the meaning, and therefore the validity and effectiveness, of treatment for mental disorders. He concludes his volume by making the case for anthropological methods as means to enrich psychiatry. He lays out a number of suggestions for how anthropology specifically and social science in general should be integrated into psychiatric training and practice. He suggests using "mini-ethnographies" during practice to better understand the cultural and social realities of patients. For practicing psychiatrists he outlines four types of illness meanings that must be understood: 1) The conventional meaning of symptoms and how these symptoms are expressed (e.g. what is "normal" and what is "abnormal" and what does it mean?); 2) The cultural significance of mental disorders (e.g. is there a great deal of stigma attached?); 3) The significance of a chronic illness in the life of a patient; and 4) The explicit explanatory models of patients, their families and practitioners (e.g. how is the disorder understood by each party?) (Kleinman, 1988 160-162).

Myers (2010) argues for the use of anthropology to understand the ways in which culture influences healthcare and vice versa. She argues that culture also helps to define what "wellness" means and thus how to tell if someone has recovered. Improved outcomes of people with a diagnosis of schizophrenia in LMIC's have been identified (Padma, 2014), and Myers discusses a number of sociocultural factors that are believed to contribute to improved outcomes for people with mental disorders in these countries. These include culturally relevant stress management practices, increased involvement of families, informal economies resulting in less pressure to conform to professional expectations and increased community cohesion (Myers, 2010 516).

Myers describes both the emerging interest in global mental health (e.g. the WHO's mhGAP) and the shift in approaches in the US towards recovery-based treatment. She worries that such practices will be exported through global mental health initiatives without taking into account local context and existing local strategies. Given the relationship between stress and schizophrenia outcomes, she argues that: "ethnographers should take stock of such [stress-reducing] strategies, by eliciting, documenting, and preserving local stress-reducing practices and local definitions of

meaningful citizenship so they can be incorporated into any on-the-ground plan to promote healing from severe mental illness” (Myers, 2010 518). She further cautions that the imposition of North American values of “meaningful citizenship”, which emphasizes autonomy and individualism, might further hinder the recovery of people with mental disorders in a global context. She concludes by arguing that there is a risk of declining schizophrenia outcomes “in the push for one global fix-all for mental health” (Myers, 2010 519). The issue of improved outcomes for schizophrenia patients some LMICs will be further discussed in the following section.

This overview of literature from advocates of a cross-cultural approach to mental health worldwide has raised a number of important issues. The interaction of biological factors with social and cultural considerations and their influence on what constitutes mental health (or ill health) challenges notions of absolute classification of mental disorder worldwide. The importance of meaning and validity for the interpretation of signs and symptoms (illness belief), help seeking related to disordered or atypical behaviour (illness behaviour) and for the diagnosis and treatment of mental disorder cross-culturally provide an interesting framework with which to consider mental health on a global scale. In Chapter 4, the challenge of studying depression cross-culturally is explored, with issues related to mental health and the Social Determinants of Health raised.

The following section reviews literature from the emerging field of global mental health. The section begins by examining literature that makes the case for global action and investment in mental health. Subsequently, literature outlining the global mental health situation is reviewed. Finally, a discussion of the intersection of transcultural approaches and global mental health approaches examines a number of assumptions made by each field and questions the extent to which each approach is distinct and/ or complementary.

3.3. Global Mental Health

3.3.1. Making the Case for Global Mental Health

In the field of global health, mental health has been traditionally neglected. Major contributors to the field of global mental health draw on evidence in order to advocate for

the urgency of mental health in global public health. In an editorial in the *American Journal of Psychiatry*, Patel, Saraceno and Kleinman (2006) wrote of the “moral case” for placing mental health at the heart of international public health. The authors draw on several evidence-based arguments, which they argue make mental health not only a significant health issue worldwide, but also an ethical imperative. They state that mental health disorders are treatable in resource-poor settings and that cost-effective and proven interventions must be supported so that they can reach people in need. They also argue that other health conditions, such as HIV/AIDS and childhood malnutrition, are associated with mental health disorders and that mental health interventions should therefore be linked to many other public health initiatives. The authors describe the human resource scarcity in mental health, exacerbated by the brain drain, which means that many of the world’s mental health systems are severely under-resourced. They also describe the terrible human rights abuses endured by people suffering from mental disorders as a result of misinformation and stigma, severe lack of resources, and absence of regulatory systems. Finally, they describe how mental disorders are also connected with rapid social change. Many countries are experiencing unprecedented change, because of which many people may experience a number of financial, social and cultural stressors. They argue that resources for mental health must be put in place to support those who are affected by this change and to help prevent negative mental health effects. They call for a global mental health advocacy initiative to promote investment in mental health worldwide.

Kleinman (2009) also takes a moral approach to calling for increased investment in global mental health. He describes the terrible conditions faced by people affected by mental illness in much of the world and argues that a unified approach to global mental health requires making a similar moral shift to that which was seen in the HIV/AIDS movement. He advocates starting from a place of understanding about the reality and “ordinary moral experience” (Kleinman, 2009 603) of people in their local context. Regarding the impact of marginalization and the social impact of mental disorders on people in much of the world, he states: “To call this sea of danger stigma is to trivialize its powerful effects and to be euphemistic about the enormous barriers it created for the development of global mental health programmes that can actually address what is most at stake for sufferers and their networks. This is, pure and simple, social death” (Kleinman, 2009 604). He cites several examples that he finds demonstrative of possible “cultural change” in mental health, including the actions of family advocacy groups in India and

China and the gradual recognition of the importance of mental health in the global health field. Despite these examples he states there is significant progress to be made on moral grounds, and calls for collective action to “improv[e] the moral conditions of those with chronic mental illness...” (Kleinman, 2009 604).

Adding to the argument made by Patel et. al. (2006) about the connection between mental health and other health concerns, Prince et. al. (2007) provide detailed evidence about the association of HIV/AIDS and other infectious diseases, non-communicable diseases such as diabetes, and intentional and unintentional injuries with mental illness. They argue that the predominant view that mental health disorders exist in isolation from other health concerns has contributed to their neglect by public health initiatives. They call for an integration of mental health considerations into all aspects of public health policy, funding and intervention. This paper is a part of the influential *Lancet* (2007) special series on global mental health, which contains a number of papers (some discussed below) that make the case for global mental health. This series led to the launch of the Movement for Global Mental Health in 2008, which engages in advocacy about mental health globally and promotes the scaling-up of mental health services, especially in LMIC’s (Patel et al., 2011; The Lancet Global Mental Health Group, 2008).

3.3.2. The Mental Health Situation in LMIC’s

In addition to making the moral case for improved attention to mental health in LMIC’s a number of papers help to understand aspects of the mental health situation in these countries. While comprehensive evidence from LMICs remains limited (Collins et al., 2011; Patel & Kleinman, 2003; Patel et al., 2006; The Lancet Global Mental Health Group, 2008), emerging evidence helps to shed light on important issues in mental health in LMIC’s.

The issue of poverty and inequity is, of course, a central concern in global health. Patel and Kleinman (Patel & Kleinman, 2003) explore the relationship between poverty and mental health disorders in LMIC’s. They conducted a review of community-based studies from LMIC’s that included both measures of mental health and poverty. They explored the relationship between mental illness and a number of indicators: income, insecurity, hopelessness, social change, education, gender and comorbidity [e.g. malnutrition, the effects of poor sanitation, etc.] They found that the strongest associations

were not with low income specifically, but with the factors that go along with poverty, especially lack of education but also insecurity, hopelessness and rapid social change. They state that the connection between poverty and mental illness is not limited to LMIC's but exists in all populations that experience the impacts of poverty. They recommend both primary (e.g. education and nutrition programs) and secondary (e.g. integration of mental health into primary healthcare) strategies to prevent mental illness in resource-poor settings. Notably, the sample (11 studies) used for this study was limited and calls attention to a gap in research from LMIC's at the time of publication. Lund et. al. (2011) also found that there is a negative cycle between mental illness and poverty and found an association between enhanced mental health intervention and improved economic outcomes.

In terms of treatment and prevention of mental disorders, a review by Patel et. al. (2007) examines the feasibility, based on effectiveness and affordability, of scaling-up mental health treatment and prevention services. This review demonstrates that much of the evidence to support the effectiveness of services in mental health comes from HIC's. Of 11,501 trials identified assessing treatment of schizophrenia, depression, alcohol use disorders and developmental disabilities, only 1% were from low income countries and 10% from low and middle income countries. Of this 10%, two thirds were from China. Also of importance, the majority of trials assessed exclusively pharmaceutical interventions, meaning the gap in evidence about psychosocial interventions is even more significant. Nevertheless, the studies that were available raised a number of considerations about mental health services in LMIC's. Without being exhaustive, a number of the key points are summarized below, paying particular attention to the studies that included an assessment of psychosocial interventions. Because of the paucity of evidence about mental health services in LMICs, it is helpful to describe the results of this review.

The results of Patel et. al.'s (Patel et al., 2007) review suggest that treatments that extend beyond the individual and involve families and communities are most effective. Group psychosocial interventions might be more effective because they "might be experienced as an extension of traditional social mechanisms, such as support through social networks and collective action" (2007). Similarly, broader social networks seem to be important for schizophrenia treatment. Research suggests that both "clinical and social outcomes" can be improved if families and communities are involved in interventions to

reduce stigma, improve adherence to medication, and decrease social exclusion (Patel et al., 2007 994)

Regarding prevention of mental illness, a number of goals of prevention strategies exist. These include: reducing incidence, prevalence and recurrence of mental disorders; reducing the duration of symptoms; reducing the risk factors for mental illness; and reducing the impact of mental illness on people, families and communities. There have been a scarce number of trials on prevention in LMIC's, with none addressing prevention of schizophrenia. A Chinese depression prevention program employed positive thinking and conflict management skills to reduce symptoms of depression. A suicide prevention program in Sri Lanka used a peer support programme to decrease suicide rates (Patel et al., 2007). More evidence is clearly needed on the effectiveness of prevention programs in LMIC's.

Despite the high prevalence of mental disorders during and after conflicts and emergencies, there is a lack of outcome studies on mental health interventions for the people affected. The majority of interventions that do exist have focused on post-traumatic stress disorder (PTSD) but, "there has been much debate about whether it is appropriate to focus on this disorder ahead of other social and mental health problems, such as the problems of people with severe pre-existing mental disorders" (Patel et al., 2007 997). Social science research has suggested that many social interventions can be effective in protecting mental health, but there is a lack of evidence about whether these interventions are effective in preventing "diagnosable mental disorders" (Patel et al., 2007 998). Overall, there is a gap in research about mental health in emergency situations, including research about how mental health interventions can help people return to the activities of their daily lives.

Regarding health spending and help seeking behaviour, three separate studies based in India suggest that the majority of out-of-pocket expenditures by families were for visits to informal sector practitioners, for care given by members of the household and for indirect costs such as travel and time. These costs "exceeded the subsequent costs of targeted clinical interventions by public health-care providers" (Patel et al., 2007 999) . This raises the question of why patients and their families spend out of pocket to access informal care before seeking support from the formal health system and what determinants impact their access to formal care.

Overall Patel et. al. (2007) give a first glance at mental health prevention and treatment services in LMIC's, but also call attention to the significant gap in mental health services research from these countries. They state: "The smallest evidence base comes from the poorest countries, most trials focus on a narrow range of mental disorders, and most assess only pharmacological interventions. Thus, most of the evidence is of limited relevance for mental health care in LMIC's" (Patel et al., 2007 1000). They call for research to inform the scale-up of effective mental health interventions in LMIC's and to demonstrate to HIC's that low cost interventions that rely on a broad range of human resources can be effective.

Prevention and treatment of mental disorders of course rely on strong health systems and mental health investment. Regarding the situation of mental health systems in LMIC's, Jacob et. al. (2007) outline the many challenges faced by examining data about mental health stewardship, spending on health and mental health, mental health beds, and human resources. They draw on 52 country profiles, of which 37 were from LMIC's. They also use case studies of Brazil, India and South Africa to illustrate both challenges and successes in mental health systems. 70% of African and 50% of South East Asian countries spend less than 1% of their health budget on mental health. Regarding mental health beds, almost 95% of South East Asian and 83% of African populations have access to less than 1 bed per 100,000 people. Human resources for mental health are also extremely scarce, with 90% of African and all South East Asian countries having less than one 1 psychiatrist per 100,000 people. Taking into account the significant mental health gap in much of the world, especially in Africa and South East Asia, it is particularly important that mental health financing be integrated into the general health budget, with specific funds allocated to mental health (Jacob et al., 2007).

The previous sections have described a number of considerations for transcultural and global approaches to mental health among populations living in or originating from LMICs. The Global Mental Health literature, in general, seems to prioritize making the case for mental health worldwide and seeking to fill a critical gap in services for the mentally ill in resource-poor settings. While some reference is made to culturally appropriate approaches, there seems to be less concern with cultural validity than with strengthening mental health capacity and advocating for action. Proponents of the transcultural approach to mental health caution that universalizing the mental health

experience will fail to capture the culturally-based understandings and approaches to mental distress, meaning that interventions might be inappropriate and, in some cases, harmful.

While these approaches seem to be at odds, it might also be argued that they are complementary and point to the need for a balance between approaches that seek to fill the global treatment gap and approaches that seek to understand the cultural dimensions of mental health in countries and populations. The next chapter further explores these factors and this need for balance between the two approaches. Though a discussion of the considerations for studying depression cross-culturally, the perspectives of both transcultural psychiatry and global mental health are taken into account and the implications for cross-cultural depression research and practice are discussed.

Chapter 4.

Considerations for Studying Depression Cross-Culturally

4.1. Introduction

In the last decade, global efforts to address the burden of depression and the shortage of available mental health services worldwide have increased. With attention to the call to address the depression burden has also come caution and criticism about the possibility of exporting Western illness constructs and inappropriate interventions around the world, especially in low and middle-income countries (LMICs) and among minority ethnic populations within Western countries. Depression as a construct and the attention the growing burden has warranted is contentious. The 2000 Global Burden of Disease Report (World Health Organization, 2008), which identified depressive disorder as one of the leading contributors to disability-adjusted life years (DALY's) worldwide, has been influential in mobilizing attention to the need for research and action on mental illnesses, especially in LMICs. There are, however, challenges associated with the concept of "depression" as a universal construct that are compounded when working in cross-cultural contexts. These challenges must be recognized and thoughtfully considered in depression research and practice cross-culturally.

This narrative review explores the challenges of studying depression from the perspectives of both transcultural psychiatry and global mental health, examining the implications for depression research cross-culturally. Two research questions are posed: 1) What are the challenges of studying depression cross-culturally from the perspectives of global mental health and transcultural psychiatry? And, 2) What are the implications of these challenges for cross-cultural depression research?

4.2. Methods

This narrative review examines the literature about depression cross-culturally from the perspectives of transcultural psychiatry and global mental health. according to

Green et. al. (2006) note that narrative reviews are helpful for presenting a broad perspective on a topic, especially related to theory and context. Because the purpose of this review is to explore high-level, conceptual issues related to studying depression cross-culturally, scientific and clinical studies of depression interventions, treatments, aetiology and epidemiology were not included. This review was conducted using a combination of snowballing and personal networking, common in qualitative research (Mertens, 2009) to identify key sources in the fields of transcultural psychiatry and global mental health. Seminal works were identified and additional sources were selected through a review of reference lists. All sources included in this review are from peer-reviewed or academic texts. Grey literature was excluded from the review due to the focus on capturing the dominant theoretical perspectives and key concepts of transcultural psychiatry and global mental health.

4.3. Results

Three major challenges with applying a universalized concept of depression globally emerge from the literature. The first is the validity of the construct cross-culturally. While depression in a Western context is associated with dysphoria (sadness, feelings of hopelessness, inability to find pleasure in activities or social relationships), the ways in which depression is experienced cross-culturally may vary significantly (Jenkins et al., 1991). Kleinman (1988) reminds us that both the experience of depression and its diagnosis are interpretive; there is no “truth”, but rather contextually influenced understandings of signs of distress and their meaning. Jenkins et. al. (1991) describe how emotions, somatization, experience and coping with suffering, and vocabulary used to describe symptoms vary extensively cross-culturally. Lee (2002) suggests that the growing “global burden of depression” actually represents the assimilation of numerous culture-bound syndromes under the Western category of depression. He describes the Global Burden of Disease report’s “uncovering” of depression as one of the leading causes of DALYs worldwide, stating that it is expected to rival cardio-vascular disease by 2020. About this, he states: “The Global Burden of Disease study has effectively buried the culture-bound syndromes and recreated them as depression. Such is the power of cultural assimilation” (Lee, 2002 153). This does not mean, however, that conditions that approximate and hold similar implications (in terms of impact on quality of life and functioning) to what Western psychiatry would classify as “depression” do not exist in the

global context. Jenkins et. al. (1991) state that even when a word for “depression” does not exist in a culture, “depressive states can be studied as a feature of local forms of suffering” (p.72). Responding to the suggestion that mood disorders do not exist at all outside of Western societies, Paykel (2008) argues that this is “an artefact of previous Western psychiatrists failing to recognize the disorder in other cultural and linguistic groups” and that “mood disorders do appear to be universal, once they are sought by local psychiatrists who understand the culture, language, and metaphors used to express mood” (p. 287). Depression is not similar to other medical conditions, in that it does not have a distinct aetiology or pathology. Chentsova- Dutton et. al. (2014) argue that the nature of depression, which involves neurological, psychological and cultural influencers, means that it is inappropriate in cross-cultural research on depression to simply attempt to map the existence of Western-defined symptoms in other cultures.

An important consideration for cross-cultural research on depression is that understandings of the body, the mind, and emotions are culturally bound. Western biomedical approaches are based on the assumption that the mind and body are separate, and this dichotomy is reflected in the DSM and ICD classification systems. Many cultures, however, do not see the mind and body as separate entities, meaning that symptom descriptions that are purely psychological may not be valid or meaningful. Conceptualizing depression as a disorder of the mind might be inappropriate or inaccurate. Emotions are also not experienced in the same ways across cultures, with variations existing in the expression and implication of emotion. Suffering, for example, may be revered or viewed as a normal part of life in some cultures (Jenkins et al., 1991). Emotion is understood as a culturally determined response to internal and external experiences. Jenkins et. al. argue that emotion should be viewed as “an essentially cultural integration of bodily experience and communication” (Jenkins et al., 1991 68). In order to understand mood disorders, emotions and the ways in which they are expressed or culturally interpreted must also be understood. In cultures where emotion is not readily expressed, for example, depression may be experienced and articulated primarily through behaviours or bodily complaints.

Depression in Western psychiatry is conceptualized as a disorder that affects an individual and is experienced through introspection. Many societies are sociocentric, meaning that depression might be experienced as relational or intra-psychic. The criteria

of classification systems like the DSM and ICD are built on the notion that depression symptoms involve a deviation from cultural norms such as “promotion of the individual self, cultivation of positive feelings, and open expression of emotions to signal personal preferences” (Chentsova-Dutton, 2014 339). Identifying these norms as universal benchmarks for emotional or mental health is problematic as it might lead to the ‘category fallacy’ as described by Kleinman (1988), wherein an illness construct from one culture is applied in another culture where it is not valid or meaningful.

The mind-body dichotomy has already been identified as a Western construct that may not apply universally, and somatic complaints are often common in patients with depression cross-culturally. Jenkins et. al. define somatization as: “the expression of interpersonal and personal distress...as an idiom of bodily complaints” (Jenkins et al., 1991 74) and note that only in modern Western society is depression primarily defined as an ‘intrapsychic’ experience. In much of the world, they state, several factors “lead to symptom pictures that may include little or no psychologically minded expression of dysphoria” (Jenkins et al., 1991 74). Somatic experiences with depression may lead to challenges in diagnosis and treatment. With somatization feelings of guilt, low self-esteem and suicidal ideation might be less common, and somatic symptoms can often lead to a delay in diagnosis as physical origins of the complaints might be sought. Somatization might also co-occur with physiological conditions, such as anemia, that might also contribute to depression (Jenkins et al., 1991).

Experiences and understandings of depression vary cross-culturally. Culture is influenced by the ‘social groupings’ that divide society, including age, socioeconomic status, and gender (Guarnaccia & Rodriguez, 1996). Also important is that these “deviant cultural scripts” (Chentsova-Dutton, 2014) which describe experiences of depression might shift over time. Culture is not static, and is influenced by numerous factors including social change, the movement of people, power structures and other processes that influence people and populations (Good & Good, 1986; Guarnaccia & Rodriguez, 1996). Along with these shifts in culture might come a shift in understandings and experiences of depression. Kleinman (Kleinman, 1988; Lee & Kleinman, 2007), for example, describes a shift in China from neurasthenia to symptoms of depression that are more consistent with Western classification. Chentsova-Dutton et. al. (Chentsova-Dutton, 2014 342) note that

“even within a single cultural context, researchers and clinicians need to attend to the range of scripts that are currently available in that context” (p. 342).

The second challenge is related to validity and involves the measurement of depression and the collection and availability of data. The epidemiological studies on which the calls for action on global mental health are based are limited in several ways. Primarily, they make use of standardised assessment measures that are based upon the DSM and ICD classification systems, which may be problematic in several respects. They may not, as described above, accurately measure “non-Western” experiences of depression, meaning that they are lacking in construct validity (Cook & Beckman, 2006; Murphy et al., 2015). These diagnostic systems also take a categorical approach to measuring depression, whereby a person who is screened is identified as either a case (has depression) or a non-case (does not have depression) (Kraemer, 2007). As described in Chapter 2, sub-threshold depression, which would be categorized as a “non-case”, may lead to significant functional impairment. Patients therefore might fail to meet the case criteria for depression using the DSM or ICD diagnostic systems, but still experience considerable impairment as a result of their symptoms, meaning that they would likely benefit from appropriate treatment (Bjelland et al., 2009). By failing to capture the level of impairment caused by sub-threshold depression, statistics representing the burden of depression in many countries likely underrepresent the degree to which people are functionally impaired and risk overlooking individuals who would benefit from treatment and support.

In addition to capturing impairment that might not be detected by categorical models, dimensional approaches to measuring depression, depending on the factors that are measured, may capture variation in “precursors” of depression (e.g. socioeconomic factors), “concomitant” factors (e.g. specific symptoms and symptom severity), and “consequences” (e.g. disability and impact on quality of life) that are not captured by categorical models (Kraemer, 2007). These factors are relevant for establishing a more comprehensive understanding of depression in specific populations and for better understanding individual experiences of depression. The capacity to identify both level of severity of depression and the degree to which patients experience socioeconomic hardship, for example, has important implications both clinically and for research in LMICs. While categorical models might capture the number of individuals who meet the criteria

for a depression diagnosis, they will fail to capture the socioeconomic circumstances experienced by patients and their potential relationship to the experience of depression and functional impairment. This is especially relevant for enhancing understanding about depression in low resource countries and vulnerable populations. Similarly, dimensional categories could provide additional information about the types and severity of symptoms experienced in specific cultural contexts. Dimensional approaches might also prove more clinically useful than categorical approaches, providing insight to inform decision-making about which treatments might be most effective in specific populations or for individuals based on their symptoms, socioeconomic circumstances and degree of functional impairment (Widiger & Samuel, 2005) Although she notes that developing consensus on which dimensional aspects are the most clinically significant is a challenge, Kraemer (2007) argues that adding a dimensional component to the DSM “may revolutionize psychiatric research” (Kraemer, 2007 515).

The data on which evidence of the global burden of depression are based are also limited in that they are only representative of a limited number of LMICs. For example, serious concerns with the validity of the data used in the 2000 Global Burden of Disease (GBD) report have been raised, ranging from concerns about the use cross-culturally of standardised assessment tools, as described above, to the quality of data and the limited number of countries (only 40, with only three from the African region and four from South East Asia) represented (Brhlikova, Pollock, & Manners, 2011). Similarly, the World Mental Health Survey, implemented by the World Health Organization, involved 28 countries, which included nine countries identified as LMICs: Brazil, Colombia, Iraq, Lebanon, Mexico, Nigeria, Peru, China, South Africa (Harvard Medical School, 2005). Of these countries, all except Nigeria are classified as upper-middle income countries (The World Bank, 2015a) and may have experienced significant Westernization, particularly among the population with higher socioeconomic status. The World Mental Health survey uses the World Mental Health Composite Diagnostic Interview (WMH-CIDI), a standardized assessment tool, using the assessment criteria as defined in the DSM-IV and ICD-10 (Harvard Medical School, 2005). As described above, these classification systems are based on Western criteria and may be problematic for use cross-culturally.

