Published in final edited form as:
J Cogn Psychother. 2014 ; 28(3): 156–167.

The Vietnam Multicomponent Collaborative Care for Depression Program: Development of Depression Care for Low- and Middle-Income Nations

Victoria K. Ngo, PhD,
The RAND Corporation, Santa Monica, California

Bahr Weiss, PhD,
Vanderbilt University, Nashville, Tennessee

Trung Lam, MD,
Da Nang Psychiatric Hospital, Da Nang, Vietnam

Thanh Dang, MD,
Khanh Hoa Psychiatric Hospital, Nha Trang, Vietnam

Tam Nguyen, MS, and
Basic Needs Vietnam, Hanoi, Vietnam

Mai Hien Nguyen, MD
Vietnam Veterans of America Foundation, Hanoi, Vietnam

Abstract

In this article, we discuss the Vietnam Multicomponent Collaborative Care for Depression Program, which was designed to provide evidence-based depression care services in low-resource, non-Western settings such as Vietnam. The article provides the program development background; the social, economic, and political context in which the program was developed; and the structure and content of the program and their underlying rationale in the context of rural Vietnam. Although the program was found to be acceptable, feasible, and effective in reducing depression outcomes, we did face challenges in implementation, which are outlined in this article. Key challenges included cultural factors (e.g., a lack of recognition of depression as a health-related entity amenable to professional treatment, relatively low levels of psychological mindedness useful for understanding of psychological interventions) and health system (e.g., lack of mental health specialists, overburdened health providers unfamiliar with behavioral interventions) factors. We discuss the strategies we employed to resolve these challenges and our successes and failures therein. We conclude with recommendations for others interested in implementing similar programs in low- and middle-income countries settings.

Correspondence regarding this article should be directed to Victoria Ngo, PhD, Rand Corporation, 1776 Main Street, Santa Monica, CA 90407-2138. vngo@rand.org.

Keywords

depression care; low- and middle-income countries (LMIC); collaborative care; task shifting; primary care integration

By 2030, unipolar depression is projected to be among the largest contributor to the world's healthcare burden in both high-income countries (HIC) as well as low- and middle-income countries (LMIC; Mathers & Loncar, 2006). It has been estimated that at any point in time, about 99 million people around the world would be suffering from depression (World Health Organization [WHO], 2008). Although effective mental health treatments exist for depression, most individuals experiencing depression fail to receive appropriate treatment. According to the WHO *Mental Health Atlas* (2011), this mental health resources and treatment gap is particularly large in Asia, the world's most populous continent. Several factors underlie this treatment gap, including individuals' lack of awareness of or access to resources, poor quality of care, stigma regarding mental health treatments, and cost of services (WHO, 2011); foremost among these factors, however, is a severe shortage of mental health professionals globally (WHO, 2006).

V_{IETNAM}

This article focuses on the Southeast Asian nation of Vietnam. With a population of more than 92 million, it is the 14th most populous country in the world (Central Intelligence Agency, 2013). The per capita annual gross domestic product (GDP) is $1,596, placing it in low- to middle-income national status (World Bank, 2012). As with many LMIC, because Vietnam began to transition from a primarily rural, agricultural economy to a more mixed industrial economy, its government made an explicit decision to focus the nation's limited resources on expanding infrastructure most directly connected to economic development (e.g., roads, seaports) with health—in particular mental health—and other social services receiving relatively little investment (Stern, 1998). The focus on economic development was successful at the national level: Vietnam is considered "a development success story" by the World Bank, with current GDP growth of about 5% per annum, having dropped from about 7.5% per annum subsequent to the 2007 world recession (World Bank, 2012). However, health and related services' infrastructure has not developed comparably. Despite the general economic development, access to health care has actually become more difficult for some segments of the population as demand has expanded, and certain aspects of the system have become privatized and less supported by government subsidies (Vuong, Van Ginneken, Morris, Ha, & Busse, 2011).