The small number of LMICs included in the GBD study and the World Mental Health survey, in addition to the use of standardized, categorical assessment criteria that

have been developed in Western countries raises concerns about the validity and generalizability of the data. Jenkins et. al. (1991) note that: “given the variability of depressive symptoms and disorders cross-culturally, the use of standard instruments must evoke strong methodological caution” (Jenkins et al., 1991 87). They describe five problems that might arise when Western measures are simply translated to other languages and are not properly validated. The first is “normative uncertainty”, which refers to the question of what is “normal” or “abnormal” in a specific culture. This includes considerations of the threshold between “normal” feelings of despair and pathology. The duration of these symptoms, in terms of clinical diagnosis, may also vary by culture or context. These considerations, which are captured within the DSM and ICD systems as fixed categories that take a “case”/ “non-case” approach to diagnosis, may differ significantly across cultures.

The second problem is the “centricultural bias” (Good & Good, 1986), in which assumptions of the universality of depression symptoms might lead to the omission or misinterpretation of important symptoms. As an example, Jenkins et. al. describe the use of metaphors (e.g. feelings of ants crawling in the brain among Nigerian patients) as likely to be misinterpreted as psychosis when relying on Western diagnostic systems. Similarly, descriptions of spiritual beliefs or encounters might be similarly misinterpreted. Chentsova- Dutton et. al. provide a case study of a Hmong immigrant to the United States who experiences taxing visitations from the spirit of an ancestor that deplete her energy (Chentsova-Dutton, 2014).

Additional problems include the “indeterminacy of meaning”, which relates to semantic equivalence. Jenkins et. al. warn that even the method of back translation is based on assumptions that may be problematic, as the method assumes that there are universal ways in which to refer to concepts and constructs across cultures. Also problematic is the question of “narrative context” (Good & Good, 1986), meaning that symptoms may be described differently based on setting. For example, patients may describe a specific set of symptoms, such as somatic symptoms, in a clinical setting, but describe different spiritual, relational, or psychological symptoms in a religious setting or among family. Understanding the diverse range of patient symptoms may require capturing illness narratives from different contextual settings.

Finally, the problem of “category validity” is encountered when using measures developed in Western cultures in diverse cultural settings. This challenge refers to whether it is appropriate to map “even culturally appropriate symptoms onto universal categories” (Jenkins et al., 1991 89). Jenkins et. al. argue that research to further examine whether there are in fact universal depression categories or “whether seeming universality is produced as an artefact of research and clinical method” (Jenkins et al., 1991 89). They cite the development of indigenously derived measures of depression, including the Indochinese Hopkins Symptom Checklist (iHSCCL) (Mollica, 1987) which was validated for use among Loatian, Cambodian and Vietnamese refugees to the United States. Research has suggested that a balance of universal constructs and culturally-specific concepts are necessary in order to measure depression in specific cultures (Murphy et al., 2015; Patel, Abas, Broadhead, Todd, & Reeler, 2001). This calls into question the validity of the universal application of Western-derived measures that have not been adequately validated for use across countries and cultures. The issue of construct validity of these instruments was raised above, and was found to be a considerable gap in studies validating depression measures for use in Vietnamese populations (Murphy et al., 2015). It seems evident that support for improved and increased epidemiological research is needed. Jenkins et. al. (1991) recommend increased ethnographic research to ensure cultural validity.

The third challenge is the diagnosis of depression in contexts of human suffering such as extreme poverty, war and insecurity, gender inequality, and rapid social change. Summerfield (2008) cautions against the diagnosis of depression in such situations without examining the broader context. He argues that the “medicalization of everyday life” may actually downplay the profound effects of, and need to address, issues such as poverty and violence. When discussing the mechanisms by which life circumstances might contribute to depression, Jenkins et. al. argue that: “the most important aspect of life events is the meaning attributed to specific and cumulatively distressing life circumstances” (Jenkins et al., 1991 80). They argue that it is not so much the implication of change but the meaning ascribed to the event that has an impact on mental health. The differing meanings ascribed to adverse life circumstances and the subsequent existence of risk factors or protective factors cross-culturally is an important factor in cross-cultural research (Kirmayer & Pedersen, 2014), again calling attention to the importance of

ethnographic research that improves understanding of risk factors and coping mechanisms in various cultures.

Risk factors for depression include poverty, inequality, lack of education, and violence (Patel & Kleinman, 2003). Social support, particularly in sociocentric societies, seems to play a role as both a risk factor (in its absence) and protective factor. For example, social connection to people with a similar cultural background was found to be a protective factor among female South East Asian refugees in the United States (Jenkins et al., 1991). Jenkins et. al. note that among people with lower socioeconomic status, protective factors such as social support may be less available (Jenkins et al., 1991). Regarding a connection between low socioeconomic status and depression, evidence of the impact not of deprivation, but of inequality, on mental health has been found (Patel & Kleinman, 2003). Social determinants such as poverty, inequality, unemployment and low educational attainment are associated with increased levels of depression (Lund et al., 2011). As previously described, adding dimensional aspects to depression measures that capture socioeconomic factors might help to further understand the degree to which these risk factors are associated with depression in populations in LMICs (Kraemer, 2007).

Knowing that factors such as social and economic inequality, social change and isolation are risk factors for depression, is it necessary to draw the same conclusions as Summerfield and state that “depression” is a natural human reaction to hardship? Patel and Kleinman (Patel & Kleinman, 2003) argue that failure to treat depression because a person’s life circumstances are difficult is comparable to failure to treat infectious disease when the infected person lives in a high-risk environment. They also note that although poverty and insecurity increase the risk of depression, they do not guarantee it. Most people in both HICs and LMICs who face poverty, inequality and other life stressors are not depressed. Chentsova-Dutton et. al. note that evolutionary studies suggest that “depression represents a breakdown in an evolved and otherwise adaptive response to scarcity and loss” (Chentsova-Dutton, 2014 338). While the implication is that depression, regardless of life circumstances, should be addressed in a way that is culturally appropriate, it does not mean that social determinants of health such as poverty, lack of access to education, and inequality should not also be addressed. Dysentery is treated with anti-parasitic medications and oral rehydration at the same time as efforts are made

to improve safe water sources, hand washing and food safety. The same must be true for depression.

4.4. Discussion

These challenges have a number of implications for depression research and intervention cross-culturally. Regarding the validity of the depression construct cross-culturally, including the validity of data collection, it is clear that depression should not be viewed as a uniform condition cross-culturally. Rather, depression must be understood in the local context in terms of the nuances of emotional expression, the cultural meaning of suffering, and concepts of the self in terms of the individual or the collective (Chentsova-Dutton, 2014 338). Diagnosis and treatment of mental disorders must reflect this cross-cultural variation. Jenkins et. al. state that culturally-validated diagnostic tools are essential for proper diagnosis of depressive disorders. In terms of treatment, as described above, Patel et. al. (2009) argue that in many cultures interventions that focus on the family or community are much more effective than individual interventions common in Western contexts. Including dimensional approaches to depression measurements that capture risk factors, symptom type and severity, and degree of functional impairment might help to further increase understanding of the socioeconomic and cultural nuances of the depression experience and to inform approaches to treatment that are appropriate for specific populations and individuals (Bjelland et al., 2009; Kraemer, 2007; Widiger & Samuel, 2005).

Regarding the validity of epidemiological data on the prevalence of depression and the significant gap in epidemiological research from LMICs, it is evident that support for improved and increased research is needed. Jenkins et. al. (1991) recommend increased ethnographic research to ensure cultural validity. There is limited mental health epidemiological data from LMICs and health services and intervention research from these countries is also scarce (Patel & Thornicroft, 2009). It is necessary that research capacity within LMICs be strengthened so that mental health research can be conducted at national and local levels within countries in order to inform policy and the enhancement of culturally appropriate services for depression.

Finally, the issue of depression within the context of conditions of human suffering can be examined from a social determinants of health perspective. As with many diseases that are associated with or aggravated by poverty, inequality, low levels of education and violence, treating the symptoms of the disease alone is insufficient. Patel and Kleinman (Patel & Kleinman, 2003) advocate for interventions that address the social determinants of mental illness (e.g. educational and nutritional programs) in addition to significantly increasing the availability of mental health services in LMIC's. This indicates that, as with many health challenges, intersectoral interventions that address upstream contributors to mental health risk factors are essential. The perspectives of Patel and Kleinman and of Summerfield are thus both important; depression should not be dismissed in LMIC's as the result of socioeconomic factors and therefore as a Western construct to explain human misery, but neither should the underlying conditions that cause human misery be ignored.

While the construct of depression certainly varies cross-culturally, the evidence that all cultures suffer from depressive disorders is strong. This points to the need for research to increase cultural validity of diagnostics, interventions and epidemiological research. Much as the cultural variation in expressions and experiences of depression cannot be ignored, the social determinants of depression must also be considered in research on depression from a global perspective.

4.5. Conclusion

This discussion of depression and the divergent opinions and approaches of transcultural and global mental health proponents leads to the broader question of what this debate means for those who are suffering from mental distress in LMIC's. What does each approach mean for people with mental disorders (whether those disorders fit into DSM categories or are culturally defined), their families, and the health systems that must support the mentally ill despite significant resource deficits? Despite the divergent approaches taken by transcultural and global mental health proponents, they seem to largely complement one another to the extent that they advocate for the urgency of mental health support and health systems globally, particularly in LMICs. Kleinman (1988) suggests that transcultural psychiatry and anthropology can help to inform the strengthening of mental health systems, so that these systems can appropriately address the burden of mental distress in a way that is valid and meaningful in each context.

Similarly, transcultural approaches must have value for understanding cultural and social determinants of illness belief and behaviour and benchmarks for measuring treatment effectiveness in diverse settings.

The gap in mental health systems and services worldwide is largely related to a gap in funding for mental health programs. Many countries spend less than 1% of their health budget on mental health (Patel & Thornicroft, 2009). Mental health has also been neglected by major global health initiatives, as represented by the Global Fund to Fight AIDS, Tuberculosis and Malaria, Bill and Melinda Gates Foundation and the Millennium Development Goals. This begs the question of the value, in terms of mobilising resources, of calling attention to cultural diversity in mental illness worldwide vs. the approach taken by the Movement for Global Mental Health which calls attention to the alarming global burden and the universality of mental illness as a means of advocating for awareness and funding on a global scale. Advocacy regarding the universality of mental disorders might be more effective in mobilizing resources for mental health worldwide. As global mental health investment grows, however, those involved must be cautious to ensure that interventions are culturally appropriate and not in danger of promoting a “one size fits all” model of mental health care.

While both transcultural psychiatry and global mental health approaches might seem to represent distinct approaches, they are not mutually exclusive. Both perspectives offer important considerations for studying depression cross-culturally. While depressive disorders seem to be experienced worldwide, depression is not a universal construct. Understanding the cultural meaning of depression is essential to enhancing epidemiological evidence, case identification and ensuring that interventions to treat depression are valid, appropriate and effective.

Chapter 5.

Conceptualizing Depression in Vietnam: Primary Health Care Providers' Explanatory Models of Depression

5.1. Introduction

Depressive disorders are a major contributor to the global burden of disease, and are expected to be the leading cause of DALY's worldwide by 2030 (Mathers & Loncar, 2006). Depressive disorders are associated with numerous comorbidities (Kessler, 2014; Prince et al., 2007) and with negative socioeconomic consequences including increased risk of intimate partner violence (Kessler, 2014) and increased absenteeism from work (Alonso et al., 2011).

Based on evidence of the high burden of depression globally and a severe shortage of mental health human resources in many LMICs (Kakuma et al., 2011), proponents of a global mental health approach have recommended the scale-up of evidence-based, low-cost interventions (Eaton et al., 2011; Patel et al., 2009). This includes the scale-up of task-shifting approaches whereby services for mental health problems are delivered by non-specialists. Such approaches, including the integration of mental health services into primary care, may effectively help to fill a critical gap in health services and to improve services access for people suffering from mental health problems including depression. These approaches, however, must take into account the socio-cultural context of depression in order to ensure that interventions are both evidence-based and culturally appropriate.

While all cultures seemingly experience symptoms that are consistent with depressive disorders, depression as an illness may be experienced, understood and treated differently across cultures (Jenkins et al., 1991). The symptoms associated with depression and the meaning attributed to those sets of symptoms may vary, thus influencing patterns of help seeking and care provision. Understanding the ways in which depression is conceptualized among diverse cultural groups is an essential component of planning for care provision in a global context and among diverse populations.

Explanatory models (EMs) refer to “the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” (Kleinman, 1980 105). EMs help to explain how people- whether they are patients, family members or practitioners- give meaning to the experience of being ill. They help to understand how and why a series of symptoms may be classified as an illness, how and why decisions are made about care and help seeking, and beliefs about illness course and outcome. Four broad components of EMs can be identified: what is the nature of an illness; what causes it? what should be done about it; what is the expected outcome? (Kleinman, 1980; Niemi, Falkenberg, et al., 2010). Understanding health care providers’ EMs can provide insight into how they understand and respond to specific illnesses. This in turn provides essential contextual information to inform the adaptation or development of tools and interventions for use within specific communities. Although providers might be considered to have ‘expert’ knowledge about specific illnesses and their required interventions, Kleinman notes that EMs are largely tacit, and are “partly conscious and partly outside awareness” (Kleinman, 1980 109).

Vietnamese beliefs about health and illness are influenced by a number of paradigms, including Buddhist, Confucian and animistic beliefs. In TVM, health is influenced by both biophysiological and cosmological concepts (Phan et al., 2004). Maintaining balance between Yin and Yang is important to maintaining good health, with environmental factors, composed of the five elements (air, earth, fire, water and wind), influencing health. Achieving balance between ‘hot’ and ‘cold’ forces are also essential to maintaining good health (Purnell, 2008). Little distinction is made between mind and body, with internal organs being associated with emotional states (Phan & Silove, 1999; Phan et al., 2004). Traditional healers have been used in Vietnam for both physical and psychological issues (Phan & Silove, 1999) and traditional medicine, including herbal remedies and interventions such as cupping and acupuncture, is integrated into the mainstream health system. Folk traditions, such as animism or the belief in ancestral ghosts and spirits, also influence health beliefs, where ‘ghosts’ might be responsible for symptoms (Nguyen, 1985; Phan et al., 2004). In addition to diverse traditional beliefs, Vietnam also has a tradition of Western psychiatry dating back to the early 20th century that has been especially influential in urban areas (Phan et al., 2004). Previous research on beliefs about depression in Vietnam has found that symptoms are often described as somatic or social and that etiology has been attributed to family conflict and pressure and

physical ailments (Niemi, Falkenberg, et al., 2010; van der Ham et al., 2011). Community awareness and help-seeking for depression were found to be low (Niemi, Falkenberg, et al., 2010; van der Ham et al., 2011).

Vietnam is a lower-middle income country with approximately 90 million inhabitants, 17% of whom live under its national poverty line (The World Bank, 2016). Vietnam is a diverse country, with 54 distinct ethnic groups (International Working Group for Indigenous Affairs, N.D.). Health care is delivered by a four-tiered system, which ranges from the central level, to provincial, district and commune-level services. Like in many countries, mental health has historically been given low priority within the health system, resulting in limited financial and human resources dedicated to mental health (Ngo et al., 2014). Mental health care is offered at 27 provincial psychiatric hospitals, which are distributed among Vietnam's 63 provinces, and at mental health departments of general hospitals operated at the district level. Hospital care for mental illness is predominantly focused on schizophrenia and epilepsy (Ng, Than, La, Van Than, & Van Dieu, 2011; Vuong et al., 2011).

Primary health care in the public sector is delivered by commune health stations (CHSs) in Vietnam, which, in addition to providing patient consultations, administer national health programs (e.g. immunization and health education campaigns) and provide antenatal care (Ngo & Hill, 2011; Ngo et al., 2014). Outpatient clinics also provide primary care services, operating as either stand-alone clinics or as part of district health centres.

The government of Vietnam has recognized the need to improve community based care for mental health, and the Ministry of Health (MOH) has included mental health care in the community as part of its five-year mental health plan (Ngo et al., 2014). In practice, however, services in the community remain predominantly focused on the management of psychopharmacological treatment for schizophrenia and epilepsy. There is very limited availability of antidepressant medications at the community level, and psychosocial interventions are almost non-existent (Niemi, Thanh, et al., 2010).

Efforts are currently underway to improve service provision for common mental disorders in primary care in Vietnam (Goldner & Nguyen, 2013; Ngo et al., 2014). Understanding primary care providers' EMs of depression will help to ensure that

community-based approaches to depression care, when scaled-up to other areas of the country, is both appropriate and acceptable to providers and the communities in which they work. This purpose of this study is to understand primary health care providers' explanatory models of depression and to describe the implications for the development of enhanced primary care services for depression in Vietnam.

5.2. Methods

5.2.1. Data Collection

This study took place in Hanoi, Vietnam between August and October 2014. We conducted 30 semi-structured interviews with primary care providers (PHPs) at eight CHSs and two outpatient clinics (OPCs) in one rural (Thach That) and one urban (Dong Da) district of Hanoi. CHSs and OPCs are often the first point of contact for patients within the Vietnamese public healthcare system and are staffed by physicians, nurses, pharmacists and physicians' assistants. Some physicians' assistants have specific training in areas such as midwifery or TVM. Table 2 displays the number and types of PHPs included in the study. The majority of providers interviewed (n=27) were female, which is representative of the composition of staff at the centres included in the study.

Table 2: Number and role of interviewees by district

	Thach That (rural)	Dong Da (urban)
Doctors	5	3
Nurses	4	7
Physicians assistants	5	3
Pharmacists	3	0
Total	17	13

Semi-structured interviews were conducted by the first author with the assistance of bilingual interpreters/ research assistants. The interview schedules and consent forms were translated from English to Vietnamese and then back-translated for semantic equivalence. The interviews were then pre-tested, with adjustments made as necessary to the interview questions and approach. The majority of interviews were recorded with the permission of the respondents, and were later transcribed by Vietnamese research assistants and translated to English by a translator with expertise in public health. Five

respondents preferred not to have the interviews recorded. In these cases, extensive field notes were taken. The research process was iterative, with ongoing discussions held between the primary author and the co-authors. Discussions regarding terminology and concepts related to depression and mental health were held frequently with the interpreters/ research assistants and with the translator of the interview transcripts.

The original study design involved the use of vignettes to elicit explanatory models. This approach was used successfully among community members and practitioners in Ba Vi, Vietnam by Niemi et. al (2010) and has been used in similar studies in other contexts (Torres, 2009). In pre-testing, however, it was evident that respondents felt they were being tested or evaluated and showed obvious discomfort with the vignettes. As a response to this, we decided to “reverse” the vignette approach, asking respondents instead to think of a patient with a mental health problem and to describe symptoms, cause, recommended intervention, and prognosis. We asked them to first describe a patient with a severe mental illness, followed by a patient with a less severe mental illness in order to establish whether discrete symptoms would emerge when respondents were unprompted by psychiatric labels.

Because PHPs are closely embedded within their communities, we asked them to position themselves both as clinicians/ experts and as community members. This was effective, as it allowed them to reflect on experiences that went beyond the clinical domain and provided insight into beliefs and behaviours within the broader community.

5.2.2. Analysis

The data were analysed using a thematic analysis approach, whereby “patterns of meaning” are identified (Crowe, Inder, & Porter, 2015) with themes emerging from the data (Braun & Clarke, 2006). The theoretical thematic analysis approach (Braun & Clarke, 2006) used reflected the design of the interview questionnaire, which was structured to elicit responses around the four components of EM’s described above, in addition to community perspectives about depression. The analysis process began with an immersion in the data through thorough readings and re-readings of the interview transcripts, This was followed by the generation of initial codes, with additional codes added as they emerged throughout the coding process. Coding was conducted using NVivo 10 software (QSR International). The codes were then grouped into categories,

from which themes were identified. Themes were then reviewed and refined, with a detailed analysis of each theme conducted for the final analysis (Braun & Clarke, 2006).

5.3. Results

5.3.1. Symptoms

Respondents were asked to first describe a patient with a severe mental illness and then to describe a patient with a less severe mental illness. We asked them to make this distinction, initially avoiding specific psychiatric labels, to establish whether symptoms of depression would emerge unprompted and whether these symptoms would be distinguishable from symptoms of other mental illnesses. Table 3 displays the most frequently mentioned symptoms of both “severe” and “less severe” mental illnesses as described by PHPs.

Table 3: Symptom description of severe and less severe mental disorders

Severe mental disorders	Less severe mental disorders
Wandering around	Don't talk or communicate
Aggressive behaviour	Keep to themselves
Destructive behaviour	Fatigue
Saying strange things	Trouble sleeping
Paranoia and delusions	Unable to work

PHPs made a clear distinction between symptoms that they associated with ‘severe’ mental disorders and those they associated with ‘less severe’ disorders. We subsequently asked respondents to provide labels for each set of symptoms. They frequently used the term for ‘schizophrenia’ (*tâm thần phân liệt*) for severe symptoms and sometimes also used a general term for ‘mental illness’ (*tâm thần*) or used informal words (*rồ, điên*), which translate as ‘crazy’. For the less severe symptoms, they often used the term for ‘depression’ (*trầm cảm*), but also sometimes referred to general ‘mental illness’ (*tâm thần*) or to *tự kỷ*, which translates to “autism”, but is also commonly used to refer to anyone who does not often socialize or talk to others (perhaps best translating to “anti-social”). The following quote illustrates the distinction between symptoms made by a PHP:

There are also patients, like in my neighborhood, who scream and wander around, or even take off all their clothes and go out on the street. Those are serious cases. There are less serious cases in which the patient just don't say anything, like depression, they don't communicate with other people. (Nurse, Dong Da district)

When asked to think specifically about depression, their description of symptoms emphasized social and functional withdrawal and disruption. The most commonly described symptoms of depression was not wanting to communicate with other people and “keeping to themselves”. Inability or unwillingness to work and reduced productivity were also described as symptoms of depression. Physical symptoms, such as fatigue, insomnia and headache were also described. Very rarely were emotional symptoms such as sadness or hopelessness associated with depression.

The clearest symptoms of depression is that they don't communicate with anyone, they don't want to, they don't want to go out, they isolate themselves and have no social relationship. (Dong Da, nurse)

PHPs noted that patients would likely not describe their own symptoms. They explained that families would bring patients to the health centre and would participate actively in the consultation, often relaying the patients' symptoms to providers. In some cases, PHPs had never seen a patient with depression, but were familiar with a family member or community member who had experienced it. In three cases, PHPs reported having experienced depression themselves.

5.3.2. Cause

Causes of depression as described by PHPs can be categorized as interpersonal, external and internal/ psychological. Family problems, including tension between spouses, pressure by parents on children, and relationships with in-laws, were the most commonly mentioned cause of depression across all categories, described as having a serious impact on mental health. Social problems or problems in the community were also described as contributing to depression, with ‘neglect’ by community described as a possible contributing factor.

External factors contributing to depression include pressure at work and financial problems. One PHP stated:

“There are many influencing factors, including family, economic situation, or being stressed at work. Many factors.” (Pharmacist, Thach That district)

Internal and psychological problems were also described, with “shock” emerging as an important cause of depression. “Shock” seems to be a psychological response to an adverse event (e.g. bereavement or sudden economic loss) or disappointment (e.g. poor performance on academic exams, not having a son). “Shock” was described as leading to depression when a person was unable to cope properly with these events.

There are many causes, for example, they don't get what they expect, or they have some kind of shock. For example, when they expect something too much but it does not happen, it would make them shocked and lose their hope in life. I think that is one type of depression. The patient feels discouraged, tired, does not like anything more. Well, it's hard. (Physician's assistant/ midwife, Dong Da district)

Addiction and substance abuse were also associated with depression, with alcohol misuse in particular described as an important cause of depression among men. Alcohol misuse by men was often described as a serious concern in many communities.

5.3.3. Interventions and approaches to care

When describing interventions and approaches to care, PHPs describe the importance of identifying the cause of the depression in order to provide advice and counselling to the patient. The advice provided would be specific to the perceived cause, within some providers stating that they would provide advice about dealing with spousal conflict or economic difficulty.

Doctors and nurses working with this type of patient need to be very patient and sympathetic when asking and consulting the patient, so that we can have the right information we need, like the cause of the disorder. For example, it might be because they are involved in some type of bad business leading to a bad financial situation or some troubles at home, or some other reason, we need to know those reasons to have an appropriate treatment instruction. (Doctor, Dong Da district)

Referrals are also a common course of action when advice is seen as insufficient. Patients considered to be suffering from a mental health problem would be referred to the district hospital (one level above the CHSs) or to a specialized mental health department or psychiatric hospital.

PHPs also described prescribing sleeping pills, vitamins, supplements and “tonics” to help the patient to restore blood flow to the brain. Anti-depressants are not available at the CHSs and cannot be prescribed by PHPs. These supplementary medications are provided in addition to advice about nutrition, rest and lifestyle changes:

We are not implementing a mental health program here, so I prescribe medicine to help sleeping and increase brain blood circulation. I combine those medicine and they feel better after a while following the prescription...I need to explain to them and advise them to eat, to take a rest, and take medicine as prescribed for 20 days, and to get rid of alcohol to recover quickly (Pharmacist, Thach That district).

Family and community support were also described as essential to care for depression. In addition to providing advice to patients themselves, PHPs indicated that they would provide advice to families about how to care for and support their depressed family member. The following quote demonstrates the various approaches to a patient with depression that might be taken by a PHP:

“Firstly, I would try to find out the cause of depression. If [they] did not have depression before, we need to know what has caused [them] to be like that. If I cannot help [them], I will advise [them] to go to see a specialist on depression, so that they can give [them] treatment. Along with that, I would encourage [their] family to support [them]. (Pharmacist, Thach That district)

5.3.4. Prognosis

PHPs believe that with proper treatment and family and community support, patients can recover from depression. Similarly to treatment, they link recovery to identifying a clear cause of the depression, stating that once the cause is known proper support can be provided, by PHPs and by family members, to help the patient to recovery.

The importance of medication was also raised, with non-adherence to medications identified as a challenge to recovery. ‘Medications’ might refer to antidepressants that are prescribed at a higher level of care, or to the types of supplements and sleeping pills described above. Importantly, while medications were connected to recovery by PHPs, the actual availability of antidepressants is very low in Vietnam.

Some PHPs also believe that mental illness exists on a spectrum, where less severe symptoms of depression might lead to more severe forms of mental illness. For

example several PHPs stated that untreated depression might lead to schizophrenia. The following quotes are from two different physician’s assistants in Thach That district:

“Receiving medicine and advice, the patient feels satisfied and the condition gets stable”

“Otherwise, if he continues being in this condition, he will get schizophrenia”

5.3.5. Community Perspectives

Awareness

PHPs indicated that although depression is seen in the community, community members have low awareness about mental illness and depression. They explain that there has been more recent coverage of depression in the media causing awareness to gradually increase, but despite this increase in awareness, they believe that very few community members would use the word “depression” to describe their symptoms. PHPs also believe that there are many people living in their communities who suffer from depression and do not seek help. Notably, many of the PHPs’ experiences with depression were based on knowledge of family, friends or personal experience rather than patients encountered through their role as health care providers.

In Thach That, the rural area, mental illness is often conceptualized in spiritual terms, and families might believe the person experiencing depression is “ghost-driven” (*ma lam*), or possessed by malevolent spirits. Although the belief in spirit possession might be more common with very severe cases of depression or psychotic disorders, it is evidently relevant to the overall understanding of mental illness EMs in rural communities.

Well, when talking about metal illness, people in the community often think of ghost-controlled [*ma lam*]. It's because of their low awareness, they think that when they see someone with strange behaviour. (Doctor, Thach That district).

Care Pathways

When asked what steps people in the community might take in response to the symptoms of depression, three pathways were identified by PHPs. The first was that the family of the patient would help them to seek biomedical care, usually at a psychiatric

hospital directly. This was particularly likely in the urban area, where access hospitals are easily accessible for families who can afford to pay a user fee. Only families unable to pay this fee would first seek help from a primary care centre.

Not seeking help at all was also described, with PHPs indicating that stigma might prevent families from seeing a mental health specialist or informing their primary care doctor of a mental health problem. For illnesses like depression, community members might not believe that biomedicine is the appropriate course of care or treatment, as described in the following quote:

“I think in Vietnam, seeing a doctor for this kind of matter seems difficult. People go to see a doctor for something specific, but for a mental matter almost no one would seek help from a doctor, even if they want to... People often think that seeing a doctor is for physical problems, not for mental health problems” (Midwife, Dong Da District)

In rural areas families might first seek help from spiritual means, by visiting a pagoda, making offerings to ancestral graves or visiting a fortune-teller. This was often described by PHPs as the first step a family in a rural area might take to address mental illness. They might seek biomedical care if the spiritual route did not prove effective. Again, this type of care might be more frequently sought for the most severe symptoms of mental illness, while families might not seek help at all for mild to moderate symptoms of depression.

5.4. Discussion

The symptoms of depression as described by PHPs in Vietnam emphasize inter-relational and functional disruption and somatic complaints, while emotional or affective symptoms are rarely described. This is consistent with previous findings from research on depression symptoms in Vietnam (Niemi, Falkenberg, et al., 2010; van der Ham et al., 2011). The lack of emphasis on affective symptoms might be due to the reluctance of patients to talk about the symptoms themselves, leading to the identification of only the most visible symptoms by family members and health workers. The predominantly relational experience of depression has also been seen in other cultures (Jenkins et al., 1991) while the reluctance of patients to disclose symptoms of depression due to self or

family stigma was found among Vietnamese patients in Vietnam and in the United States (Do et al., 2014).

The emphasis on relational and somatic symptoms of depression might mean that Western-derived measures will fail to detect cases of depression in Vietnam. The absence of somatic symptoms in standard international diagnostic instruments has been associated with underreporting of depression in Vietnam (Liddell et al., 2013; Murphy et al., 2015; Rees et al., 2012) This underlines the importance of using measures that are rigorously validated, including for construct validity, in cross-cultural research and practice (Murphy et al., 2015),

The family plays an important role in the illness experience in Vietnam. In addition to playing an active role in the identification of illness and patient consultations, the family is simultaneously described as the potential cause of depression and an important source of support to the patient. The role of family support as a protective factor for depression has been demonstrated in other contexts (McKenzie et al., 2004) Family trouble emerged as the most common cause of depression, while PHPs also described the importance of the family for patient care and recovery. Social and familial expectations were also linked to cause. Pressure to perform well on exams was commonly cited as a cause of stress leading to depression among youth, while the failure of a child to achieve academically was cited as one cause of “shock” for parents. Failure to have a male child was also described as a potential cause of depression among women. Although the topic was often discussed with some humour, a poor relationship with a mother-in-law was also described as a cause of depression among women. In addition to the relational nature of symptoms, the importance of the family suggests that mental health and wellness is embedded within the relational realm, with familial and social support and expectations playing a substantial role in the experience of depression. This suggests that approaches to screening and treatment that focus solely on the individual might be inappropriate and that approaches that include families should be explored. Of course, given the complex nature of families as both possible causes of depression and essential to the recovery process, family roles in patient treatment should be negotiated with care.

Also important was the use of alcohol by men, which was described as a potential cause of depression, and also as a serious concern in and of itself. There is little research on depression among men in Vietnam, although previous research has shown that rates

of alcohol abuse among men is high (Minh, Huong, & Giang, 2008; Vuong et al., 2011). This points to the need for more research about men's mental health, including the relationship between depression and alcohol use. It also indicates a need for improved capacity in identifying and addressing substance use at the community level.

PHPs state that they would take on a counselling or advising role for patients experiencing depression despite the lack of formal training in this area and the absence of psychosocial interventions in the country. Advice is connected to identifying a clear cause of depression, which can then be discussed and negotiated together, along with support from the family. Referrals are also common, which is indicative of the structure of the health care system in Vietnam and the role of primary care centres as gatekeepers to the higher levels of care. As case detection for mild and moderate depression is currently very low in primary care it is unlikely that many such cases are referred to higher levels of care. However as screening for depression becomes further integrated in primary care practice, PHPs will require training to deliver appropriate treatments in order to minimize unnecessary referrals to specialists and to provide support to patients in a context with very limited mental health human resources within the system as a whole (Kakuma et al., 2011). Supported self-management is one intervention that is currently being tested in Vietnam (Blisker, Goldner, & Anderson, 2012).

Much of the discussion about depression with PHPs was based not on clinical but on experiential knowledge. Many had seen only one or two patients with diagnosed depression, but knew of friends or family who had experiences of depression. Some had experienced depression themselves. All PHPs indicated that they believe there are many people living in their communities with depression, but that people are both unlikely to seek help or to identify their symptoms with the term 'depression'. This suggests that there is likely a gap in case detection where patients may present with somatic symptoms or show other signs of depression during consultations for other health concerns but are not screened or diagnosed. This is unsurprising given the low levels of training of PHPs in mental health.

PHP's lack of clinical experience with patients with depression is also likely due to low levels of help-seeking by community members. PHPs believe that community awareness about depression is very low, and that help seeking for depression in primary care is very limited. These findings are consistent with other studies in Vietnam (Niemi,

Falkenberg, et al., 2010; van der Ham et al., 2011). When depression is very serious families, especially in dense urban areas where hospitals are easily accessible, might seek help directly from a psychiatric hospital. Help seeking for mental health problems might, however, be limited due to fear of stigma and the belief that biomedical health services are only appropriate for physical health problems. Enhanced community awareness about depression and other mental illnesses are essential for improved service access in Vietnam. More research is needed to understand community EMs about depression and help-seeking behaviours.

In rural areas, spiritual beliefs, including beliefs about spirit possession, influence illness EMs and help seeking. The notion of mental illness having spiritual origins was not raised by PHPs in the urban area, which suggests that EMs might differ somewhat between rural and urban populations. This distinction was found within the greater Hanoi area, which represents only a small portion of the Vietnamese population. Vietnam is a diverse country, with numerous minority ethnic groups as well as cultural and linguistic differences between the north, central and southern regions. The diversity of Vietnam must be considered when planning mental health interventions, and research about locally distinct EMs should be undertaken prior to service planning and implementation in regions where no such research has previously been conducted.

PHPs provided a consistently defined set of symptoms and causes that they associated with a syndrome called 'depression' (*trầm cảm*). This suggests that despite low levels of awareness within the community, depression is a culturally valid construct and is a condition that is present within the community. PHPs did, however, display a lack of knowledge about depression and mental illness in general. For example, many talked about depression as if it exists along a continuum of 'mental illness', where depressive symptoms would turn into schizophrenia if untreated. Some PHPs, despite identifying discrete symptoms of 'severe' and 'less severe' disorders would later describe symptoms of psychosis when asked directly about a patient with depression. This also points to the conflation of psychiatric symptoms under the broad category of 'mental illness'. Some PHPs also described the need to test for depression using biometric tests or electroencephalography. As PHPs receive very little to no mental health training it is not surprising that their formal knowledge of mental disorders is limited. This points to the need for improved mental health training for primary care providers, both in their initial

training and through professional development opportunities. Such training programs would be enriched by taking into account culturally specific EMs of mental illness so as to ensure that they are appropriate and acceptable and that they lead to the delivery of care that is meaningful for communities.

5.5. Limitations

As described above, this research took place in two districts of Hanoi and is therefore not representative of the broad diversity of Vietnam or of the Vietnamese diaspora communities living in many countries worldwide.

The cultural origins and linguistic limitations of the primary author meant that the collaboration of Vietnamese colleagues was essential to this research. Every effort was undertaken to validate study materials and to ensure semantic equivalence between original and translated transcripts. There are always risks associated with conducting research where language and culture might create a barrier. However, we feel that the collaboration with colleagues in Vietnam and the iterative nature of the research process helped to minimize this risk.

5.6. Conclusions

Understanding primary care providers' EMs can provide essential guidance for the planning and implementation of mental health interventions in diverse contexts. Understanding EMs helps to inform the development and adaptation of instruments and interventions that are both evidence-based and tailored to the local context, making them more acceptable and appropriate for communities and providers.

Help-seeking for depression is low in primary care in Vietnam. Further research about community EMs and help-seeking behaviour will contribute to an enhanced understanding about how depression is conceptualized in the country, providing more insight into how to ensure that services for depression are acceptable and accessible to communities. Research is also needed in diverse cultural groups, including minority populations, and across the different regions of the country.

The findings of this study support the value of understanding EMs when planning for enhanced mental health service delivery in a global context. EMs help us to understand how depressive disorders are manifested, recognized and addressed in diverse contexts. They can help to improve measurement and screening instruments and to inform the development of interventions that make sense in specific cultural contexts.

Chapter 6.

Barriers and Facilitators to the Integration of Depression Services in Primary Care in Vietnam: Individual, Organizational and Structural Factors

6.1. Introduction

In response to a critical gap in mental health service access and availability in low and middle-income countries (LMICs), the integration of mental health services into primary care has been recommended (Patel & Thornicroft, 2009; World Health Organization & World Organization of Family Doctors, 2008). Although common mental disorders (CMDs) like depression are a major contributor to the disease burden and a significant cause of disability in LMICs (Mathers & Loncar, 2006; Murray et al., 2012), services for people suffering from these disorders are often unavailable. Approaches to treatment for depression that include screening, psychoeducation and problem solving have been recommended for use in primary care as a means to improve service availability in contexts where specialist services and resources are limited (Patel et al., 2009).

Vietnam is a lower-middle income country (The World Bank, 2015a) with a population of approximately 91 million people (World Health Organization, 2015b). In 2010 an estimated 20.7% of the population was living below the national poverty line of USD \$2.25 per person, per day, with ethnic minority populations disproportionately affected (Badiani et al., 2013). While epidemiological evidence about the prevalence of CMDs is limited, existing studies suggest that prevalence is similar to that found in much of the world, with rates of approximately 20% identified in some studies (Fisher et al., 2013; Fisher et al., 2004; Harpham, Huttly, De Silva, & Abramsky, 2005).

In Vietnam, mental health specialist services are limited, with the mental health system predominantly addressing psychotic disorders and epilepsy in tertiary care facilities (Kakuma et al., 2011; Vuong et al., 2011). The government of Vietnam has taken steps towards enhancing mental health services at the community level. The government introduced the National Community Mental Health Program (CMHP) in 2000 to improve

community based-care for people with mental illnesses through the integration of services into primary care (Ng et al., 2011). The goals of the CMHP are to enable primary care services to identify and provide treatment for people with severe mental illness, by enhancing mental health knowledge among primary care providers (PHPs), screening at the community level, and through the treatment and management of patients with mental illnesses including the provision of medications at regular intervals at primary care centres (Ng et al., 2011). The CMHP involves the local (commune), district and provincial levels of care, with coordination between the levels for referrals, training and the prescription of medications. In practice, the activities of the CMHP at the commune level are limited, emphasising referrals and the provision of medications. Ng et. al. (2011) found that although the CMHP is operating in all 63 Vietnamese provinces, it covered only approximately 64% of the national population. They found that 63% of patients enrolled in the CMHP were treated for schizophrenia, 35% were treated for epilepsy, and only 2% were treated for depression. The exclusion of high prevalence conditions from treatment under the CMHP demonstrates a considerable shortcoming, as psychosocial interventions for depression are minimally available in Vietnam and antidepressants are not prescribed or available at the primary care level (Niemi, Thanh, et al., 2010; Vuong et al., 2011).

In addition to the CMHP, the government of Vietnam has developed a National Mental Health Strategy for 2015-2020, which involves the Ministry of Health (MoH) and the Ministry of Labour, Invalids and Social Affairs (MOLISA), in addition to several NGOs and international technical advisors (Goldner et al., 2015). Through this Strategy, the government of Vietnam continues to prioritize the enhancement of services for mental illness at the community level. In partnership with MOLISA, initiatives are taking place to improve the availability of community-based psychosocial care for depression. For example, a “Supported Self-Management” intervention for depression (Blisker et al., 2012), based on principles of cognitive behavioural therapy, has been pilot tested in three provinces and is being expanded to an additional eight provinces where it will be tested in a randomized control trial (Goldner & Nguyen, 2013). These initiatives and the support of the government of Vietnam indicate promising steps toward the enhancement of depression services in primary care.

As steps are being taken to enhance community-based mental health service provision in Vietnam, it is important to identify factors that might impede or facilitate the

integration of services for depression in primary care. Integrating mental health services in primary care requires assuring the capacity of primary care services to deliver “first line interventions”, including identification of mental disorders, treatment, patient management and referrals, delivered as part of general health services (World Health Organization and World Organization of Family Doctors, 2008). In Vietnam, PHPs including general practice physicians, physicians’ assistants, nurses and pharmacists working in commune health stations (CHSs) and outpatient clinics (OPCs) act as the frontline of primary care service delivery. These PHPs provide care to patients with general health concerns, manage provincial programs, including immunization and epidemic prevention programs, and provide antenatal care. As services for patients with depression are expanded, PHPs will be responsible for the delivery of care to patients. Understanding barriers and facilitators to the delivery of these services from their perspective can help to identify and mitigate any challenges to service delivery, and to leverage existing opportunities for success.

This study examines barriers and facilitators to the integration of services for depression in primary care from the perspective of PHPs in one rural and one urban district of Hanoi province, Vietnam. Recognizing the importance of multiple levels of influence on the experience of health service delivery (Urquhart, Porter, Grunfeld, & Sargeant, 2012; Urquhart, Porter, Sargeant, Jackson, & Grunfeld, 2014; Urquhart, Sargeant, & Porter, 2011), this study considers factors that might influence the integration of mental health services in primary care at the individual, organizational and structural levels. This allows for the analysis of the factors at all levels of the system that contribute the implementation of new interventions and approaches to care (Urquhart et al., 2012; Urquhart et al., 2014). Understanding these factors can help to identify windows of opportunity and potential challenges to successful integration of services for depression in primary care.

6.2. Methods

6.2.1. Theoretical perspectives

The integration of enhanced services for depression in primary care involves the implementation of evidence-based approaches that depend on multiple complex factors. To understand the complexity of the implementation process, it is useful to draw on theory

to help to “identify, describe and explain important elements of the implementation process” (May, 2013 2).

Contextual Interaction Theory (CIT) (Bressers, 2004) is useful for understanding the influence of individual, organizational and structural factors on actors involved in the implementation process. The theory, originally developed for use in the area of natural resource management (Bressers, 2004; Owens & Bressers, 2013) was used by USAID in the development of a conceptual framework for a Policy Implementation Barrier Analysis in the area of HIV/AIDS policy (Spratt, 2009). CIT is helpful for identifying and understanding barriers and facilitators to the implementation of policies and programs. The theory assumes that the variables that influence implementation are interactive, and that their influence depends on “contextual circumstances” (Spratt, 2009 2). The theory was designed to examine how the *motivation*, *information* and *power* of actors, and the nature of their interaction with other actors, might predict the outcomes of the policy process. Because this study is concerned with identifying barriers and facilitators to the implementation of an intervention from the perspective of only one group of actors (PHPs), it utilizes an adapted approach to CIT which draws on the theory’s core constructs of motivation, information and power, but does not emphasize the question of interaction between multiple actors. CIT is a helpful framework for examining how individual, organizational and structural factors within the broad context of mental health service delivery influence the motivation, information and power of PHPs. This in turn can help to identify barriers and facilitators to the integration of services for depression in primary care from the perspective of these PHPs.

The core constructs of CIT (motivation, information and power) are appropriate for examining individual, organizational and structural variables and their interaction. *Motivation* can be defined as internal (e.g., attitudes, self-efficacy) and external (e.g. normative, economic, social, political variables). *Information* includes technical knowledge, general knowledge about the policy or program being implemented, about how to comply with the policy or program, and access to information. *Power* can be understood in terms of capacity (e.g. financial, personnel, time) or control. Control may be formal, based on legislation, regulation or formal roles in an organization, or may be informal, related to perceptions of leadership, influence, etc. (Bressers, 2004; Owens &

Bressers, 2013; Spratt, 2009). Motivation, information and power are used to categorize the variables of interest in this study.

6.2.2. Variables of Interest

The variables of interest fall under the three core constructs of CIT: motivation, information and power (Bressers, 2004; USAID, 2009; Owens and Bressers, 2013). The variables may also be identified as individual, organizational, structural or a combination of these. Variables of interest were identified based upon a review of relevant literature.

Table 4: Variables of Interest

MOTIVATION	Level
Internal	
<i>Attitude, Stigma and Discrimination</i>	
Familiarity with people with mental illness (CMD)	Individual
Explanatory models and health beliefs (including aetiological beliefs) ³	Individual
Perceived need/ perception of mental illness as significant in primary care	Individual
Perceived role or efficacy (could vs. should)	Individual
Perceptions of people with mental disorders (including characterizations of people with mental illness and social distance measures)	Individual
External	
Social/ cultural environment and norms ⁴	Structural
National or organizational priorities in the health sector	Structural
INFORMATION	
Pre-service training in mental health	Individual/Structural
In-service training in mental health	Individual/Structural
Training of and supervision by management	Organizational
POWER	

³ Results related to this variable are discussed in Chapter 5

⁴ Results related to this variable are discussed in Chapter 5

Capacity	
Resource availability: medicines and equipment, financial, personnel, space, etc.	Organizational
Perceived workload	Individual/ Organizational
Perceived self-efficacy	Individual
Control	
Leadership or champion within organization	Organizational

Motivation- Internal

Attitudes, Stigma and Discrimination: Understanding the attitudes of health workers towards the integration of mental health services into primary care is essential to assessing barriers and facilitators to primary care integration. As shown in Table 4, the ‘attitudes’ variable is broken down into five sub-variables that assess attitudes towards mental health care integration and people with mental illness. These variables also capture stigma and discrimination.

Familiarity with people with mental illness, in the form of increased interaction either personally or professionally, has been associated with lower levels of discrimination and with more positive attitudes (Arvaniti et al., 2009; Read & Law, 1999). Studies in LMICs indicate that health workers often drastically underestimate the prevalence of mental illness in their district or from within their patient population (Muga & Jenkins, 2008). This may lead them to feel that integrating mental health services in primary care is unnecessary.

Several studies indicate that health workers often perceive their capacity to help people with mental illness to be low and believe that specialists are the most appropriate providers of care for these patients (Abiodun, 1991; Horevitz & Manoleas, 2013; Mbatia, Shah, & Jenkins, 2009; Muga & Jenkins, 2008; World Health Organization, 2007a). In a Kenyan study, Muga and Jenkins (2008) describe a distinction in perceived self-efficacy, where attitudes about which health workers “could” help people with mental illness and which health workers “should” varied. Health workers believed that treating mental illness should be the role of specialists. This belief about their role was found to be barrier to the integration of mental health services in primary care.

Characterizations of people with mental illness as frightening, out of control, weak, etc. are associated with stigma and discrimination (Baker et al., 2005; Muga & Jenkins, 2008; Read & Law, 1999). Social distance is also a concept used to measure stigma and discrimination and uses indicators such as whether a respondent would consider working with, living with/ near, marrying, etc. someone with a mental illness (Abiodun, 1991; Read & Law, 1999).

Motivation- External

National or organizational priorities in the health sector: Jenkins et. al. (2013) found that while mental health care integration was a priority at the organizational level, competing priorities driven by donors (including HIV/AIDS, immunization, and malaria) made implementation difficult in the Kenyan context. Competing priorities in the health sector may similarly influence the success of the integration of mental health services in primary care.

Information

Training in mental health: The degree to which health workers have received formal education in mental health may affect their capacity to implement integration of mental health services (Abiodun, 1991; Arvaniti et al., 2009; Foster et al., 2008; Kakuma et al., 2011; Muga & Jenkins, 2008; Njogu, Akhwale, Hamer, & Zurovac, 2008; Owens & Bressers, 2013; Read & Law, 1999). Similarly, in-service training and continuing professional development may influence the capacity of PHPs to implement services for mental health in primary care (Abiodun, 1991; Arvaniti et al., 2009; Foster et al., 2008; Muga & Jenkins, 2008; Njogu et al., 2008). While staff training is important, failure to train management can affect the level of support and supervision that health workers receive and therefore the success of new program initiatives (Jenkins et al., 2013).

Awareness of guidelines, policies or recommendations related to mental health: The existence of national or organizational policies and guidelines has an impact on implementation of policies and programs (Jenkins et al., 1991; Njogu et al., 2008; Owens & Bressers, 2013). For example, Jenkins et. al. (2013) found that the absence of clear targets for mental health service affected everything from staff supervision to drug ordering and reporting systems in Kenya.

Power- Capacity

Resource availability: The existence of necessary resources (e.g. financial, human and technological) is essential to the success of the implementation of new interventions. Appropriate and sufficient medications and equipment, financial resources, sufficient numbers of and sufficiently trained personnel, and adequate and appropriate (e.g. private) space are all essential resources that facilitate mental health service integration in primary care (Chang et al., 2013; Jenkins et al., 2013; Njogu et al., 2008; Owens & Bressers, 2013).

Perceived workload: Perceptions by health workers about their existing workload and the impact of the recommended change on it are important for assessing the capacity of health workers to implement new programs or interventions (Jenkins et al., 2013; World Health Organization, 2007a).

Power- Control

Leadership or champion within the organization: The existence of a leader within an organization is important to promote successful implementation or change within an organization (Chang et al., 2013; Owens & Bressers, 2013). For example, Chang et al. (2013) found that a “mental health champion” in an organization was influential to others and important for promoting the implementation of new programs and policies.

6.2.3. Data Collection

Data collection for this mixed methods study took place in Hanoi, Vietnam from August to December 2014 and consisted of semi-structured interviews and an online survey.

Interviews

30 semi-structured interviews were conducted by the first author with the support of a Vietnamese research assistant who provided bilingual interpretation. Interviews were conducted at eight CHS's and two OPCs in one urban (Dong Da) and one rural (Thach That) district of Hanoi province. Interview respondents included physicians, physician's assistants, nurses, and pharmacists. Some physician's assistants have specialised training in midwifery or traditional Vietnamese medicine (TVM). Table 5 displays the

number and type of PHPs included in the study. The majority of PHPs interviewed (n=27) were female, which is representative of the composition of staff at the centres included in this study.

Table 5: Number and role of interviewees by district

	Thach That (rural)	Dong Da (urban)
Doctors	5	3
Nurses	4	7
Physicians assistants	5	3
Pharmacists	3	0
Total	17	13

The interview schedules and consent forms were translated from English to Vietnamese and then back translated for semantic equivalence. The interviews were pre-tested, with adjustments made as necessary to the interview questions. Twenty-four interviews were recorded. Six respondents preferred not to have their interview recorded and in these cases extensive field notes were taken. The recorded interviews were transcribed in Vietnamese by two research assistants and subsequently translated from Vietnamese into English for analysis by a bilingual translator.

The interview data were analysed using a thematic analysis approach, which allows for the identification of “patterned responses” within the data (Braun & Clarke, 2006 82). Theoretical thematic analysis was used, allowing for analysis to be structured around the initial variables of interest, with additional themes identified as they emerged throughout the analysis process. Analysis began with immersion in the data through thorough reading and rereading of the interview transcripts. A coding frame was developed using the initial variables of interest, with additional codes added as they emerged. Coding of the data was conducted using NVivo 10 software (Q. S. R., 2012). Themes were identified from within each category of the coding frame, and were then reviewed, refined and analysed in detail (Braun & Clarke, 2006).

Survey

A survey was implemented with PHPs in Hanoi, including primary care physicians, physicians’ assistants and nurses. A list of all the commune health centres in Hanoi was used as the sampling frame. Probability sampling was used to ensure a representative

sample of the population of commune health workers in Hanoi. Commune health stations were randomly selected from a list of all CHSs (n=579) in Hanoi, with every fourth commune centre selected for a total of n=150 communes, representing 26% of communes in Hanoi. CHSs that were included in the interviews were excluded from the sampling frame. The inclusion criterion for the survey was being employed as a PHP in a CHS at the time of the survey.

The sample size for survey participants was calculated using an 80% confidence interval with a margin of error of ± 5 . Based on 579 CHSs, targeted sample sizes for each population were determined to be: physicians (n=130), and nurses and physician's assistants (n=150). The 80% C.I. was chosen in order to balance accuracy with feasibility, given both time and resource constraints. In the context of choosing an appropriate sample size for a pilot study for a randomized control trial, Cocks and Torgerson (2013) recommend using an 80% C.I., as it "will satisfy the need for reasonable certainty [for trial decision making] but would be small enough to deliver a study with a reasonable budget and timeframe..." (p. 198).

The response rate was higher than anticipated, with 331 completed responses received. Three districts (two rural and one urban) had response rates that were three times higher than anticipated. This was likely due to the incentive that was offered to respondents (mobile phone credit worth the equivalent of \$2.50), as is common practice in Vietnam. We thus excluded a randomly selected portion of the responses from the communes with inflated response rates to ensure that response rates from each district were similar based on the desired response of two PHPs per CHS. The responses from the data sets with excluded responses were compared with the responses from the full set, and the data did not show differences in the distribution of responses that could be considered significant.

The final analysis includes 231 completed responses. Table 6 displays the type, gender distribution and location (urban or rural) of providers that responded to the survey. There is some discrepancy in totals due to incomplete data; there were 227 responses to the "gender" variable, 222 responses to the "type of provider" variable, and 226 responses to the "location" variable. A total of 71 physicians responded, which was 32% of the whole sample of PHPs. PAs comprised 50% (n= 110), and other PHPs made up the remaining 18% (n= 41). For each of the three professional groups, from 57% to 78% were female.

Of the sample of PHPs, 52 (23%) were based in urban settings and 174 (77%) were based in rural sites. Responses were received from 17 rural districts and 12 urban districts of Hanoi.

Table 6: Professional characteristics of the survey sample by gender

Variable	Female (N=147)		Male (N=80)		All^a	
	(n)	(%) ^b	(n)	(%) ^b	(n)	(%) ^c
Profession						
Physician	47	66%	24	34%	71	32%
Pas	63	57%	47	43%	110	50%
Other ^d	32	78%	9	22%	41	18%
Total ^a	142		80		222	100%
Urban or rural						
Urban	38	73%	14	27%	52	23%
Rural	108	62%	66	38%	174	77%
Total ^a	146		80		226	100%

^aTotal varies due to missing data

^bRow percent

^cColumn percent

^dNurses (66%), midwives (10%), TVM practitioners (5%), unspecified (19%)

The survey instrument included yes/ no answers, Likert scales and fill-in questions. A draft survey was developed prior to conducting field research and was revised based on emerging data from the qualitative interviews. While the original composition was largely maintained, several questions were added or removed based on contextual appropriateness. The wording was revised to better define mental illness and CMDs including depression. This was based on the emerging data from the interviews, which suggested a very low level of awareness of CMDs among commune health workers. Questions were also added based on additional contextual knowledge gained from the interviews (e.g. details related to the delivery of the CMHP). The survey was distributed using email and SMS text message, which is widely utilized by health workers in Vietnam. Fluid Surveys ("FluidSurveys ", 2016), which allows for the creation of surveys in Vietnamese, was used. Descriptive statistics are used to describe the extent to which the variables of interest may act as barriers and facilitators to the integration of services for CMD in primary care. A chi-square test of independence was used to examine where there was a significant association between the variables of interest and the profession, location and gender of PHPs. The use of both quantitative and qualitative methods allows for the

identification of barriers and facilitators and for an enhanced understanding of the context and experience of the PHPs included in the study.

6.3. Results

6.3.1. The context of primary care

In order to understand the day-to-day context in which PHPs work, we asked each interviewee to describe a “typical day”, including their schedule, workload and usual tasks. PHPs generally worked from 8:00 a.m. to 5:00 p.m. with a two-hour break for lunch. The number of patients seen a day at each health centre varied by type of clinic and location. In the urban area an OPC saw approximately 150 patients per day, while a CHS saw approximately 40-50 patients per day. Some saw only 1-10 patients per day, and concentrated mainly on the delivery of programs. In the rural area, both OPCs and CHSs saw fewer patients, with OPCs seeing approximately 20-25 per day, and CHSs seeing approximately 10-15 per day.

Responses by survey participants to how many patients are seen per month varied considerably, with responses ranging from 800 to less than 10, with a mean of 32.3 patients per month.

CHSs were managed by a physician, who is the only doctor on staff. These physicians took on management duties in addition to program implementation and patient care. Managers had little discretion over the programmatic direction of their individual centres, as programs and priorities are mandated by the provincial ministries and district centres.

The tasks of PHPs included the management and implementation of programs and ongoing and emergency patient care. Programs are mandated by the provincial Department of Health (DoH), managed by the district health centre and implemented at the commune level. PHPs described the immunization program as the most time-consuming and labour-intensive program delivered at the commune level. Other programs included the epidemic prevention program and the CMHP, although numerous programs

are implemented by each CHC. Each staff member is responsible for several programs, as demonstrated in the following quote:

I am in charge of 6 programs. Well, traditional medicine, and seniors health program, disabled healthcare program, bronchial asthma, leprosy and school health. (Physician's assistant, urban area)

Ongoing patient care at CHSs and OPCs includes treatment of minor or chronic conditions and emergencies. PHPs described the most commonly seen conditions among their patient populations, which include: chronic diseases among the elderly (diabetes, cardiovascular disease, hypertension); respiratory infections in children; chronic obstructive pulmonary disease in adults; ear-nose-throat, eye and dental infections; antenatal care and gynaecological issues; influenza; fever; and digestive disorders. In addition to providing patient care, PHPs described helping with maintenance and cleaning of the clinic, organization and inventory of supplies, and management of patient records.

One staff member at each CHS, usually a physician's assistant, is in charge of the CMHP. Their responsibilities include managing records for the patients enrolled in the program, distributing medications on a biweekly schedule as prescribed by a specialist, and coordinating with patients and their families to ensure they collect their medications according to the schedule. CHCs manage approximately 35-45 patients who are enrolled in the CMHP, most of whom are diagnosed with schizophrenia or epilepsy. Other patients may have a diagnosis of depression, intellectual disability or dementia, although these conditions were seen much less frequently. OPCs were not involved in implementing the CMHP, but study participants might make referrals of patients to higher levels of care when mental health problems are suspected.

6.3.2. Familiarity with depression

PHPs demonstrated low levels of familiarity with patients with mental illness including CMDs. Familiarity with mental illness among PHPs was largely based upon their experience with the patients enrolled in the CMHP or on experiences within the community. For example, some mentioned seeing community members displaying signs of psychosis. Many stated they have never or have rarely seen a patient with depression, with much of their experience of depression based on family, friends or personal

experience (see Chapter 5). Those PHPs who have experience with patients with depression described only one or two instances where they had seen such a patient:

Interviewer: Have you had a patient with depression?

Respondent: I met one a few years ago. He was a soldier aged 60,70. He experienced headache, sleep-loss continuously. (Nurse, rural area)

Tables 7 and 8 display survey responses about whether PHPs see patients with mental illness during an average month, and the estimated number of patients per month with general mental illness, severe mental illnesses and CMDs.

Table 7: Patients with mental illness seen in a month

Do you see patients with mental illness during an average month?							
		Yes		No			
		(%)	N	(%)	N	Row N	Chi-square and <i>p</i> -value
Profession							
	Physicians	70%	50	30%	21	71	
	PA's	61%	69	39%	44	113	
	Other	71%	29	29%	12	41	
	All	67%	151	33%	74	225	2.2438;.325659*
Location							
	Urban	52%	27	48%	25	52	
	Rural	69%	123	31%	55	178	
	All	60.5%	139	39.5%	91	230	5.235;.022137**
Gender							
	Female	65%	96	35%	51	147	
	Male	69%	55	31%	25	80	
	All	67%		33%		227	0.2759;.599407*

* The result is not significant at $p < .05$

** The result is significant at $p < .05$

Table 8: Estimated average patients per month with mental illness

	Range	Mean
Approximately how many patients with mental illness per month?	0-24	3.49
Approximately how many patients with severe mental illnesses per month?	0-15	1.42
Approximately how many patients with CMDs like depression per month?	0-12	2.13

The results in Tables 7 and 8 indicate that PHPs believe they see a low number of patients with mental illness per month. Using a chi-square test of independence, a statistically significant variation in perception about numbers of patients with mental illness was found between rural and urban PHPs: $X^2 (2, N=230) = 5.235, p < .05$. 52% of urban and 69% of rural PHPs indicated that they see a patient with mental illness in a given month.

Both mental illness generally and depression are perceived by PHPs to have low prevalence within the CHS patient population. Table 9 displays the perceived prevalence of CMD in the patient population, while Table 10 displays perceived prevalence in the community population:

Table 9: Perceived depression prevalence in CHS patients population

In your opinion, how widespread (WS) are CMDs like depression among the patients that visit your CHS?											
		Very Widespread		Moderately Widespread		Not Widespread		N/A		Row N	Chi-square and p -value
		(%)	N	(%)	N	(%)	N	(%)	N		
Profession											
	Physicians	16%	11	25%	18	58%	41	1%	1	71	
	PA's	3%	3	20%	22	71%	78	6%	7	110	
	Other	2%	1	24%	10	63%	26	10%	4	41	
	All	7%		23%		64%		5.7%		222	17.3145; .008194**
Location											
	Urban	2%	1	14%	7	78%	39	6%	3	50	
	Rural	8%	14	25%	44	63%	112	5%	9	177	
	All	5%		19.5%		70.5%		5.5%		227	5.4683; .140545*
Gender											
	Female	8%	12	18%	26	69%	101	5%	7	147	
	Male	4%	3	31%	24	60%	46	5%	4	77	
	All	6%		24.5%		64.5%		5%		224	6.1118; .106297*

*The result is not significant at $p < .05$.

** The result is significant at $p < .05$.

Table 10: Perceived prevalence of depression in community population

In your opinion, how prevalent are CMDs like depression in the community in general?													
		High prev		Mod.high prev		Mod. low prev.		Very low prev.		N/A		Row N	Chi-square and p -value
		(%)	N ^a	(%)	N	(%)	N	(%)	N	(%)	N		
Profession													
	Physicians	19%	13	33%	23	33%	23	15%	10	0%	0	69	
	Pas	3%	3	37%	42	35%	40	24%	27	2%	2	113	
	Other	0%	0	29%	12	51%	21	15%	6	5%	2	41	
	All	11%		33%		39%		18%		3.5%		223	28.3482; .000412**
Location													
	Urban	2%	1	37%	19	40%	21	21%	11	0%	0	52	
	Rural	9%	16	33%	58	36%	64	19%	34	2%	4	177	
	All	5.5%		35%		38%		20%		1%		229	4.343; .361567*
Gender													
	Female	8%	12	32%	46	36%	52	21%	31	3%	4	145	
	Male	6%	5	36%	29	39%	31	19%	15	0%	0	80	
	All	7%		34%		37.5%		20%		1.5%		225	3.0946; .542113*

^a Chi-square statistic is displayed after N

* The result is not significant at $p < .05$.

** The result is significant at $p < .05$

PHPs in the study reported their perception that mental illness and depression is more widespread in the community however still do not see it as a widespread problem (Table 10). The perceived prevalence of depression in both the CHS patient population and the community population shows similar trends. Physicians estimate the prevalence of CMD in both populations to be higher than other PHPs, which is consistent with the results described above where a higher proportion of physicians indicate that they see patients with mental illness each month. For both perceived prevalence in the patient population and the community population, chi-square tests show that there is a statistically significant difference based on profession: patient population, $X^2=(2, N=222)= 17.3145, p<.05$; community population, $X^2=(2, N=223)= 28.3482, p<.05$. For perceived prevalence in the patient population, 16% of physicians state that they believe depression is “very widespread”, compared with 3% of physician’s assistants and 2% of other PHPs. Regarding community prevalence, 19% of physicians, compared with 3% of physician’s assistants and 0% of other PHPs indicated that depression has a high prevalence. The perceived prevalence is also slightly higher among rural respondents and female respondents, although these differences are not statistically significant.

PHPs do believe that there is a gap in help seeking for depression among community members, wherein people in the community might have symptoms but do not want to come to the health centre. While in urban areas people might go directly to a mental health hospital, in rural areas, as described in Chapter 5, they might seek spiritual help. The following quote describes the familiarity of a PHP with mental health patients enrolled in the CMHP and beliefs about mental illness in the community:

Well, there are patients coming to the CHS to get the medicine, I am not managing them so I am not sure. There may be about twenty-eight or twenty something. There are also other people in the community who have symptoms of mental disorder but they don't want to disclose about that, they hide it. They don't go to the CHS but when we look at them we know they are having mental disorders. (Nurse, rural area) Training

Survey respondents indicated whether they have received pre-service and in-service training on mental health (Table 11):

Table 11: PHPs pre-service and in-service training about mental health

Received pre-service training about mental health							
		Yes		No		Row N	Chi-square and <i>p</i> -value
Profession		(%)	N	(%)	N		
	Physicians	95%	67	6%	4	71	
	PAs	77%	87	23%	26	113	
	Other	68%	27	33%	13	40	
	All	80%		20%		224	14.0425; .000893**
Location							
	Urban	77%	40	23%	12	52	
	Rural	81%	143	19%	34	177	
	All	79%		21%		229	0.3746; .540516*
Gender							
	Female	82%	120	18%	26	146	
	Male	80%	64	20%	16	80	
	All	81%		19%		226	0.1641; .68542*
Received in-service training about mental health							
Profession		Yes		No		Row N	Chi-square and <i>p</i> -value
		(%)		(%)			
	Physicians	83%	59	17%	12	71	
	PAs	67%	76	33%	37	113	
	Other	72%	28	28%	11	39	
	All	74%		26%		223	5.6048; .060663*
Location							
	Urban	75%	39	25%	13	52	
	Rural	71%	125	29%	51	176	
	All	73%		27%		228	0.3145; .574942*
Gender							

	Female	73%	106	27%	39	145	
	Male	71%	57	29%	23	80	
	All	72%		28%		225	28.6522; <.00001**

*The result is not significant at $p < .05$.

**The result is significant at $p < .05$.

95% of physicians, 77% of physician’s assistants and 68% of “other” professionals state that they were trained in mental health pre-employment, while 83% of physicians, 67% of physicians assistants and 72% of “other” professionals indicated that they received in-services mental health training. For pre-service training, a statistically significant difference was found by profession: $X^2(2, N=224)= 14.0425, p <.05$, while for in-service training, gender was found to be a statistically significant variable: $X^2(2, N=225)= 28.6522, p <.00001$.

Despite the fact that the majority of PHPs indicated that they have received some amount of training in mental health either prior to their employment, or as professional development, training in mental health emerged as a significant gap for all types of PHPs. In terms of pre-service training, nurses receive minimal training on mental health that is limited to theory with no clinical practice. Some nurses note that their training included a limited focus on communication with patients and on rehabilitation, which they associate with working with patients with mental illness. This was not considered an integral part of their training:

We talk about the way to communicate with others, with the surrounding environment. But I didn't pay attention to what the teacher said. I was taught that I need to be tactful when working with patients, or when asking them about their history, but it's was not a specialized class, so it was not detailed. (Nurse, rural area)

Pharmacists receive general training and do not spend dedicated time learning about psychopharmacology. Prescriptions for patients in the CMHP are written by specialists and distributed by the physician’s assistant responsible for the program, so it is unlikely that pharmacists in primary care currently require extensive knowledge in this area.

Physicians receive approximately four weeks of both theory and clinical training All physicians are required to complete this unit on psychiatry in medical school.

Although 77% of physicians' assistants indicated in the survey that they had received pre-service mental health training, in interviews physician's assistants stated that they did not receive specific training in mental health in vocational college:

When I was a student in the Medical Intermediate School in Hanoi, there were some lessons on neurology but not about mental problems. I was there from 1990 to 1993, so I didn't know much about mental health. It's only when I started this job in the program that I learned more about mental health. (Physician's assistant in charge of the CBMH program, rural area)

Some PHPs receive in-service mental health training, which is offered at the district health centre, or at national or provincial mental health hospitals. Some PHPs indicate that they have received mental health training at the CHS. This training is only provided to physician/managers and the physicians' assistant who is responsible for the CMHP. As described above, the PHP responsible for the CMHP is not required to have any previous or concentrated training in mental health, but rather will receive training only when they become responsible for this program:

I used to be in charge of mental health program for about 2-3 years. There were times when people from mental hospital came here and talked about all the symptoms, treatment methodology for severe mental illness. I had a chance to attend those events and got instructed on mental illness, but it was a long time ago. When I started working, I used to work in that program but my main responsibility was to receive and provide medication for the patients so I don't really have deep knowledge about mental illness. (Physician's assistant, urban area)

PHPs describe the limitations of the policy of training only select staff members in mental health. They note that this limits their capacity to identify and provide care to patients who might be experiencing mental health problems. As described above, PHPs express a strong desire to receive enhanced mental health training, no matter what their role is in relation to the CMHP. They recognize that restricting professional development training in mental health to one or two staff members at each CHC means that their capacity to identify mental health problems in their general patient population is limited.

Despite low levels of knowledge and familiarity with people with mental illness, PHPs enthusiastically express interest in receiving more training in this area. All PHPs surveyed indicated strongly that they would like to learn more about diagnosing and treating people with mental illness (see Table 12).

Table 12: Interest in receiving more mental health training

I would like to learn more about diagnosing and treating people with CMDs such as depression											
		Strongly agree		Somewhat agree		Somewhat disagree		Strongly disagree		Row N	Chi-square
		(%)	N	(%)	N	(%)	N	(%)	N		
Profession											
	Physicians	78%	53	19%	13	2%	1	2%	1	68	
	PAs	71%	80	29%	32	1%	1	0%	0	112	
	Other	78%	32	22%	9	0%	0	0%	0	41	
	All	75%		24%		0%		0%		221	4.8587; .562056*
Location											
	Urban	69%	35	28%	14	2%	1	2%	1	51	
	Rural	76%	133	23%	40	1%	2	0%	0	175	
	All	72.5%		25.5%		1.5%		1%		226	4.268; .233946*
Gender											
	Female	72%	104	26%	38	1%	1	1%	1	145	
	Male	81%	63	18%	14	1%	1	0%	0	78	
	All	76.5%		22%		1%		0.5%		223	2.7656; .429192*

*The result is *not* significant at $p < .05$.

The results of the survey show that the majority of PHPs would like to receive additional training about mental illnesses. When asked to respond to the statement “I would like to learn more about diagnosing and treating people with CMDs such as depression” 78% of physicians, 71% of physician’s assistants and 78% of “other” professionals indicated that they “strongly agree”, while 19% of physicians, 29% of physicians assistants, and 22% of “other” professionals selected “somewhat agree”. Responses were somewhat lower in urban (69% strongly agree) vs. rural (76% strongly agree) and among females (72% strongly agree) compared to males (81% strongly agree), but there was no statistically significant difference among any of the variables.

In interviews all participants indicated that they would like to be offered more training in mental health and that they would be willing to take the time to learn and implement new skills. PHPs describe the need for better training for health workers:

Here we always want to improve people's awareness about mental illness, so that they can know about the cause of the problems, and we can have a better treating method that addresses the right causes. For example, some may need medication, some just need psychological therapy. (Physician, rural area).

6.3.3. Perceived role, self-efficacy and workload

Many PHPs see the role of diagnosis and treatment of mental disorders as belonging to specialists. They see their main role as providing referrals for more specialized services and providing complementary care in the form of advice or supplementary medications. These include sleeping pills, vitamins and “tonics” and traditional remedies such as lotus tea. They also describe referrals as being part of their main role with patients with mental health problems:

No. We don't prescribe them [psychotropic medications] here. We just scan and detect the patient. For patients with a mild mental health problem, we introduce about the problem and counsel them to take some support medicine, like medicine for the neurological system, to improve the brain blood circulation so that the patient can get rid of the headache⁵. If we know exactly the patient's problem, we will advise them to go an appropriate level of health care. (Physician, urban area)

⁵ Many PHPs describe the use of “tonics” or vitamins to improve blood circulation to the brain. This is described in the context of reducing the somatic symptoms of mental illness, including headache.

Some PHPs also associate care for patients with mental health problems only with the CMHP, and refer to working with patients with mental health problems as “not my job”. Because of the emphasis on programs within primary care, and the designation of programs to specific PHPs, it is likely that this statement reflects the actual role and responsibility given to PHPs, rather than an explicit unwillingness to provide care to patients with mental health problems.

In relation to perceived capacity to diagnose and treat patients with mental health problems, PHPs describe the need for enhanced knowledge and training in order to provide better services for patients with mental health problems. They state that without proper knowledge their capacity to provide care to patients with mental illness is limited. PHPs also state that making referrals, even with mild cases of mental illness, is required under the CMHP:

Well, even for mild mental disorders, we still need to refer the patient to a higher level so that the doctor there can diagnose if the patient is really having mental problem. (Nurse, urban area)

Despite the perception that care for patients with mental health problems might be beyond their role or capacity, PHPs do describe advantages to patients receiving services the primary care level. PHPs commonly refer to the financial vulnerability of people with mental illness and their families. For example, people with schizophrenia currently receive VND 270 000 per month (\$12.00 USD) in support and PHPs often describe the need for expanded financial support to patients with other mental illnesses like depression. They also raise the issue of insurance, as patients not covered by social or voluntary insurance may be unable to afford medications. Given this financial vulnerability, PHPs note that the CHS and OPCs are optimal places for patients to access care for mental health problems, because they are more accessible both geographically and financially for patients who are poor:

Patients with mental disorders are very poor, so taking them to the commune health center will help them get better care. (Survey participant)

PHPs also display a willingness to take on the role of care providers to people with CMDs like depression. When asked about their workload, interview participants express their willingness to learn and to take on new tasks despite being responsible for patient

care and numerous programs. When asked if they felt they had the ability to learn new skills given their current workload, PHPs responded favourably, as shown in Table 13:

Table 13: Capacity to learn new skills given current workload

Given my current workload, I feel confident that I could take time to learn new skills													
		Strongly agree		Somewhat agree		Somewhat disagree		Strongly disagree		N/A		Row N	Chi-square and <i>p</i> -value
		(%)	N	(%)	N	(%)	N	(%)	N	(%)	N		
Profession													
	Physicians	60%	42	36%	25	3%	2	1%	1	0%	0	70	
	PAs	50%	57	46%	52	2%	2	2%	2	0%	0	113	
	Other	56%	23	39%	16	2%	1	2%	1	0%	0	41	
	All	55%		40%		2%		2%		0%		224	2.3166; .888403*
Location													
	Urban	56%	29	39%	20	6%	3	0%	0	0%	0	52	
	Rural	54%	96	42%	74	1%	2	2%	4	0%	0	177	
	All	55%		40.5%		3.5%		1%		0%		229	5.2465; .154611*
Gender													
	Female	58%	85	40%	59	1%	1	1%	1	0%	0	146	
	Male	49%	39	45%	36	4%	3	3%	2	0%	0	80	
	All	53.5%		42.5%		2.5%		2%		0%		226	5.1294; .162564*

*The result is *not* significant at $p < .05$

When asked if they feel confident to take on new skills given their current workload, 60% of physicians, 50% of physicians assistants and 56% of other PHPs strongly agreed, while 36% of physicians, 46% of physicians assistants and 39% of other PHPs somewhat agreed. There is little difference in responses from urban (56% strongly agree, 39% somewhat agree) and rural (54% strongly agree, 42% somewhat agree). While female PHPs showed higher levels of agreement (58% strongly agree, 40% somewhat agree) compared with male (49% strongly agree, 45% somewhat agree), this difference was not statistically significant. Overall PHPs showed a willingness to take on new skills despite their existing workload.

While interview participants did not openly describe feeling overworked, survey participants were more candid about the perceived burden of aspects of their workload. They identified the number of programs allocated to each CHS as a challenge and recommended a reduction in the number of programs and volume of paperwork in order to allow them to improve patient care. In the space allocated for “other comments”, two survey participants stated:

Too many health programs at the same time are constraining our capacity to take care of people's health. Unnecessary programs should be cut off. (Survey participant)

It is necessary to reduce paperwork so that we can focus more on taking care of the people's health. We are now under too many health programs, which cause a lot of stress on daily work. (Survey participant)

Because interviews took place within CHSs and OPCs, it is likely that interview participants did not feel as comfortable to openly express the challenges they face in their day-to-day tasks. The survey allowed respondents to express their concerns more candidly and anonymously.

6.3.4. Attitudes

The attitudes expressed by PHPs toward patients with mental illness emphasize the perceived challenges of working with patients with mental illness. They describe the need to approach patients with mental illness gently, tactfully and, at times, cautiously. This approach is described as necessary due to the perceived volatility of patients and due to the challenges of “coordinating” with patients with mental illness.

In general when consulting the doctor needs to be tactful, to understand the patient's psychology....not like flattering....but we need to understand the patient's psychology to succeed. If we just keep all the regulations as for other patient, it will not work out. Sometimes the doctor has to please the patient.... Otherwise....they will leave, will not coordinate or go under treatment. Very difficult. (Doctor, rural area)

When checking these patients, we always have to keep a gentle manner, if we make them angry, they can even beat us. So hard! (Physician's assistant, rural area)

Many PHPs describe challenges within the CMHP of patients not understanding the schedule for filling their prescriptions, arriving on the wrong day or forgetting to pick up their medications.

PHPs also describe a number of skills and characteristics they believe are necessary for interacting with patients with mental illness that suggests empathy and a sense that these patients are vulnerable. They describe the skills needed to work with patients with mental illness as effective communication, patience, tact and understanding:

Well, for them, most of them feel very tired, they have lost their passion. I don't think there is anything negative. But they don't want to communicate with people, they are afraid to. We need to be tactful to get information from them. Otherwise they will not coordinate with us. Well, in some case, if the doctor does not have good skills, the patient would even refuse to take the medicine. That's a challenge for people working with mental illness patients. We need to have a kind manner when working with them. (Doctor, urban area)

We included questions related to social distance and attitudes toward people with CMDs in the survey to elicit anonymous responses that might not emerge during interviews due to possible social desirability bias. We asked participants about their willingness to spend time socially with a friend who had been diagnosed with depression, whether they would feel uncomfortable living in close proximity to a neighbour who had been diagnosed with an anxiety disorder, and whether they would be confident in the ability of a colleague who had returned after time off for a depressive episode to perform their tasks. As shown in Table 14, when asked if they would be willing to spend time socially with a friend with depression, PHPs showed a high level of willingness, with 76% of physicians, 72% of physician's assistants, and 85% of other PHPs selecting strongly agree. The distribution of responses was similar by location and gender.

When asked about discomfort about living in close proximity to a neighbour with an anxiety disorder, the distribution of responses was more evenly distributed across response categories. There was a statistically significant difference by profession: $X^2(2, N=222)=13.8754, p<.05$, with physicians showing higher levels of discomfort. 21% of physicians indicated that they would be uncomfortable living near a person with an anxiety disorder, compared with 6% of physicians assistants and 7% of other PHPs.

Regarding confidence in a colleague who has experienced depression, PHPs displayed a high degree of confidence, with 44% of physicians, 35% of physicians assistants, and 46% of other PHPs selecting strongly agree, while 44% of physicians, 52% of physician's assistants, and 39% of other PHPs selected somewhat agree. The distribution of responses was similar by location and gender.

Table 14: Social distance measures

I would be willing to spend time socially with a friend who has been diagnosed with depression											
		Strongly Agree		Somewhat agree		Somewhat disagree		Strongly disagree		Row N	Chi-square and <i>p</i> -value
		(%)	N	(%)	N	(%)	N	(%)	N		
Profession											
	Physicians	76%	53	23%	16	0%	0	1%	1	70	
	PAs	72%	80	24%	27	4%	4	0%	0	111	
	Other	85%	35	15%	6	0%	0	0%	0	41	
	All	77%		21%		2%		0%		222	8.1729; .225704*
Location											
	Urban	79%	41	19%	10	2%	1	0%	0	52	
	Rural	74%	130	23%	40	2%	4	1%	2	175	
	All	76.5%		21%		2%		0.5%		227	0.9699; .808527*
Gender											
	Female	78%	113	19%	28	3%	4	0%	0	145	
	Male	73%	58	25%	19	0%	0	1%	1	79	
	All	75.5%		22%		1.5%		0.5%		224	4.7084; .194434*
I would be uncomfortable living next door to a neighbour who has an anxiety disorder											
		Strongly Agree		Somewhat agree		Somewhat disagree		Strongly disagree		Row N	Chi-square

		(%)		(%)		(%)		(%)			
Profession											
	Physicians	21%	15	30%	21	17%	12	31%	22	70	
	PAs	6%	7	31%	34	17%	19	46%	51	111	
	Other	7%	3	24%	10	10%	4	59%	24	41	
	All	11%		28%		15%		45%		222	13.8754; .031059**
Location											
	Urban	8%	4	33%	17	14%	7	46%	24	52	
	Rural	13%	23	29%	51	16%	28	42%	74	175	
	All	10.5%		31%		15%		44%		227	1.4796; .68698*
Gender											
	Female	14%	20	26%	38	16%	23	45%	66	146	
	Male	8%	6	35%	27	14%	11	44%	34	78	
	All	11%		30.5%		15%		44.5%		224	2.9972; .392063*
I would have confidence in the ability of a colleague who has had depression to do her job effectively.											
		Strongly Agree		Somewhat agree		Somewhat disagree		Strongly disagree		Row N	Chi-square
		(%)		(%)		(%)		(%)			
Profession											
	Physicians	44%	31	44%	31	10%	7	1%	1	70	
	PAs	35%	40	52%	59	11%	12	2%	2	113	
	Other	46%	19	39%	16	10%	4	5%	2	41	

	All	42%		45%		10%		3%		224	4.2537; .642389*
Location											
	Urban	39%	20	50%	26	10%	5	2%	1	52	
	Rural	40%	70	47%	83	11%	19	2%	4	176	
	All	39.5%		48.5%		10.5%		2%		228	0.1607; .983665*
Gender											
	Female	40%	58	46%	67	12%	17	2%	3	145	
	Male	41%	33	48%	38	9%	7	3%	2	80	
	All	40.5		47%		10.5%		2.5%		225	0.509; .916904*

*The result is *not* significant at $p < .05$.

** The result is significant at $p < .05$.

6.3.5. Resources

PHPs described several resource needs in relation to providing mental health services in primary care. Private space for patient consultation is frequently mentioned as necessary but not readily available by interview participants:

We don't treat patients with mental illness here. In Vietnam there has been no mental treatment in primary health care. This clinic is small, it would be good to have a room for the doctor to talk with the patients so that they can understand their health problems more. (Nurse, urban area)

As shown in Tables 15 and 16, though the majority of survey respondents believe that private space is necessary for consulting patients with CMDs like depression, many PHPs indicate that private space is unavailable at their health centre. Physicians indicated a higher availability of private space than other PHPs, with 66% responding yes, compared with 51% of physicians assistants and 47% of other PHPs, though the results were not statistically significant. There was a statistically significant difference by location: $X^2(2, N=213)= 11.7703, p<.05$. While rural respondents' yes responses were somewhat higher (56%) compared with urban respondents (51%), 22% of urban respondents indicated that private space was sometimes available, compared with 6% of rural respondents.

Table 15: Necessity of private space to consult with patients with depression

Is privacy (e.g., an examination room where no other patients can see or overhear) necessary for consulting with patients with CMDs like depression?											
		Yes		No		Sometimes		N/A		Row N	Chi-square and <i>p</i> -value
		(%)	N	(%)	N	(%)	N	(%)	N		
Profession											
	Physicians	84%	59	7%	5	7%	5	1%	1	70	
	PAs	79%	89	6%	7	12%	14	3%	3	113	
	Other	80%	31	10%	4	10%	4	0%	0	39	
	All	81%		8%		10%		1%		222	3.1977; .783661*
Location											
	Urban	80%	41	8%	4	12%	6	0%	0	51	
	Rural	80%	141	7%	12	10%	18	3%	5	176	
	All	80%		7.5%		11%		1.5%		227	1.5966; .660165*
Gender											
	Female	81%	117	5%	7	12%	17	2%	3	144	
	Male	79%	63	11%	9	8%	6	3%	2	80	
	All	80%		8%		10%		2.5%		224	3.9474; .267201

*The result is not significant at $p < .05$.

Table 16: Availability of private space for consulting patients with depression at CHSs

Does your CHS have private space available for consulting patients with CMDs like depression?									
		Yes		No		Sometimes		Row N	Chi-square and <i>p</i> -value
		(%)	N	(%)	N	(%)	N		
Profession									
	Physicians	66%	44	31%	21	3%	2	67	
	PAs	51%	55	36%	39	12%	13	107	
	Other	47%	17	42%	15	11%	4	36	
	All	55%		36%		12%		210	6.785; .147694*
Location									
	Urban	51%	25	27%	13	22%	11	49	
	Rural	56%	92	38%	62	6%	10	164	
	All	53.5%		32.5%		14%		213	11.7703; .00278**
Gender									
	Female	57%	77	32%	43	11%	15	135	
	Male	51%	39	42%	32	7%	5	76	
	All	54%		37%		9%		211	2.7815; .248894*

*The result is not significant at $p < .05$.

**The result is significant at $p < .05$.

The need for more staff was also described, especially in relation to the demands of numerous programs. As shown in Table 17, 56% of survey participants overall agree that they would be able to provide better care to patients with depression if there were more staff. A much higher proportion of physicians (78%), however, selected “strongly agree”. The chi-square test showed a statistically significant difference on this variable: $X^2(2, N=222) = 43.7232, p < .00001$.

Table 17: Perceived ability to provide improved services with more staff

Our CHS would be able to provide better care for people with CMDs like depression if we had more staff													
		Strongly agree		Somewhat agree		Somewhat disagree		Strongly disagree		N/A		Row N	Chi-square and <i>p</i> -value
		(%)	N	(%)	N	(%)	N	(%)	N	(%)	N		
Profession													
	Physician	78%	53	13%	9	3%	2	3%	2	3%	2	68	
	PAs	50%	57	43%	49	3%	3	3%	3	3%	3	113	
	Other	39%	16	37%	42	5%	2	12%	5	7%	3	41	
	All	56%		31%		4%		6%		4%		222	43.7232; <0.00001**
Location													
	Urban	48%	25	40%	21	4%	2	4%	2	4%	2	52	
	Rural	58%	101	31%	54	3%	5	5%	9	3%	5	174	
	All	53%		35.5%		3.5%		4.5%		3.5%		226	2.1576 .706804*
Gender													
	Female	50%	72	35%	50	4%	6	6%	9	4%	6	143	
	Male	68%	54	26%	21	1%	1	3%	2	3%	2	80	
	All	59%		30.5%		2.5%		4.5%		3.5%		223	7.2206; .124682*

*The result is not significant at $p < .05$.

**The result is significant at $p < .05$.

The fact that there is only one physician and that physicians' assistants are minimally trained emerged as an issue in interviews:

Generally speaking, we do not have many staff here at the commune level. I am the only doctor here, while there are so many health programs, 36 programs with many tasks and patients to check. Therefore, doctor's assistants are in charge of checking the patients as well. However their capacity is limited, leading to many difficulties in checking, and treating patients with mental illness. (Doctor, rural area)

PHPs also suggest that more resources be allocated to traditional or supplemental medicines (e.g. "tonic", vitamin B6) by the government. They note that that provision for these types of treatments has declined in recent years, with a shift toward biomedicine. This is mentioned especially in the rural area, which was previously part of another province and has recently amalgamated with Hanoi:

Yes, we used to have tonic in the medication for patients until a few years after merging with Hanoi, now the tonic has been cut off, we just have medicine specifically for the disease. (Physician's assistant, rural area)

Anti-depressants are not prescribed at the CHC level and are not readily available. As shown in Table 18, the majority of PHPs (69% of physicians, 63% of physician's assistants and 65% of other providers) expressed concern about the ability of patients to access antidepressant medications. Urban respondents showed slightly higher concern (75%) compared with rural PHPs (61%), but the difference is not statistically significant. These concerns are most prominently related to the availability of antidepressant medications at the CHS pharmacy, but also to their availability at private pharmacies and to their cost (see Table 19). When asked to provide "other" responses to the question of why antidepressant medications might be unavailable, the majority of responses indicate that antidepressant medication is managed by the CMHP and thus requires a prescription from a higher level of care, or that these medications are not available on the market.

Table 18: Perceived patients access to antidepressant medications

When patients are prescribed medications for CMDs such as depression (e.g., antidepressant medications) are you concerned about their ability to access these medications?									
		Yes		No		Sometimes		Row N	Chi-square and p-value
		(%)	N	(%)	N	(%)	N		
Profession									
	Physician	69%	48	26%	18	6%	4	70	
	PAs	63%	71	24%	27	13%	15	112	
	Other	65%	26	28%	11	8%	3	40	
	All	66%		26%		9%		222	3.1673; .530228*
Location									
	Urban	75%	38	20%	10	5%	3	51	
	Rural	61%	107	29%	51	10%	18	176	
	All	68%		24.5%		7.5%		227	3.263; .195639*
Gender									
	Female	67%	96	22%	32	11%	16	144	
	Male	59%	47	35%	28	6%	5	80	
	All	63%		28.5%		8.5%		224	4.936; .084754*

*The result is not significant at $p < .05$.

Table 19: Perceived reasons for lack of access to antidepressant medication

If you answered "yes" or "sometimes", why wouldn't patients be able to access medications (choose all that apply)?						
		They are not available at the CHS pharmacy	They are not available at private pharmacies	They are too expensive for patients to afford	Other	Row N ^b
		(%) ^a	(%)	(%)	(%)	
Profession						
	Physicians	69%	58%	53%	9%	55
	PAs	66%	54%	46%	17%	87
	Other	40%	60%	37%	23%	30
	All	58%	57%	45%	16%	172
Location						
	Urban	52%	77%	52%	11%	55
	Rural	66%	49%	57%	22%	128
	All	60%	63%	54.5%	16.5%	183
Gender						
	Female	61%	61%	50%	13%	115
	Male	63%	50%	41%	21%	56
	All	62%	55.5%	45.5%	17%	171

a Responses exceed 100% as participants were asked to select more than one response if applicable

b Responses are lower than total sample as this question applied to those who selected "yes" for the previous question (Table 18)

There also might be a gap between the medications prescribed and available in the hospital and those distributed through the CMHP at the commune level.

Well, I would just want to say that the situation of mental [tam than] problems in this community is relatively relevant to the general situation of the whole country... A majority of the patients are poor, their economic situation gets worse after they have the illness, so they would really like to receive more support, on health care, on medication. For example, they want to receive medication at the commune for a long time, and in a relatively efficient manner. That means that they want to receive the exact medicine prescribed by the doctor, not the medicine in the same group. Some patients feel uncomfortable about that and some even say something like they are allergic to that type of similar medicine, or that the medicine is not as good as the previous one that they received in the hospital, something like that. Or some patients would like to receive tonic but they are not eligible to; they feel uncomfortable, too. Therefore, they would like there to be more financial support for this program so that it is possible for them to receive the same medicine as prescribed. (Physician's assistant, rural area)

It was also noted that health communication budgets were recently cut, limiting the amount of informational marketing (referred to as 'propaganda' in Vietnam) that can be done on mental health via community radio or loudspeakers. Community awareness emerged consistently as an important component of improving mental health care in the community and CHCs engage in numerous communications activities as part of their programs.

6.3.6. Support and Supervision

Another issue that emerged, especially among survey respondents, is the need for better support for the staff member responsible for the CMHP. In open-ended responses in the survey, suggestions for improved support ranged from more remuneration to improved supervision and direction for working with these patients:

Allowance for staff working in the mental health program, regular training to improve knowledge on mental health care and full provision with more diversified medicine for patients with mental disorders [are needed]. (Survey participant)

There should be an allowance/support for staff working in the community mental health program so that they can work better. (Survey participant)

PHPs also discussed the CMHP and its limitations. They described a lack of support by the higher levels of the health system for front-line primary care staff implementing the program. They also described other limitations of the program in terms of coverage and patient care:

Although there is a health worker on mental health in the commune health center, it is necessary to have training for all other health staff... Because they are in the community, they are the first to detect people with mental disorders. More training on mental health should be organized in the community. There should be more specialized staff working for the community mental health program to diagnose, detect and provide effective, early treatment for the patients, so that the patients can access early treatment for their common mental health problems. (Survey participant)

6.4. Discussion

6.4.1. Barriers

Barriers to the integration of services for CMD emerged that are related to knowledge and familiarity with people with mental disorders. PHPs' familiarity with patients with mental health problems was largely restricted to the patients enrolled in the CMHP, meaning that they have very limited familiarity with CMDs like depression. When asked to estimate the number of patients with mental illness overall, severe mental illness and CMD that visit the CHS per month, PHP's estimates were very low. The slight variation in numbers between overall mental illness and both severe mental illness and CMD might be indicative of a lack of awareness or understanding about the classification of mental disorders, as was suggested by the findings in Chapter 5. Some respondents entered the term for schizophrenia (*tâm thần phân liệt*) in the section that specifically asked about CMDs; many PHPs in the sample did not differentiate between types of mental illness and had low levels of knowledge in this area.

Compared with epidemiological data, PHPs underestimated the prevalence of depression in the community and likely underestimated prevalence rates in their patient populations, although low help seeking and low numbers of patients in some CHSs and OPCs might contribute to this. A higher number of rural PHPs indicate that they see a patient with mental illness in a given month compared with their urban counterparts. This

might be attributable to different help-seeking behaviours in the urban areas, where the accessibility of hospitals means that patients might be taken directly to a tertiary facility instead of to the CHS when a mental health problem is suspected. This is consistent with the findings in Chapter 5. These low numbers of patients attending primary care facilities and the low levels of help seeking and community awareness about depression suggests that efforts to improve community-based care should include community outreach and awareness activities.

Physicians' estimates of prevalence both in primary care and in the community were somewhat higher than other PHPs, which may be a result of more training in mental health, both in medical school and through annual in-service training. Despite the majority of PHPs indicating that they received both service and in-service mental health training, levels of knowledge about mental illness and depression in particular were low. PHP responses, such as the use of the term "schizophrenia" when asked about CMDs, suggest that they have difficulty classifying different mental illnesses, and likely associate the term "mental illness" with schizophrenia or epilepsy (see Chapter 5). This points to the need for enhanced training, including training on screening and detection, about depression.

In terms of their perceived self-efficacy in the detection and treatment of depression, PHPs in the study saw these activities as the role of specialists, while their role was to make referrals or to provide complementary treatments including the provision of tonics or other supplements. Because of the structure of primary care service provision, PHPs who were not involved in the CMHP might describe providing care to patients with mental illness as not being within their scope or role. Lack of training for the detection and treatment of patients with depression combined with the allocation of patients with mental illness to the CMHP seemed to reinforce this low level of perceived role and self-efficacy. PHPs did indicate, however, that CHSs and OPCs were more accessible to patients and that with enhanced training and support they believed that services for depression could effectively be delivered at this level.

Training in mental health also emerged as a major barrier to the integration of services for depression in primary care. While the majority of PHPs indicate that they received some mental health education during their pre-service training, it is often minimal.

Physicians must take a unit on psychiatry during medical school, which includes both in-class and clinical training. Given the structure of the mental health system and its emphasis on treating schizophrenia and epilepsy, however, it is unlikely that they receive adequate training about depression or about psychosocial approaches to treatment. Other PHPs receive very minimal mental health training, with physician's assistants relying on in-service mental health training only if they are allocated responsibility for the CMHP.

The training of only designated PHPs in mental health emerged consistently as a barrier to the integration of services for mental health in primary care. Many PHPs noted that all primary care staff should be trained in order to be able to detect and properly care for patients with mental illnesses. Limiting training to only physicians and staff members responsible for the CMHP sets apart the provision of services for mental illness and poses a barrier to its meaningful integration in primary care.

The inability of physician managers to determine program or policy direction may act as a barrier to the integration of services for CMD in primary care. While physicians are supportive of the need for enhanced mental health services in their centres, which is certainly an asset, they are constrained by the top-down nature of primary care delivery in which programs are the mandate of the higher levels of the health system.

PHPs identify several barriers related to resource availability in CHCs and OPCs. Private space for consultation with patients with CMD is identified as both important for effective patient care and as something that many primary care centres do not have. Numbers and capacity of personnel are also described as gaps. Compared with other professions, a much higher proportion of physicians indicated that more staff is important for providing better care. This suggests that in their role as managers they are challenged by what they perceive as a shortage of staff. As previously described, PHPs are often responsible for several programs at a time, placing high demands on all members of staff. As managers, physicians would be most aware of these staffing challenges. Each CHC is managed by one physician, leaving much of patient care including assessments to physicians' assistants who have limited training overall and might receive no training in mental health. Each PHP is also responsible for several programs, in addition to routine patient care, emergency care and administrative and maintenance tasks. Despite the

willingness of PHPs to receive more training in mental health, the realities of their daily responsibilities might pose a barrier to effectively implementing new interventions for CMD.

PHPs also describe a reduction in funding for supplements and complementary medicines that were previously provided at the primary care level. These supplements are described as beneficial to alleviate insomnia and headache and other somatic symptoms that might be associated with depression in Vietnam (see Chapter 5), and PHPs describe patients' expectations of receiving these supplements. Inconsistent availability of psychotropic medications are also described as a challenge for patients in the CMHP, as patients perceive either generic medications or medications within the same classification as those prescribed as unsatisfactory. While the emphasis of this study is on enhancing psychosocial services for depression in primary care, these considerations are important for the overall enhancement of mental health services at this level. It is possible that an expectation of accessing supplements, traditional herbs and other complementary remedies might influence help seeking for mental health services among patients.

Although the CMHP has improved referrals and access to medications at the community level, especially for people with severe mental illnesses and epilepsy, its existing structure creates several barriers to the effective integration of mental health services in primary care. Because the CMHP is one of the many programs that are implemented by CHSs, it seems to set mental health services apart from 'mainstream' service delivery, limiting PHP involvement in mental health service to referrals and allocation of medications, which is the responsibility of one PHP at each centre. This means that mild to moderate depression is unlikely to be detected in patients visiting the CHC for other concerns or with somatic symptoms. It also means that patients with mild to moderate depression, if their symptoms are suspected to indicate a mental illness, will be referred to a higher level of care. This likely places a strain on patients and on the mental health system. If mild to moderate depression could be detected and treated in primary care, the number of referrals could be reduced.

PHPs also note that the number of programs that must be implemented by each CHC impedes their ability to provide patient care. One physician manager describes PHPs

at her center sharing responsibility for 36 programs. The volume of programs suggests that PHPs are over burdened. CHCs are embedded within their communities and, as PHPs describe, are convenient and accessible for patients. It seems that the enhancement of the capacity of CHCs to provide patient care, including mental health care, would be beneficial to patients and welcome to PHPs.

6.4.2. Facilitators

In terms of facilitators, despite having low knowledge about and familiarity with patients with depression, PHPs do not display overtly negative attitudes toward patients with mental illness. Social distance scores suggest that PHPs would be comfortable to socially interact and work with people who have experienced depression. Higher social distance scores related to an anxiety diagnosis are likely due to limited knowledge and awareness of anxiety disorder, which is often not differentiated in Vietnam as a discrete condition (Wagner, Manicavasagar, Silove, Marnane, & Tran, 2006). PHPs do describe challenges related to working with patients enrolled in the CMHP, many of whom have schizophrenia. Some PHPs describe these patients as volatile and uncooperative. This points to the need for enhanced training, support and supervision for the staff members responsible for the CMHP. PHPs also describe patients with mental illness as vulnerable and requiring a tactful, gentle approach to care. While perceptions of people with mental illness as weak have been associated with increased stigma (Read & Law, 1999) this attitude might also suggest empathy towards these patients.

PHPs indicate a high level of interest in receiving more training and developing new skills in mental health. Despite their low perceived self-efficacy, they believe that CHCs and OPCs could be optimal places for patients with CMD to receive care. Despite heavy workloads and numerous responsibilities they recognize the need for more training in mental health and welcome new opportunities to obtain this training. This presents an important opportunity for the further integration of mental health services in primary care; PHPs are willing and interested in enhancing their capacity and believe that, given the right skills and supervision, they can be effective and appropriate providers of mental health care for depression.

6.5. Conclusions

The results of this study highlight a number of important barriers and facilitators to the integration of services for depression in primary care in Vietnam. Using the constructs of CIT, at the individual level the motivation of PHPs appears very strong, however their information is currently limited. PHPs both need and want enhanced training in mental health, seeing it as important and relevant to their roles. Despite estimating the prevalence of mental illness in primary care and the community as low, they see CHCs and OPCs as appropriate places for the delivery of services for depression, recognizing that that these centres are more accessible to patients who are poor and who might be unable to access hospitals or other higher level services. While the low levels of knowledge and perceived self-efficacy of PHPs might be seen as barriers, their high motivation to learn and to deliver services to people with depression appears to be an important facilitating factor for the integration of services for depression in primary care. With enhanced training, their familiarity with people with depression, perceived role efficacy and self-efficacy are likely to be strengthened as well.

At the organizational level, the CIT construct of power-control appears to be low. While managers display a high degree of motivation to improve mental health services at the primary level, their discretion in terms of program direction is limited. The construct of power-capacity is also low. Limited resources affect their ability to deliver enhanced mental health services, with issues such as space, numbers and capacity of personnel, and availability of both supplements and medications acting as barriers.

Many of the barriers to the integration of services for depression in primary care seem to originate at the structural level. It is evident that the CIT constructs of information and power are low among PHPs. While they are enthusiastic about learning new skills in mental health, PHPs also describe feeling overburdened by the number of programs they deliver, with each PHP being responsible for up to six programs each. Some PHPs question whether all programs are necessary, and suggest that overseeing these programs detracts from their ability to provide patient care. While it is beyond the scope of this study to assess the quality of primary care programs, it is possible that primary care

service delivery could be improved by reviewing and redesigning programmatic structures and streamlining them for the accomplishment of program objectives.

Enhanced capacity building of all staff in the form of both pre-service training and professional development programs could enhance the knowledge and skills of PHPs and their ability to effectively implement integrated services for mental health. As described above, PHPs are clearly motivated to receive more training and to learn about strategies for treating depression. Changes to the quality and scope of mental health training will have to be implemented by authorities at higher levels within the health and education systems.

While the CMHP is an important step towards providing care for mental illness in primary care, it has several limitations that may be seen as barriers to the meaningful integration of mental health services in primary care. Because PHPs seem to associate “mental health” only with the CMHP, it is not seen as part of the purview of general health care services in primary care. The majority of patients enrolled in the CMHP are diagnosed with schizophrenia or epilepsy, while common mental disorders are rarely treated under the program despite having much higher prevalence. This means that these common mental disorders go undetected and untreated. Despite the goals of the CMHP, in practice it is almost exclusively limited to the referral of patients to tertiary care and the subsequent distribution of medications. The CMHP also only provides in-service mental health training for health centre managers and the staff member responsible for the program. All these factors mean that mental health is set apart from routine patient care and that PHPs have very little or no training in screening for or providing treatment for common mental disorders. In order for depression services to be implemented in primary care, it is necessary that mental health, especially detection and treatment for common mental disorders, be reframed as part of the general health services offered by all PHPs at CHSs and OPCs. Given low levels of help seeking, community outreach and awareness initiatives should be introduced as part of enhanced mental health services in primary care.

The program and policy directions of primary care centres in Vietnam are determined in a top-down manner, meaning that the power of PHPs to implement change

is limited without clear policy direction from the higher levels within the system. The high levels of motivation among PHPs to improve service delivery for depression in primary care is very encouraging, but will require changes at the structural level in order to facilitate meaningful and effective integration of mental health services at this level. It is promising that the government of Vietnam continues to prioritize enhanced community-based care for mental illness, including depression, and that they are supportive of adopting psychosocial interventions that can take place at the level of primary care. With a commitment to training PHPs in screening and the implementation of low-cost psychosocial interventions, and investment in community outreach and awareness, services for depression may become successfully integrated into primary care in Vietnam.

Chapter 7.

Discussion and conclusions

In the last decade, increased attention to the critical gap in mental health services, particularly in LMICs, has led to a call for enhanced and expanded mental health services through approaches such as task shifting, including the integration of mental health services into primary health care. Advocates for a global mental health approach recommend scaling-up such services in order to improve coverage and access by people in LMICs who are suffering from mental health problems (Lancet Global Mental Health Group, 2007; Patel et al., 2007; Patel et al., 2011). The improvement and expansion of mental health services is of critical importance in order to end the unnecessary suffering of people with mental illnesses in LMICs. Efforts to enhance and scale-up mental health services must however take into account the social and cultural settings in which services are to be delivered to ensure that these services are valid and acceptable to communities. This means that there is a need to balance the urgency of the demand for mental health services with the need to ensure that approaches to mental health care are developed and delivered in a way that is respectful and responsive to the social and cultural contexts in which mental illness is experienced. This balance may appear as a tension between emic and etic approaches, where those who call attention to the universality of mental health disorders (an etic approach) are at odds with those who argue that the experience of mental illness is deeply embedded in cultural context and thus not generalizable (an emic perspective).

Through this study, I sought to explore that tension and to understand ways in which the process of integrating services for depression in primary care can take place in a way that respects the balance between the need for expanded services while accounting for the local context. This study includes a narrative review that examines considerations for studying depression cross-culturally. It also seeks to understand barriers and facilitators to the integration of depression services in primary care in Vietnam in the context of increasing momentum around community-based services for common mental disorders in that country. I examined explanatory models of depression and social and cultural norms around mental illness in order to understand the conceptualization of

depression from the perspective of PHPs in Hanoi. I also examined other barriers and facilitators to the integration of depression services in primary care that exist at the individual, organizational and structural level and affect the motivation, information and power of PHPs. The results of this study have implications for the ongoing process of the development and expansion of community-based mental health services in Vietnam. The findings of this study and themes that emerge throughout are also relevant for the broader context of global mental health and cross-cultural studies of mental health. These findings and their implications are discussed below.

7.1. Revisiting Theory: Explanatory models and Contextual Interaction Theory

In this study, I drew on two theoretical frameworks to guide my inquiry and analysis. As described in Chapter 5, I used the concept of explanatory models (EMs) to understand how depression is conceptualized in Vietnam. EMs help to explain the meaning that is given to illness by patients, communities, healthcare practitioners, and all other actors within a health or social system (Kleinman, 1988). They help to understand how various actors identify and experience the nature and cause of an illness and help to identify beliefs about what can be done to treat or manage an illness and what the expected outcome of an illness might be (Kleinman, 1988). Instead of presuming that illnesses exist entirely in the biological realm, the EM framework acknowledges that the experience of illness is also imbedded in social and cultural context. Understanding how illness is experienced, understood and addressed is an important component of planning for the development and delivery of health services that are meaningful, appropriate and acceptable in specific sociocultural contexts.

Using EMs as a framework through which to understand how depression is conceptualized in Vietnam from the perspective of PHPs was very useful. Drawing on EMs as a theoretical framework allowed me to begin the qualitative component of this study with open questions about the nature of mental illness broadly, and depression more specifically, in order to elicit PHPs' understandings of depression. Using the concept of EMs to inform the study design and analysis meant that I did not have to rely on biomedical or DSM/ICD understandings of depression as a starting point, but rather, through the use

of “reverse vignettes” encouraged PHPs to draw a picture of both the nature of depression and the approaches used in primary care and within the community to address it.

The use of the EM framework within this study, which is concerned with barriers and facilitators to the integration of services for depression in primary care, was very valuable in terms of identifying the distinct depression experience in Vietnam, and for identifying the beliefs PHPs have about the illness, the approaches they would take to address it, and their understanding of the depression experience in the broader community. This will provide valuable information about the sociocultural context and the depression experience that will inform the development of enhanced services for depression in Vietnam.

I also used Contextual Interaction Theory (CIT) as a theoretical framework to enable me to identify barriers and facilitators to the integration of services for depression in primary care at the individual, organizational and structural level. CIT is based on the assertion that factors influencing the motivation, information and power of individuals interact to enable or prevent them from implementing policy initiatives (Bressers, 2004; Owens & Bressers, 2013). The key constructs of the theory- motivation, information and power- include factors that are both internal (e.g. knowledge and attitudes) and external (e.g. policy and organizational structures) to individuals.

Using CIT as a framework to understand and assess barriers and facilitators to the integration of depression services in primary care was helpful in several respects. The constructs of motivation, information and power were appropriate categories through which to understand the variables of interest in this study. The examination of these variables as both internal and external factors allowed for the analysis to account for barriers and facilitators that exist at the individual, organizational and structural level, meaning that I was able to understand the broad context in which these barriers and facilitators take place despite studying only one group of actors (PHPs). This allowed me to elicit a comprehensive understanding of the ways in which system level factors interact with the day-to-day experience of PHPs including the organizational context of CHSs, and their individual knowledge and attitudes about mental illness and depression. CIT thus

proved to be a useful framework for simultaneously focusing on one group of actors and capturing the influence of the broader social and health system context.

Using both EMs and CIT as theoretical frameworks proved helpful for developing the methodology of this study and allowing for an analysis that simultaneously captures the sociocultural context of depression in Vietnam, and the individual, organizational and structural factors that are likely to influence the integration of services for depression in primary care in Vietnam. Although the study focuses only on the perspective of PHPs, these frameworks allowed for the analysis to capture and pull in other contextual factors, including community-based beliefs and help-seeking behaviours, organizational challenges related to program delivery and patient care, and structural-level factors that might influence the delivery of enhanced services for depression in Vietnam. The implications of these findings for depression service delivery in primary care are further discussed below.

7.2. Implications for the Expansion of Community-Based Depression Care in Vietnam

7.2.1. The role of primary care providers

The findings of this study point to a disconnect between the epidemiological data on depression prevalence and the experience of PHPs as clinicians. Although many PHPs have had some experience with depression either personally or among family or friends, they generally have very low familiarity with depression. They estimate the prevalence of depression both among their patient population and the general community to be much lower than the epidemiological data suggests. They note that patients are unlikely to describe symptoms as 'depression' and that although awareness of depression is growing it is still not well recognized or understood. The low level of enrolment of patients with depression in the CMHP also suggests that help seeking and detection are very low within the Vietnamese health system as a whole. PHPs do however describe symptoms (e.g. not wanting to talk, inability to perform work or household tasks, insomnia, headache) that they identify as depression in clinical settings. This suggests that depression is

experienced in Vietnam, but that help seeking at the primary care level and screening for and detection of depression are very limited.

Despite the low levels of familiarity with depression in Vietnam, PHPs are an important source of knowledge about depression, mental illness and both formal and informal systems of care in Vietnam. PHPs working at CHSs and OPCs in Vietnam are at the frontline of primary health care services and are thus important in several respects for the integration of services for depression in primary care. PHPs are uniquely situated as both community members and healthcare providers. While their formal knowledge and training about mental health is very limited, they have rich experiential knowledge acquired through both clinical practice and their experience within the community. Shifting role identities of community health workers (CHWs) were described by Mlotshwa et. al. (2015), who found that CHWs in South Africa might alternately consider themselves to be community 'outsiders' and 'insiders' or 'brokers' between the health system and communities. They also found that because of their role within the community, CHWs could identify with patients in terms of sociocultural and socioeconomic experience. Although PHPs in Vietnam are formal health sector employees and not volunteers, they seem to have a similar experience in that they are situated both as community members and clinicians, and are able to negotiate between the two contexts. For example, in the rural district of Hanoi, PHPs' explanatory models of depression focus on psychosocial aetiology and symptoms that emphasize social and functional disruption and somatic symptoms. They understand, however, that community members might experience mental health problems in spiritual terms, attributing causation to ancestral ghosts and seeking spiritual rather than biomedical help. PHPs also describe seeing very few patients with depression in a clinical setting, but many have had personal experience with it through friends, family or having experienced it themselves. This unique position suggests that PHPs, with enhanced training about screening and interventions, are well placed to provide depression care to patients within their communities. Their understanding of the explanatory models of patients in addition to the socioeconomic circumstances in which patients live means that PHPs hold valuable knowledge about how depression is conceptualized in Vietnamese communities, and that they are well suited as brokers between the community and the formal healthcare sector.

PHPs also demonstrate substantial motivation to take on the role of providing depression services to patients in primary care. PHPs are enthusiastic about the possibility of receiving enhanced training in mental health and call for training opportunities to be offered to all staff at CHSs and OPCs. PHPs recognize the limitations of their training and are eager to learn more. They also describe CHSs as appropriate locations for such services to be offered. They state that because many patients are poor and are unable to travel to district or provincial hospitals, enhanced services at the commune level would be more convenient and accessible for patients. Although some PHPs describe the provision of mental health services as being outside the scope of their professional role, it seems that they believe that with enhanced training and resources at the CHS level, primary care is an appropriate place for the provision of care for mild to moderate depression.

Despite low levels of training and limited resources for depression care at CHCs and OPCs, PHPs consider one of their main roles with patients with mild to moderate depression as identifying a cause and providing advice. PHPs already describe the provision of advice or counselling to patients and their families as something they would do if they saw a patient with depression. While currently the main role of PHPs is to provide referrals to patients who might have mental health problems, PHPs seem to envision themselves in this counselling and advising role. This suggests that with enhanced training and capacity to deliver psychosocial interventions for depression such as supported self-management, PHPs are willing to take on this role and implement these interventions.

The role of PHPs as community members and clinicians, their high levels of motivation to participate in enhanced mental health training and their perception of their own role as providers of advice and counselling to patients with mild to moderate depression are all important facilitators for the integration of services for depression in primary care. PHPs are the implementers of enhanced community-based mental health services, and their cooperation, enthusiasm and expertise are essential to the success of any such initiatives.

There are also a number of factors acting as barriers to the integration of services for depression in primary care from the perspective of PHPs. The CMHP designates one PHP, usually a physician's assistant, to administer the CMHP. This means that other

PHPs might see screening for and treating mental illnesses like depression as outside of their role or responsibility. PHPs often referred to the staff member who is the “mental health person” as having primary responsibility for working with patients with mental illnesses. The nature of this role emphasizes the provision of medications after a patient has been referred to a specialist, and does not include screening or detection of mental illnesses or counselling or other forms of treatment. This is a product of the structure of the CMHP. PHPs are aware of this shortcoming, calling for in-service training in mental health to be offered to all PHPs rather than only to CHS managers and the staff member designated to the CMHP.

A similar barrier is the number of programs that are administered by each CHS. PHPs indicate that they each might be responsible for up to six programs, creating a heavy workload and limiting their ability to concentrate on day-to-day patient care. PHPs expressed frustration with this structure and expressed their desire for program delivery to be streamlined in such way that they are able to balance these tasks with patient care.

Despite these barriers, the apparent willingness of PHPs to learn more and to provide enhanced mental health services, along with their in-depth knowledge of their communities, are very positive factors that are likely to facilitate efforts to enhance community-based depression care in Vietnam.

7.2.2. Understanding depression in Vietnam

Essential to planning for the enhancement of appropriate services for depression in primary care in Vietnam is an understanding of how depression is conceptualized, or understood, in that country. Chapter 5 details the results of a study of the explanatory models of depression among PHPs in Hanoi, and also highlights their understanding of how depression is experienced within their communities. These findings have several implications for the integration of depression services into primary care in Vietnam

As described above, the findings of this study suggest that depression (*trầm cảm*) is a recognized condition in Vietnam and that it is identified by a consistent set of symptoms. PHPs’ descriptions of the symptoms of depression do not however emphasize emotional or affective symptoms as would be described in Western nosology. Very rarely

did PHPs use the terms “sadness” or “hopelessness” to describe the experience of depression. This must be considered in the processes of integrating services for depression in primary care.

PHPs in Vietnam largely describe the experience of depression in Vietnam in relational and functional terms, rather than being described as an introspective experience. As described above, while in a Western context depression might be associated with rumination, sadness and despair, in Vietnam PHPs describe it in terms of the disruption of social interaction (not wanting to talk or communicate) or functional capacity (not being able to work effectively or at all). It is possible that these symptoms of depression are described by PHPs because they are observable features of the impact of depression; patients may be unwilling or unable to describe any internalized thoughts or feelings that they experience and these may thus go unacknowledged. However these relational descriptions of the experience of depression were repeated by each PHP and seem to describe the illness experience as it is understood in this context. They are also consistent with previous research on depression in Vietnam (Niemi, Thanh, et al., 2010; van der Ham et al., 2011).

The relational and functional experience of depression in Vietnam also raises the question of narrative context, where patients might not consider a health centre the appropriate context in which to describe their symptoms (Good & Good, 1986; Jenkins et al., 1991). PHPs note that patients might not consider CHSs or OPCs to be the appropriate place to seek help for a mental health problem like depression. They might seek spiritual help, or deal with it alone or within the family. This study suggests that help-seeking for mild to moderate depression is nearly nonexistent, and that PHPs’ experiences with depression occur largely outside of the clinical setting. It is likely then that patients might not see health care centres as the appropriate narrative context to describe the symptoms of relational and functional disruption. PHPs thus might see patients with somatic symptoms such as insomnia or headache, which they are unlikely to identify as depression without mention of other symptoms. As described above, however, PHPs envision part of their role as advisors and counsellors to patients and their families. These psychosocial approaches appear to be appropriate for the types of symptoms Vietnamese patients with depression experience. With enhanced training of PHPs in recognizing, screening for and

treating depression, it is possible that community members will increasingly see the primary health centre as an appropriate context in which to receive psychosocial support and advice. It is important, though beyond the scope of this study, to understand the existing coping and help-seeking mechanisms of patients and their families and to ensure that enhanced depression services in primary care are responsive to patients' needs and appropriate for their own experiences of depression.

With the discussion of enhancing depression services in primary care, which includes increased screening and diagnosis, it is important to revisit the discussion of the implications of diagnosis for patients. Kirmayer (2005) describes the explicit purpose of diagnosis in part as informing prognosis and the course of treatment. The implications of diagnosis, however, may impact the patient and their family in several respects, some positive and some negative. Diagnosis might lead to improved care for depression and to the legitimization of a patient's symptoms and the impact they have on a patient's life. It may also, however, lead to stigmatization and social marginalization. With enhanced screening for and diagnosis of depression in Vietnamese primary care contexts, it is likely that patients and their families will experience both positive and negative effects. This is an important consideration when discussing the possibility that enhancing services for depression in primary care will involve a shift in the community conceptualization of the symptoms of depression from a problem that might be spiritual or relational in origin, to one that is labeled as a "mental health problem". Efforts should therefore be made to counter the possible stigmatizing effects of the depression diagnosis.

The results of this study suggest that depression in Vietnam is predominantly conceptualized in psychosocial terms, with little emphasis on emotional effects and emphasizing relational and functional disruption. This psychosocial conceptualization of depression presents several opportunities for the integration of depression services in primary care. In relation to the discussion of the effects of diagnosis and the possibility of increased stigmatization, there are perhaps opportunities to minimize the impact of a depression diagnosis by emphasizing the psychosocial dimensions of depression in a way that is meaningful and appropriate for Vietnamese communities. Similarly, the existing conceptualization of depression as a psychosocial experience seems to be an important facilitator for the development of psychosocial interventions for use in primary care. The

concept of depression in Vietnam does not appear to be consistent with Western biological models. There is therefore an opportunity to develop enhanced services for depression in such a way that existing conceptualizations and experiences of depression are respected, while simultaneously enhancing appropriate supports that will provide care to patients that is currently unavailable.

7.2.3. The community perspective

While this study focuses on the perspective of PHPs working in primary care centres in Vietnam, it is important to consider factors related to the community when discussing implications for the integration of mental health services in primary care. The aforementioned dual identity of PHPs as both clinicians and community members means that they can offer insight into how depression is understood in the community, as described above. They are also able to offer insight into the existing patterns of resort of community members coping with symptoms of depression and other mental illnesses, thus offering insight that can inform both the development of community-based depression services and the direction of future research.

One gap that emerged throughout the study is in help seeking for depression in primary care. PHPs indicate that very few patients will describe symptoms of depression in a primary care setting, although many have had friends, family members or personal experiences with depression. While PHPs, despite low levels of knowledge and training about depression, are familiar with the construct and its symptoms, they indicate that people in the community are unlikely to use the term 'depression' to describe symptoms. While community awareness of depression is growing somewhat as a result of increased coverage in the media, awareness remains low. Many PHPs describe the need for community awareness initiatives to be part of any enhanced services for depression in primary care. Awareness-raising, through radio and community loudspeaker 'propaganda', is already within the mandate of CHCs. Health promotion campaigns using radio and loudspeakers, and sometimes workshops or presentations, were described by PHPs as effective approaches that have previously been taken by primary care centres in numerous areas of health promotion. These could be integrated into efforts to improve community-based depression care and could help to improve community awareness and

help seeking. In their recommendations for improving depression care in LMICs, Patel et al. (2009) recommend awareness raising as a means to address stigma. When discussing low help seeking for mental health problems, PHPs also describe the need for enhanced community outreach. The low numbers of patients at some CHSs further support the need for outreach and screening to take place in the community. Schools and community organizations are also possible targets for both awareness raising and community outreach (Patel et al., 2009).

The role of families also emerged as an important consideration for depression care among Vietnamese communities. Families were described as integral to both the experience/ cause of depression and to overcoming it. While a conflict with a family member or family pressure might be identified as a cause of depression, the family was also likely to be involved in decisions regarding help-seeking and providing essential support to help the patient recover. This is consistent with the relational experience of depression as described above. The important role of the family suggests that interventions to treat depression that focus only on individuals may be inappropriate for use in Vietnam. This is consistent with research in other LMICs. In their review of treatments for depression in LMICs, Patel et al. (2007) found that interventions that extend beyond the individual to involve families or communities are more effective, while McKenzie, Patel and Araya (2004) describe family support as an important protective factor for post-partum depression in LMICs. Ways in which to involve families in depression care for patients in Vietnam should thus be explored.

Also emerging as important in the community is the misuse of alcohol by men. PHPs frequently describe alcohol misuse as a concern in the community, and associate it both with depression and as a standalone issue. This points to the need for increased attention to alcohol use among men in Vietnam, in addition to further research on depression among men and the relationship between alcohol use and depression.

While this study raises several important issues of relevance to depression in Vietnamese communities, the study population was limited to PHPs. Further research examining community member explanatory models of depression, help-seeking behaviour

and attitudes and stigma towards depression would all be beneficial and would further inform the development of services for depression in primary care.

7.2.4. Structural factors

Much of the success of the integration of enhanced services for depression in primary care depends on factors that exist at the structural level. While the Government of Vietnam has prioritized the enhancement of community-based care for mental illnesses including depression, the results of this study suggests there is a gap between these policy priorities and what occurs in practice. While the high levels of motivation of PHPs is certainly a facilitating factor that will likely promote the integration of services for depression in primary care, the information and power of these PHPs is hindered by limitations that exist at the structural level. These limitations must be addressed to promote the effective integration of mental health services in primary care.

The successful integration of mental health services in primary care requires a number of supports, including adequate pre-training and in-service training of PHPs, supervision and support of PHPs by mental health specialists and the allocation of financial and human resources to support successful service delivery in primary care (Funk et al., 2008; World Health Organization and World Organization of Family Doctors, 2008). As described in Chapter 6, training, supervision, resources and compensation were all identified as gaps by PHPs during this study. While the existence of the National Mental Health Strategy in Vietnam and the government's stated interest in enhancing care for depression at the community is certainly promising, tangible efforts with respect to these important factors will have to be made to ensure that the integration of services for depression in primary care is effective.

The delivery of mental health services in primary care currently takes place under the CMHP. The CMHP has improved community-based management of schizophrenia and epilepsy, led to enhanced in-service training for program staff, and contributed to reductions in relapse, hospital admissions and length of hospital stays (Ng et al., 2011). Ng et al. (2011) note several challenges with the CMHP however, including the lack of salary and incentives for program staff, limitations in the availability of the designated

program budget, limited community and family outreach and support mechanisms, and a lack of specialist doctors at the district and provincial levels to provide supervision.

This study has identified a number of similar challenges related to the CMHP that are likely to act as barriers to the integration of mental health services in primary care. While the goal of the CMHP is to integrate mental health services in primary care, in practice it seems to set the delivery of mental health services apart from the day-to-day operations of primary care centres. The program is managed by one staff member whose role is predominantly to manage the allocation of medications to patients enrolled in the program based on the prescription of a doctor at a higher level of care. Under the CMHP, the staff member responsible for the program and the managing physician of the health centre attend annual in-service mental health training. This means, however, that all other staff working in primary care receive no training in mental health, including in screening or treatment of mental health disorders. While patients displaying symptoms of psychosis would likely be referred to a higher level of care, it is unlikely that depression would be identified in patients visiting the health centre. The practice of only training selected staff was consistently identified by PHPs as a shortcoming of the program.

An additional shortcoming that emerged, and that was identified in Ng et. al.'s (2011) study, was the near absence of patients with common mental disorders such as depression in the program. The majority of patients enrolled suffer from psychotic disorders or epilepsy. While given the high prevalence of depression and other common mental health disorders, this suggests that there is a considerable gap in the CMHP. It also suggests an opportunity for further development of services for these common mental disorders. Should the CMHP as it currently exists be expanded to include more patients with depressive disorders, it is likely that the only treatment they would receive would be antidepressant medications allocated in the same way as the medications for patients currently enrolled in the program. This represents a risk, as antidepressant medications might not be necessary for many patients with mild or moderate common mental disorders. As described above, the conceptualization of depression by PHPs and members of the community in psychosocial terms represents an opportunity for the expansion of psychosocial approaches to treatment at the primary care level. These approaches should be introduced so as to provide appropriate care to patients with

depression and to avoid an overreliance on psychopharmacological treatments where they might not be necessary. Similarly, the practice of referring all patients with a suspected mental health disorder to a higher level as is currently done under the CMHP is likely to place an unnecessary burden on both patients and the health system should depression be integrated into the CMHP as it currently exists. Patients with mild or moderate depressive disorders are unlikely to require referrals to a higher level of care if screening and psychosocial treatments are available at CHCs and OPCs. PHPs indicate that commune level services are more accessible and appropriate for patients who might be unable or unwilling to travel to district or provincial hospitals. Enabling PHPs to screen for and offer psychosocial treatments for depression at the primary care level can help to reduce the number of unnecessary referrals, while ensuring that more severe or emergency cases are referred as needed.

7.2.5. Recommendations

A number of recommendations can be made for the integration of enhanced services for depression in primary care in Vietnam:

1) Bolster psychosocial interventions for depression in primary care:

The conceptualization of depression as a largely psychosocial experience in Vietnam indicates that the enhancement of depression services in primary care should emphasize psychosocial approaches to care. Although formal psychosocial services are not available in primary care at this time, PHPs already describe the provision of counselling and advice as an important part of their role. This is an important opportunity for the introduction, through enhanced training and capacity building, of psychosocial interventions (e.g. supported self-management) for depression in primary care. These types of interventions are also consistent with the way in which depression is conceptualized in Vietnam, suggesting they are socio-culturally appropriate and likely to be highly acceptable for both PHPs and patients. This represents a means by which to mitigate some of the challenges related to diagnosis discussed above. The emphasis on the psychosocial, rather than biomedical, aetiology of depression is likely to be more meaningful to patients and their families. The findings related to the importance of the

family in all aspects of the depression experience also suggest that psychosocial interventions that involve the family might be most appropriate for use in Vietnam.

The findings of this study suggest that the enhancement of psychosocial interventions for depression in primary care will also have several additional benefits. Vietnam has very limited psychosocial care providers such as social workers, psychologists or counsellors, meaning that these services are essentially unavailable in the country. The delivery of such services at CHSs and OPCs will be more accessible to patients, while referrals to tertiary facilities are likely to be geographically and financially inaccessible. The limited numbers of specialist mental health service providers in addition to the concentration of such services in large, tertiary facilities means that PHPs may lack proper referral routes, especially in rural areas. In areas where referrals are more feasible, cutting down on unnecessary referrals for mild to moderate depression, enhanced delivery of psychosocial interventions will also reduce the burden on the mental health system, given the limited mental health specialist workforce. The provision of psychosocial services in primary care is also likely to prevent the unnecessary prescription of antidepressant medications that is likely to occur with referrals to specialist services. Antidepressant availability is currently low in Vietnam, and the establishment of best practices for service delivery for mild to moderate depression through the use of evidence-based, locally appropriate psychosocial interventions in primary care could be an important step in the development of effective community-based mental health services in Vietnam.

2) Improve screening and detection of depression in primary care:

There is a need for enhanced screening and detection of depression in primary care in Vietnam. These screening tools and measures must be validated for the local context so as to avoid the 'category fallacy' that Kleinman (1988) cautions against. This indicates the need for validated screening tools that reflect the depression construct in Vietnam (Murphy et al., 2015). The introduction of dimensional measures of depression may also be more appropriate for capturing the degree to which patients are functionally impaired, in addition to their socioeconomic circumstances and the type and severity of their symptoms (Bjelland et al., 2009; Kraemer, 2007). The low levels of help seeking for

depression suggest that screening and detection should also be conducted through community outreach initiatives in addition to screening among primary care patients.

Enhanced efforts to screen for and diagnose depression must be conducted in a way that carefully considers the implications of a depression diagnosis in several respects. The first is the possible stigmatizing effect of a diagnosis on patients and their families. Also important to consider is the possible conflict or shift in conceptualization of depression that results from a diagnosis. Patients might not consider their symptoms to be indicative of a “health” or “mental health” problem, and a diagnosis that emphasizes a biomedical approach to depression might be disruptive or inappropriate. Diagnoses of depression and related interventions should be made in such a way that resonates with the patients’ understanding of their symptoms and provides appropriate and acceptable support. Further research to understand the possible implications of a “depression” diagnosis for patients will be required to plan effectively for the enhancement of screening and diagnosis in such a way that minimizes the possible impact on patients and their families.

3) Enhance community outreach and awareness activities:

Low levels of awareness about depression in the community suggest that efforts to improve community-based depression care must include community outreach and awareness activities. CHSs already work with local radio, make use of village loudspeakers, and run workshops for community members on various health promotion topics. These mechanisms, in addition to partnerships with organizations such as schools and commune people’s committees, could be used to improve awareness of depression and the availability of depression services at CHSs and OPCs in a way that is locally appropriate and consistent with local conceptualizations of depression. Building awareness about depression is an important way to improve help-seeking and to contribute to the reduction of stigma (Patel et al., 2009).

4) Address structural-level barriers to service provision for depression:

The integration of services for depression in primary care in Vietnam requires structural-level commitments. The National Mental Health Strategy introduced by the

government of Vietnam is a promising first step and represents a commitment to community-based mental health service delivery.

The successful integration of services for depression in primary care will require investment and commitment in several areas. The current structure of primary care service delivery and the CMHP has an impact on the perceived role and self-efficacy of PHPs. These programs should be revisited to support the meaningful integration of services for depression in primary care. Important steps would include the provision of in-service training to all PHPs and an increase in emphasis on screening and detection of depression in primary care. As described above, psychosocial services for depression, delivered by PHPs, should also be introduced.

Training emerged as a significant gap throughout this study, with PHPs receiving minimal mental health training both pre-service and through professional development. Training about depression detection and treatment should be enhanced and should be tailored to reflect locally appropriate symptoms of depression. Training programs must not be solely modeled on Western models that might be invalid or inaccurate in the local context. The successful integration of depression services in primary care will also require adequate support and supervision by mental health specialists and the allocation of adequate resources to support the staff members that implement these services. Community and family support services should also be expanded to complement the care delivered by the formal health sector (Goldner et al., 2015).

5) Expand the evidence-base about depression in Vietnam

Further research is needed in a number of areas related to depression in Vietnam. The issue of alcohol misuse among men emerged as an important challenge in Vietnamese communities; research is needed about both alcohol misuse among men and about the relationship between alcohol use and depression in this population.

Further research is also needed to understand the perspectives of community members in Vietnam, including research that considers the diversity of Vietnam, including its numerous ethnic minority populations. Research about the conceptualization of

depression, help seeking and existing care strategies will help to further inform the development of appropriate services for depression at the community level.

Finally, it is important to enhance research about the prevalence of depression and related risk factors in Vietnam. Epidemiological evidence is limited, and must be expanded. As described in Chapter 4, epidemiological data collection on depression must include measures and methods that account for construct validity and the dimensional aspects of depression so as to accurately capture the prevalence and impact of depressive disorders in Vietnam. Another gap is in research examining the risk factors for depression in the country, although there are a number of factors that are likely to act as determinants of depression in Vietnam. The country's history of conflict and of rapid socio-economic transition is likely to have an impact on the mental health of the population (Dzator, 2013; Lee et al., 2015; Phillips et al., 1999; World Health Organization, 2001). Other factors such increased rural to urban migration, an increase in precarious labour, gaps in access to health and social services and rates of substance use are also important in Vietnam and must be considered when examining mental health in the country (Van Huy et al., 2015; Vuong et al., 2011). PHPs involved in this study express concerns about the poverty and vulnerability of patients with mental health problems and their families, stressing the need for enhanced social and economic supports for the patients. Other factors that must be further explored through research are impacts of family and social pressures on mental health, the impact of domestic violence and, as previously mentioned, the issue of alcohol use and depression among men in Vietnam.

7.2.6. Next Steps

This study has identified a number of facilitators and barriers to the integration of services for depression in primary care, in addition to several areas that would benefit from further research. As described in Chapter 1, this study has taken place in the broader context of activities that are intended to enhance and expand services for depression in primary care in Vietnam. Beginning in 2016, the supported-self management intervention for depression and related training program for PHPs will be scaled-up to eight provinces in northern, central and southern Vietnam, and will be tested in an RCT. My involvement with this initiative, the leadership of Dr. Goldner and Dr. Vu Cong Nguyen and the

partnership with the implementing organizations in Vietnam represent an important opportunity for the findings of this study to inform the scale-up of this initiative.

Similarly, the relationship between SFU, PHAD and MOLISA, including our participation in the ongoing development of policy planning for enhanced community-based mental health services in the country, mean that there are significant opportunities for integrated knowledge translation to take place. The partnership with MOLISA represents an excellent opportunity for the findings of this study to inform further service development, however enhanced relationships with the Ministries of Health and Education are likely necessary for recommendations such as improved mental health training and improvements to the CMHP to take place. Overall, however, the momentum that is currently occurring in Vietnam towards the enhancement of community-based depression care, in addition to the favourable partnerships with key stakeholders in the country, represent an excellent opportunity for this study to contribute to the implementation of efforts to increase the integration of services for depression in primary care.

7.3. Balancing Global Mental Health and Transcultural Approaches: Lessons and Implications

The findings of this study have implications beyond Vietnam, and can contribute in several ways to the fields of global and transcultural mental health. As described above, this study explores the tension between the urgency of expanding availability, access and coverage of mental health services in LMICs and the need to ensure that these services are developed and implemented in such a way that they are valid and acceptable in the local context. This study examines the highly contextual conceptualization of depression in Vietnam, and the factors that might facilitate or impede the integration of services for depression in primary care. Although these factors are specific to Vietnam, the findings may inform similar investigations in other contexts. In particular, the inclusion of the cultural component in a study examining barriers and facilitators to the integration of mental health services in primary care is novel, and can shed light onto ways in which to navigate the important balance between the enhancement of service availability and coverage and the need to ensure that services are culturally and contextually appropriate.

Several considerations for the fields of global and transcultural mental health are discussed below.

7.3.1. Depression in a global context

At the core of this study is the question of whether ‘depression’ is a valid construct cross-culturally. The global mental health and transcultural psychiatry approaches were described in Chapter 3, with specific considerations for studying depression cross-culturally discussed in Chapter 4. While global mental health approaches to the question of mental illness do acknowledge that variations in mental illness experience exist across cultures, they argue that the universal experience of mental disorders is of most importance. Patel (2012) suggests that experts in global mental health and transcultural psychiatry are in agreement that:

...despite the important contextual influences on how mental disorders were experienced, explained and acted upon, these health conditions affected people in all cultures and societies and were neither a figment of the “Western” imagination nor a colonial export (Patel, 2012 7).

Proponents of a transcultural approach to mental health, however, remain critical that global mental health approaches are based on the assumption of the global prevalence of ‘neuropsychiatric disorders’, “which it assumes are biologically determined entities with stable features, course and outcomes” (Kirmayer & Pedersen, 2014 760). The question of the universality of the mental illness experience thus represents a persistent tension.

The results of this study, however, suggest that despite this divergence the approaches may be complementary. The findings of the narrative review described in Chapter 4 suggest that although depression as it is described in Western diagnostic systems should not be viewed as a uniform condition cross-culturally, experiences that may be described as “depressive states” seem to be experienced in all cultures (Jenkins et al., 1991). The diversity of the experience of depression is of fundamental importance. As described in Chapter 4, depression in “non-Western” societies may not be experienced as dysphoria or through introspection, but rather through somatic symptoms, relational, or intra-psychic experiences. The findings from Vietnam described in Chapter 5 support this; although depression as a construct is valid in Vietnam, the experience of depression

varies from what would be described as the norm in Western contexts. This distinction means that cross-cultural variations in the experience of depression must be reflected in approaches to diagnosis and treatment. As described in Chapter 4, improved epidemiological methodology must be adapted to make use of culturally validated measures and data collection techniques so as to ensure the category validity of data about depression prevalence in a global context.

When considering the convergence between global mental health and transcultural approaches, both the universality of depressive conditions and the cross-cultural variation in the experience of these conditions are of great importance. Global mental health proponents call attention to the fact that in many contexts people with mental disorders like depression suffer with no available treatment. They seek to improve the evidence base relevant to treating mental disorders in a global context and to mobilize resources for both research and action in this area. As a complement to these efforts, the transcultural approach to mental health is essential to ensure that efforts to enhance services for depression are grounded in the local experience and are valid and acceptable for the populations in which they are implemented.

7.3.2. Global mental health and the scale-up of services

At the centre of the global mental health mandate is a call to scale-up mental health services in low resource settings. In their 2007 call to action, the Lancet Global Mental Health Group (2007) argues that scaling up mental health services is the most important priority for global mental health. They recommend that mental health service scale-up be informed by “scientific evidence on cost-effective treatment”, a human rights-based approach and improved investment in global mental health research (Patel, 2012). Patel (2012) cites the mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings (World Health Organization, 2010) as providing a “foundation for scaling up” mental health services. He states that the existing body of research has answered the question of “what” needs to be scaled up, and that the outstanding research question is “how” to implement the process of scale up in countries. As described in Chapter 2, the Lancet Global Mental Health Group (2007) describes existing evidence on the effective delivery of mental health services in LMICs as “now

good”, while Patel and colleagues have advanced recommendations for “packages of care” for depression and other mental health disorders that might be scaled-up in low resources settings (Patel et al., 2009; Patel & Thornicroft, 2009). The question of how to implement this scale-up, including the integration of services for depression in primary care, is described as a pressing gap in the global mental health evidence (Becker & Kleinman, 2013).

Patel (2012) notes that the biggest barrier to achieving scale-up is the “enormous scarcity and inequality in the distribution of skilled human resources in low resource settings” (Patel, 2012 8) both between and within countries. Global mental health proponents state that evidence supports the effectiveness of task shifting to non-specialist providers as an effective way by which to achieve the scale-up of mental health services. They recommend task shifting to primary care providers, lay health workers and other non-specialists, while stressing the importance of specialists playing a supervisory role in order to ensure that task shifting approaches are effective (Eaton et al., 2011; Patel, 2012; Saraceno et al., 2007).

The findings from Vietnam suggest that for task shifting approaches to be effective, numerous other mechanisms must be put in place to support the role of PHPs in the delivery of depression care. These include enhanced training both in pre- and in-service contexts that improve the mental health knowledge and capacity of all PHPs. Such training must include instruction that reflects culturally and contextually appropriate constructs and approaches to screening and treatment. Enhanced resources and improved compensation for PHPs will also be essential to the effective delivery and eventual scale-up of these services. Support, supervision and monitoring by specialists are also described as critical to the effectiveness of task shifting approaches (Eaton et al., 2011; Patel, 2012; Saraceno et al., 2007). The role of specialists must be enhanced to ensure that providers are supported in their role and in order to maintain quality of service delivery. The successful implementation of task shifting approaches will likely require the participation of numerous sectors, including the health, social services and education sectors. It also requires concerted policy commitment by governments to ensure that mental health systems overall are strengthened. As described above, programs and policies that are in place must work to support the effective integration of services in

primary care. Where such programs might impede the delivery of comprehensive services, including psychosocial and pharmacological interventions, at the community level they must be revisited and revised to ensure that they do not in fact hinder effective service delivery.

This study also suggests that task shifting may be beneficial as more than a solution to mental health human resource scarcity. PHPs have valuable insight into communities that might be missing among specialists or health care practitioners working at higher levels of the health system. The unique contextual knowledge that PHPs possess as both clinicians and community members can therefore help to enhance the cultural acceptability of services when they are integrated into primary care. This is consistent with studies on task shifting for the delivery of mental health services in other contexts (Mendenhall et al., 2014). As efforts to enhance mental health service delivery through task shifting approaches are expanded in LMICs, consideration should be paid to the contextual knowledge and local experience of PHPs and lay health workers. Capturing their knowledge and involving them in the development of services can help to ensure that enhanced mental health services are appropriate for the local context.

The call to scale-up mental health services through task shifting in LMICs is based on several claims that are outlined above, including the existence of sufficient evidence about effective mental health service delivery in low resource settings and the existence of a critical gap in mental health service provision. These claims warrant some interrogation and discussion in order to explore how a transcultural approach to mental health might complement the global mental health perspective and thus strengthen approaches that seek to scale-up services for depression in LMICs through task shifting. These issues are discussed below.

7.3.3. Responding to the call for mental health service scale-up

As described above, the global mental health call to scale-up services for mental health in low resource settings through task shifting is based upon the claim that evidence about what types of services should be scaled-up is sufficient. Kirmayer and Pedersen (2014) note that this claim assumes that “standard treatment can be readily applied across

cultures with minimal adaptation” (Kirmayer & Pedersen, 2014 760) and express concern that in the exigency of responding to the gap in mental health services in the global context, approaches to mental illness and its treatment will be introduced that are not culturally or contextually appropriate. They also caution that with the emphasis placed on the importance of scale-up the types of approaches introduced may be predetermined and emphasize medications or simple behavioural interventions rather than undertaking to design or implement more appropriate treatments, including psychosocial interventions.

This study demonstrates that within the global mental health mandate of addressing a gap in mental health treatment through the integration of mental health services in primary care, it is both important and possible to assess local contextual factors prior to the scale-up of services. But while Patel (2012) argues that the “what” of scale-up has already been answered in the global mental health evidence base, the results from Vietnam suggest that contextually-based investigation about both the “what” and “how” remain important. The findings about how depression is conceptualized in Vietnam demonstrate that depression is largely understood in psychosocial and relational terms, suggesting that psychosocial interventions are likely to be most appropriate and effective for patients in that context. The study also showed that help-seeking for depression in primary care is low, and that the emphasis on program delivery in many CHSs means that community outreach and other steps may be needed to ensure that community members are screened and that depression services reach those who need them. Contextual research of this nature is therefore necessary prior to introducing new interventions in order to ensure that it is both contextually and culturally appropriate.

The nature of the evidence on which the call to scale up services is based is also an important methodological factor to consider. Kirmayer and Pedersen caution that “evidence based practice makes many assumptions about the nature of evidence, its means of production and application in practice” (Kirmayer & Pedersen, 2014). Though they note that the commitment to evidence-based practice has been an important step in lessening the potential bias in research that might occur with, for example, influence from the pharmaceutical industry, they argue that research remains influenced by specific forces that might bias how it is produced, interpreted and applied. They acknowledge that global mental health research is currently working to increase the evidence base about

psychosocial interventions, but stress that this research must include the study of community-based approaches, resources and coping strategies that exist indigenously. They argue that global mental health intervention research must also meaningfully consider local contexts and needs. This study used a mixed methods approach to understand barriers and facilitators to the integration of mental health services in primary care. The inclusion of qualitative research was essential to understanding the ways in which depression is conceptualized in Vietnam, in addition to fostering a deeper understanding of the contextual factors that might influence the delivery of services for depression in primary care. This points to the importance of qualitative inquiry in global mental health research, as it can enrich crucial understandings of culture and context and thus inform the development and implementation of services for depression that are meaningful in the local context.

Green (2001) raises a concern about the type of research that is prioritized and valued, questioning the applicability of the results of RCTs when applied to diverse populations and contexts due to the highly controlled nature of the study environment. Discussing the concept of 'best practices' for interventions in diverse populations, he suggests that more helpful than using research to inform universal 'best practices' for health interventions would be to develop best practices for the *process* of planning interventions. This, he argues, could involve ways in which to engage communities, ways in which to assess community needs and context, the identification of existing resources, etc. This, he argues, would lead to the ability of local planners to adapt interventions to their circumstances in a way that would make them more effective and facilitate their implementation. In this study, I have used mixed methods to assess barriers and facilitators to the integration of depression services in primary care in Vietnam. Using a methodology that incorporates global mental health, transcultural psychiatry and Contextual Interaction Theory, I assessed numerous factors and processes that will inform planning for the integration of services in primary care and which capture the local context, from cultural factors to the training, resources and workflow of PHPs. While the results are specific to Vietnam, the approach may be used in other contexts to inform the planning of mental health service integration in primary care. The findings of the study do suggest that this type of analysis is necessary to inform mental health service integration in primary

care; research that is embedded in local context and captures contextual realities is necessary to inform approaches to intervention and scale-up within specific contexts.

Related to this is the persistent gap in research from LMICs on mental health interventions. As described in Chapter 2, there is a large gap in mental health research that is based on LMICs (Patel et al., 2007). While investment in global mental health research has grown in the last decade, there remains a need to enhance the evidence-base. This includes, as described above, studies that capture the local and cultural contexts of LMICs using qualitative and mixed methods. There is also a need to strengthen research capacity in LMICs to ensure that research is responsive to local priorities and that global mental health leadership is fostered within these countries (Ruiz-Casares, 2014).

As previously described, the call to scale-up mental health services is a response to a gap in treatment for mental illnesses in many LMICs. This gap in formal treatment is certainly an urgent problem that has led to the needless suffering of many people. As Kleinman (2009) argues, it has been a “failure of humanity”. While this gap in services for people with mental health problems must certainly be addressed, it is also important to understand and acknowledge existing systems that may be used in countries or within communities to address mental distress (McKenzie et al., 2004). Kirmayer and Pedersen argue that although global mental health is established on the language of psychiatry, “there are local ways of understanding mental health and social problems that are important to understand, not only because they govern help-seeking and coping but also because they may provide novel strategies for intervention” (Kirmayer & Pedersen, 2014 769). They argue that understanding the ways in which people in communities cope with and address distress can inform treatment and prevention efforts. Understanding culture, they argue, is not only relevant at the individual level, but is also essential to inform policy, systems and services.

The results of the study in Vietnam support the importance of understanding local experiences of and approaches to depression. In the rural area of Hanoi, PHPs describe how community members often conceptualize mental ill health in spiritual terms, attributing the experience to ancestral ghosts and seeking spiritual help by visiting pagodas or

making offerings to ancestors. PHPs also describe the use of traditional medications such as lotus tea to treat the symptoms of depression such as sleep loss. These local understandings are important for the development of mental health services as they can help to better understand help seeking for mental distress among communities. The attribution of depression symptoms to spiritual causes suggests that people would be unlikely to seek medical help for such symptoms. This means that efforts to enhance supports should consider these spiritual explanatory models both in terms of screening for depression and in developing approaches to care that are locally relevant and acceptable.

This study also demonstrates that the experience of depression is psychosocial and relational, and that the family plays a central role as both the potential cause of mental distress and a source of support to the patient. This suggests that depression interventions must take into account the role of the family and the ways in which they currently cope with family members who experience symptoms of depression. Understanding these existing explanatory models and coping strategies is important for the further enhancement of strategies to care for people with depression. Similar attempts should be made in other settings to capture existing local approaches to care and help seeking for mental illnesses (Kirmayer & Pedersen, 2014; McKenzie et al., 2004).

The scale-up of task shifting approaches in LMICs is an important way to enhance service availability and accessibility for people living with mental illnesses in those countries. These efforts, however, should be preceded by research that explores the contextual factors, including culturally based understanding and experiences of mental illness, that are essential to planning for and delivering services. These contextual factors should inform the development of approaches to diagnose and treat mental illness, and to inform efforts to address help seeking and mental health awareness-raising. These approaches should be complementary to local systems of coping and care, ensuring that they are relevant to the communities in which they are implemented.

7.3.4. Mobilizing action: balancing global and transcultural approaches

As discussed in Chapter 4, the gap in services for mental health disorders is related to the scarcity of funds allocated to mental health by national governments and

international funding agencies. While there has been increased funding in global mental health in recent years (Patel, 2012), the funding allocated to mental health by international donors lags far behind funding for other global health priorities (Saraceno et al., 2007). As previously noted, the global mental health movement has used the universality of mental illness as rationales and appeals for action to increase investment in mental health globally. In global mental health advocacy, such a focus on universality can be an uncomfortable juxtaposition to an emphasis on the role of transcultural approaches to mental health. Saraceno et. al. (2007) notes that “contradictory messages” due to the differing perspectives of mental health leaders and advocates might be unappealing to funders; they found that this fragmentation across mental health stakeholders has been an impediment to progress on mental health investment and improvement in some countries. They also note that mental health issues and concepts are not easy to communicate in a way that appeals to funders. Indeed, a common misconception is that mental health problems like depression are “Western” exports or even complaints reserved for the affluent. What is the risk, then, of emphasizing the cultural variation in the experience in mental illness?

The findings of this study do suggest that depression is experienced in Vietnam in a way that is distinct from the experience of depression in Western countries and that efforts to improve depression care must therefore take into consideration these cultural and contextual issues in order to ensure that services are valid and acceptable. But with this finding also comes the evidence that depression does exist in Vietnam; it is a meaningful construct that causes suffering and impedes functioning, and for which treatment is largely non-existent. The core message that action, including increased investment and research on mental health in LMICs is urgently needed is not lost when cultural variation in the experience of depression is described. The suffering of people with mental illnesses who have no access to treatment should mobilize funders to invest in mental illness. These investments, however, must be made in such a way that respects the cultural and social context in which services will be developed. A “one size fits all” approach will not work and will lead to waste of resources and, at worst, harm.

Steps to improve services for mental illnesses in LMICs must account for this balance between the urgency of the need and the imperative of contextual

appropriateness. Research that examines the cultural and contextual environment in which services will be integrated prior to developing, testing and scaling-up these interventions is essential. Partnerships with local stakeholders, including health care providers, communities, governments and NGO's will also help to ensure that the enhancement of mental health services is responsive to local priorities and appropriate for the local context. This study provides a deep contextual understanding of the concept of depression in Vietnam and the primary care context in which services for depression will be introduced. Ongoing efforts, working with local government and NGO partners, to scale-up services for depression in Vietnam present an important opportunity for this research to inform the delivery of services for depression in primary care in Vietnam. The approach taken in this study also demonstrates the necessity of embedding a comprehensive understanding of local experiences of mental illness and the context in which services are to be delivered into efforts to enhance mental health service delivery. This approach is essential to pursuing the integration of enhanced services for mental illness and their scale-up in a way that is meaningful, appropriate and respectful of local context and of the individuals who suffer from mental illnesses like depression.

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Appendix A.

Semi-structured interview schedule

Interview # _____

Barriers and Facilitators to the Integration of Mental Health Services in Primary Care in Vietnam from the Perspective of Health Workers: Individual, Organizational and Structural Factors

Date: _____

Sex of respondent: _____

Introduction (to be read by interviewer):

Thank you for agreeing to participate in this interview and for completing a consent form for the study entitled “Barriers and Facilitators to the Integration of Mental Health Services in Primary Care in Vietnam from the Perspective of Health Workers: Individual, Organizational and Structural Factors”. I’d like to remind you that I’m conducting this research as part of my PhD in Health Sciences at Simon Fraser University in Canada, and that I’m working in partnership with the Institute of Population, Health and Development in Hanoi.

My purpose with these interviews is to understand what factors might make it harder or easier for doctors and nurses working in commune health centres to integrate services for common mental disorders like depression into their everyday practice. With the help of my interpreter I’m going to ask you 25 questions about patients with mental health problems, your experience treating people with common mental disorders, about how you think about people with common mental disorders and treating them, about your training and about your work environment. The purpose of this study is not to assess the quality of primary care in Hanoi, but rather to understand the work and day to day experience of health workers. The overall goal of the study is to learn how to ensure that any steps to integrate mental health services into primary care are appropriate and meet the needs of health workers.

I’m going to start by asking you some general questions and will then ask you to tell me about patients with mental health problems based on your experience. After that, I’ll ask you some more specific questions about working with patients with mental health problems, about your training and experience, and about your work load. I’d be happy to answer any questions you have before we begin.

What is your date of birth? _____

What is your professional role? _____

How long have you worked in your current job? _____

Can you tell me a bit about a typical day for you? [Probing questions: When does it start? When does it end? Do you take breaks? How many patients do you see on an average day? What are the common health issues that you deal with? How long to do usually spend with a patient? Is it usually enough time? Do adult patients usually come alone or with family members?]

In general, what types of health issues would you say are given the most time and resources at this CHC? Why do you think these priorities have been chosen?

Part 1 Preamble:

We know that although mental health problems are experienced by people all over the world, that they can often be experienced differently by different cultures. The symptoms people experience and the words they use to describe them, for example, can be different around the world. Understanding more about how mental health problems are experienced in specific cultures can help us to better understand how to treat and care for people with mental health problems around the world. So far, there hasn't been much research on how mental illness is experienced specifically in Vietnam. Because you are both a health worker and a community member, you have special expertise in how local people experience illness. We're going to ask you some questions about your experiences with patients or people in your community.

Please think about someone who might have a severe mental health problem:

What types of symptoms does the patient have?

How does the patient act?

Are there symptoms that specifically affect a person's: 1) mind? 2) body? 3) emotions?

What words might the patients use to describe their symptoms or feelings?

What words might the patient's family use to describe how the patient is feeling or acting?

Is there a medical name for the symptoms that this patient has?

Is there a traditional or informal name for the symptoms that this patient has?

What type of person is most likely to experience this problem? (Are they a man or a woman? What is their family situation? What is their economic situation? What other things might make them more likely to experience this problem?)

How would you interact with the patient? What would happen during your appointment? What questions would you ask? What if any tests would you order? What else would you do?

Any other comments about your experience with patients like this?

(If they haven't talked about depression yet) Can you please think about a patient who has depression? *(If they aren't familiar with depression)* Can you think of a time that a patient's emotional distress made it hard for them to function in their daily life?

What types of symptoms does the patient have?

How does the patient act?

Are there symptoms that specifically affect a person's: 1) mind? 2) body? 3) emotions?

What words might the patients use to describe their symptoms or feelings?

What words might the patient's family use to describe how the patient is feeling or acting?

Is there a traditional or informal name for depression or emotional distress?

What type of person is most likely to experience this problem? (Are they a man or a woman? What is their family situation? What is their economic situation? What other things might make them more likely to experience this problem?)

How would you interact with the patient? What would happen during your appointment? What questions would you ask? What if any tests would you order? What else would you do?

Any other comments about your experience with patients like this?

Would you like to add anything or say anything more about mental health problems among your patients?

Part 2:

Of the patients you see in an average month, how many would you say suffer from mental illness? What types of mental illnesses do they suffer from?

How significant an issue are common mental disorders like depression among patients visiting commune health centres?

What types of specific services, interventions or resources do people with common mental disorders like depression who visit commune health centres need?

What types of skills do people that treat people with mental disorders need to have to offer these services? What type of resources do they need to have?

Are there any challenges related to providing mental health services at this CHC? For example, do you have enough medications? What about training? What about working with the patients? Anything else?

In general, who is the most appropriate person to diagnose and treat people with depression?

Do you think that diagnosing and treating someone with depression is something that you can do? Do you think that diagnosing and treating people with depression should be part of your job? (Probing questions: do you think it is part of your role to work with patients with mental illness? Why? Why not? If not, what types of services and providers are more appropriate or more prepared?)

How do you think people in your community feel about people with common mental disorders like depression or anxiety? (Follow-up questions: what would they think causes depression or anxiety? What would they think about the character of someone with depression or anxiety? What type of opinion would they have about someone with depression or anxiety?)

What do people in your community think should be done about people who have mental health problems?

What do you think people in the health sector (like other people with the same job as you) community think about mental health? For example, what would they think about someone who decides to study psychiatry/ mental health nursing?

Part 3:

Tell me about the type of mental health training you received in medical/ nursing school. (Follow-up; What types of training? How much? Did you receive training

on common mental disorders like depression and anxiety? Was it offered to everyone? If not, why did you choose to take it?)

Have you ever received professional development training on mental health? (If yes, can you please describe it? Why did you take it? Was it mandatory? Did your colleagues also take it?)

Does your commune health centre do anything specific to make mental health services available to patients? If yes, have they done this since you've been working here? If not, when did they start? What motivated them to start?

OPTIONAL: What types of health issues are prioritized on a national level? (Follow up: why do you think these issues have been prioritized? By whom? How do these priorities get identified? How do they play out in the day-to-day operations of a commune health centre (e.g. funding, training opportunities, available medicines?)

If you were offered the opportunity to strengthen your ability to diagnose and treat common mental disorders (e.g. additional training courses, use of new screening tools, for example) what would be your reaction? (Probing questions: do you feel like you have enough time to do this? Do you feel like these skills could fit in with the rest of your workload?) What types of information, support or resources would help?

Appendix B.

Survey Questionnaire

“Barriers and Facilitators to the Integration of Mental Health Services in Primary Care in Vietnam from the Perspective of Health Workers: Individual, Organizational and Structural Factors”.

Doctoral Research Study for PhD in Health Sciences, Faculty of Health Sciences, Simon Fraser University, Vancouver, B.C., Canada

Researcher: Gillian (Jill) Murphy, PhD Candidate, Simon Fraser University

Thank you for agreeing to complete this questionnaire. As described in the consent form, the purpose of this study is to understand the factors that may influence the success of programs to improve the integration of services for Common Mental Disorders such as depression and anxiety in commune health centres in Hanoi, Vietnam.

While we use the term “Severe Mental Disorders” to refer to conditions such as schizophrenia and epilepsy, the term ‘Common Mental Disorders’ refers to conditions such as depression, anxiety and medically unexplained somatic symptoms (known as ‘somatization’) which are common in primary health care populations in many parts of the world. . This questionnaire will take approximately 30 minutes to complete.

Please remember that your participation in this questionnaire is completely voluntary.

If you have any questions or concerns about the study you can contact me at: [...] or by phone at [...].

By filling out this questionnaire, you are consenting to participate: CONTINUE SURVEY	
By filling out this questionnaire, you are consenting to participate: EXIT SURVEY	
Questions	Responses

1: What is your professional role?	<ul style="list-style-type: none"> 1. Doctor 2. Doctor's Assistant 3. Other (please specify)
2. What is your gender?	<ul style="list-style-type: none"> 1. Female 2. Male
3. Please select the type of professional qualification you have.	<ul style="list-style-type: none"> 1. 6 year Medical degree 2. Masters Degree in Medicine (Please Specify Specialty) 3. Nursing degree 4. Other (Please specify)
4. In what year did you complete these qualifications?	Select from drop down menu
5. During your training, was any time given to learning about mental disorders?	<ul style="list-style-type: none"> 1. Yes 2. No 3. Not applicable
6. If you selected "yes" for #5, approximately what percentage of time was dedicated to learning about mental disorders during your training?	Fill in:
7. Have you taken additional training about mental health as part of your professional development?	<ul style="list-style-type: none"> 1. Yes 2. No
8. If you answered "yes" to #7, please indicate when (in years) you took this additional training.	<ul style="list-style-type: none"> 1. Within the last year 2. [Fill in] years ago
9. If you answered "yes" to #7, please indicate where the training was offered.	<ul style="list-style-type: none"> 1. My commune health centre 2. My district health centre 2. Bac Mai Hospital/ National Institute of Mental Health 4. Other (please specify)
10. Please select your level of agreement with the following statement: In my current professional role, I would benefit from more training about mental disorders.	<ul style="list-style-type: none"> 1. Strongly agree 2. Somewhat agree 3. Somewhat disagree 4. Strongly disagree 5. Not applicable
11: Approximately how many patients do you see during an average week?	Fill in:

12. Of the patients you see in an average week, do you usually see any patients that suffer from a mental illness?	1. Yes 2. No
13. If you selected "yes" for #12, approximately how many patients do you see during an average week that suffer from a mental illness?	Fill in:
14. If you selected "yes" for #12, approximately how many patients do you see during an average week whose primary reason for consultation is a mental illness?	Fill in:
15. If you selected "yes" for #12, approximately how many of the patients that you see in an average week suffer specifically from a Severe Mental Disorder (e.g. schizophrenia, epilepsy)?	Fill in:
16. If you selected "yes" for #12, approximately how many of the patients that you see in an average week suffer specifically from a Common Mental Disorder (e.g. depression anxiety or and somatization)?	Fill in:
<p><i>Please use to following statement to respond to questions 17 and 18:</i></p> <p>As a health care worker, you deal with many different health concerns among patients. Thinking about the full spectrum of health concerns that affect your patients, how would you rate Common Mental Disorders such as depression in terms of:</p>	
17. Relative prevalence in the commune health centre patient population?	1. High prevalence 2. Moderately high prevalence 3. Moderately low prevalence 4. Very low prevalence 5. Not applicable
18. Relative prevalence in the community in general?	1. High prevalence 2. Moderately high prevalence 3. Moderately low prevalence 4. Very low prevalence 5. Not applicable
19. Relative severity in terms of impact on patients' lives?	1. High severity

	<ul style="list-style-type: none"> 2. Moderate severity 3. Moderately low severity 4. Low severity 5. Not applicable
<p>20. Please select your level of agreement with the following statement: Commune health centres are the appropriate place for people with depression and other Common Mental Disorders to receive care.</p>	<ul style="list-style-type: none"> 1. Strongly agree 2. Somewhat agree 4. Somewhat disagree 5. Strongly disagree
<p>21. Reflecting on your own experience, how confident are you that you can diagnose a patient with a Common Mental Disorder such as depression?</p>	<ul style="list-style-type: none"> 1. Very confident 2. Somewhat confident 3. Not very confident 4. Not at all confident 5. Not applicable
<p>22. Reflecting on your own experience, how confident are you can effectively treat a patient with a Common Mental Disorder such as depression?</p>	<ul style="list-style-type: none"> 1. Very confident 2. Somewhat confident 3. Not very confident 4. Not at all confident 5. Not applicable
<p>23. Please select your level of agreement with the following scenario: Your friend just told you that he suffers from depression. You no longer want to spend time with him socially.</p>	<ul style="list-style-type: none"> 1. Strongly agree 2. Somewhat agree 3. Somewhat disagree 4. Strongly disagree
<p>24. Please select your level of agreement with the following scenario: Your sister-in-law complains of headaches and pain in her limbs that could not be diagnosed medically and which has affected her ability to perform daily tasks. You think she is being lazy.</p>	<ul style="list-style-type: none"> 1. Strongly agree 2. Somewhat agree 3. Somewhat disagree 4. Strongly disagree
<p>25. Please select your level of agreement with the following scenario: Your neighbour is fearful of leaving his house and has been diagnosed with an anxiety disorder. You feel uncomfortable with him living nearby.</p>	<ul style="list-style-type: none"> 1. Strongly agree 2. Somewhat agree 3. Somewhat disagree 4. Strongly disagree
<p>26. Please select your level of agreement with the following scenario:</p>	<ul style="list-style-type: none"> 1. Strongly agree

<p>Your colleague has recently returned to work after taking time off to undergo treatment for depression.</p> <p>You are confident in her ability to do her job effectively.</p>	<p>2. Somewhat agree</p> <p>3. Somewhat disagree</p> <p>4. Strongly disagree</p>
<p>27. Does your commune health centre have a specific protocol for providing mental health services to patients (e.g. diagnosis, training)?</p>	<p>1. Yes</p> <p>2. No</p> <p>4. Don't know</p>
<p>28. Does your commune health centre have a specific protocol for providing referrals to patients with mental health problems?</p>	<p>1. Yes</p> <p>2. No</p> <p>4. Don't know</p>
<p>29. Have you been involved in discussion(s) with other coworkers about providing mental health services to patients?</p>	<p>1. Yes</p> <p>2. No</p>
<p>30. If you answered "yes" to #29 , did the discussion(s) take place in a formal meeting?</p>	<p>1. Yes</p> <p>2. No</p>
<p>31 . If you answered "yes" to #29, did the discussion(s) take place informally (e.g. among colleagues at lunch or during a break)?</p>	<p>1. Yes</p> <p>2. No</p>
<p>32 . If you answered "yes" to #29, did the discussion(s) include managers or directors of the commune health centre?</p>	<p>1. Yes</p> <p>2. No</p>
<p>33. If you identified that a patient was suffering from a Common Mental Disorder such as depression, what would you do?</p>	<p>1. Refer them to the district health centre</p> <p>2. Refer them to a general hospital</p> <p>3. Refer them to a psychiatric hospital</p> <p>4. Prescribe medication</p> <p>5. Other (please specify)</p>
<p>34. When patients are prescribed medications for Common Mental Disorders such as depression, where would they usually access these medications? (Chose all that apply)</p>	<p>1. From a pharmacist at the commune health centre</p> <p>2. From a private pharmacy</p> <p>3. From a hospital pharmacy</p> <p>4. Other (please specify)</p>
<p>35. When patients are prescribed medications for Common Mental Disorders such as depression (e.g. antidepressant medications), are you concerned about their ability to access these medications?</p>	<p>1. Yes</p> <p>2. No</p> <p>3. Sometimes</p>

<p>36 . If you answered "yes" or "sometimes" to #35, why wouldn't patients be able to access these medications? (Chose all that apply)</p>	<ol style="list-style-type: none"> 1. They are unavailable in the pharmacy 2. They are too expensive for patients to afford 3. Other (please specify)
<p>37 . Is privacy (e.g. an examination room where no other patients can see or overhear) necessary for consulting with patients with Common Mental Disorders such as depression?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 3. Sometimes 4. Not applicable
<p>38 . If you answered "yes" or "sometimes" to #37, does your commune health centre have private space available to allow for effectively consulting with patients with Common Mental Disorders such as depression?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 3. Sometimes
<p>39 . Please select your level of agreement with the following statement: Our commune health centre would be able to provide better care to people with Common Mental Disorders such as depression if we had more staff.</p>	<ol style="list-style-type: none"> 1. Strongly agree 2. Somewhat agree 3. Somewhat disagree 4. Strongly disagree 5. Not applicable
<p>40 . Please select the most accurate response to the following statement: The number of patients I see each day makes my workload difficult to manage.</p>	<ol style="list-style-type: none"> 1. Always 2. Sometimes 3. Never
<p>41 . Please select the most accurate response to the following statement: The number of patients I see each day causes me stress.</p>	<ol style="list-style-type: none"> 1. Always 2. Sometimes 3. Never
<p>42 . Please select the most accurate response to the following statement: I wish I were able to spend more time during consultations with my patients.</p>	<ol style="list-style-type: none"> 1. Always 2. Sometimes 3. Never
<p>43 . Please select your level of agreement with the following statement: The amount of paper work I have each day makes my workload difficult to manage.</p>	<ol style="list-style-type: none"> 1. Always 2. Sometimes 3. Never 4. Not applicable
<p>44 Please select your level of agreement with the following statement: My responsibilities related to specific programs makes my workload difficult to manage.</p>	<ol style="list-style-type: none"> 1. Always 2. Sometimes 3. Never 4. Not applicable

<p>45. Please select your level of agreement with the following statement: The amount of paper work I have each day causes me stress.</p>	<p>1. Always 2. Sometimes 3. Never 4. Not applicable</p>
<p>46. Please select your level of agreement with the following statement: Given my current workload, I feel confident that I could take the time to learn new skills.</p>	<p>1. Strongly agree 2. Somewhat agree 3. Somewhat disagree 4. Strongly disagree 5. Not applicable</p>
<p>47 . Please select your level of agreement with the following statement: Given my current workload, I feel confident that I could put new skills into practice.</p>	<p>1. Strongly agree 2. Somewhat agree 3. Somewhat disagree 4. Strongly disagree 5. Not applicable</p>
<p>48. Please select your level of agreement with the following statement: I would be reluctant to learn and implement new skills without being offered an increase in my salary or benefits.</p>	<p>1. Strongly agree 2. Somewhat agree 3. Somewhat disagree 4. Strongly disagree 5. Not applicable</p>
<p>49 . Please select your level of agreement with the following statement: I would like to learn more about diagnosing and treating people with Common Mental Disorders such as depression.</p>	<p>1. Strongly agree 2. Somewhat agree 3. Somewhat disagree 4. Strongly disagree</p>
<p>49 . Is there is a person at your commune health centre who has taken a leadership role to improve services for people with Common Mental Disorders such as depression?</p>	<p>1. Yes 2. No 3. Don't know</p>
<p>50. As far as you know, is there a national policy about mental health?</p>	<p>1. Yes 2. No 3. Don't know</p>
<p>Please feel free to provide any additional comments that you think might be relevant to this study:</p>	