Comparable to its Southeast Asian neighbors, Vietnam spends about 6.8% of its GDP on health care (WHO, 2013). Health care is provided in a four-tier system, at the (a) central (national hospitals), (b) provincial, (c) district, and (d) commune (which represents approximately 10,000 persons) levels, with the primary care point of entry into the system the commune health station (CHS). In the 5-year health development plan from the Vietnamese Ministry of Health (MOH; 2010), the availability of more advanced medical procedures such as organ transplant and endoscopic surgery in at least some areas of the country is noted. However, although "community mental health" is mentioned as a national

health target, the discussion of mental health consists of three sentences in the 51-page report, reflecting overall MOH priorities. Schizophrenia and epilepsy are mentioned but not depression. With the exception of upper- and upper middle–class individuals in the two major cities (Ho Chi Minh City and Hanoi), access to mental health services is provided through a network of 27 provincial psychiatric hospitals distributed across the 64 provinces or through mental health departments in district-level general hospitals (Niemi, Malqvist, Giang, Allebeck, & Falkenberg, 2013). These facilities focus mainly on schizophrenia, bipolar disorder, and epilepsy but not depression.

The Vietnam MOH has recognized some need for treatment resources for common mental health problems such as depression and anxiety and has formulated a 5-year mental health plan that extends services to CHS (MOH, 2010). Because of budget restrictions, however, implementation has been limited. At the time of our project initiation, depression care in primary care was essentially nonexistent and available older generation medications (e.g., tricyclics) were the primary treatment option for depression.

Social factors play a key role in limiting access to mental health care. As in most countries —HIC as well as LMIC—stigma can have a significant impact on help seeking in Vietnam, underlying lack of access because individuals with mental illness avoid seeking help because of shame or fear of discrimination (Vuong et al., 2011). Mental health treatment in Vietnam also faces additional specific challenges, particularly for common mental health conditions such as depression (as opposed to treatment of schizophrenia and seizure disorders). These include (a) a cultural lack of recognition of depression as a disease entity that can be ameliorated through the medical system, in particular through psychiatry; (b) a lack of psychological-mindedness, which can make implementation of psychotherapies involving cognitive components especially challenging; (c) a lack of mental health personnel at all levels; and (d) even within the current mental health personnel, almost no training regarding evidence-based screening and behavioral treatment options for depression (Niemi et al., 2013).

In Vietnam as in many other LMIC, what is called “depression” based on Western conceptualizations may be unrecognized as a discrete pathological entity by many within the population. In Asia, depression typically presents with a mixture of negative affect and somatic complaints, emphasizing the latter (Phan, Steel, & Silove, 2004). When they do seek help, Vietnamese often use traditional approaches (e.g., herbal medicines, native healers), compounding challenges for health personnel’s attempts to provide treatment.

Vietnam faces a severe shortage of mental health specialists, as is true for most LMIC. This has been exacerbated by unintended consequences of increased freedom within Vietnam. Previously, graduating medical students were assigned specialties by the government based on the country’s needs as perceived by the government. With freedom to choose ones’ specialty now instituted, few medical students choose psychiatry (Vuong et al., 2011). This lack of new psychiatrists entering the system exacerbates the existing shortage of mental health professionals, although a recently opened graduate program in clinical psychology is producing a small number of evidence-based-trained clinical psychologists (Weiss et al., 2011) who may begin to address this shortage.

Task Shifting in Primary Care

Task shifting or task sharing of mental health care is one approach used to address shortages of mental health resources in LMIC. They involve focused and relatively brief training of non–mental health workers (e.g., general practitioners [GPs], nonmedical personnel) with a circumscribed and highly structured role (Fulton et al., 2011; Patel, Simon, Chowdhary, Kaaya, & Araya, 2009). For instance, physician's assistants might be trained to conduct depression screenings using a depression interview but would have no training or competency in other aspects of mental health care. Such a strategy is not new and has been used for decades within other areas of medicine (e.g., HIV care; Lewin et al., 2005). Regarding mental health, relatively simple treatments for depression such as behavior activation and problem-solving therapy have been shown to be effectively managed by non–mental health specialist health workers, such as nurse care managers, who coordinate care and deliver behavior activation, problem-solving therapy, and manage medications, with support from mental health specialists (e.g., Mutamba, van Ginnekan, Paintain, Wandiembe, & Schellenberg, 2013; Unutzer et al., 2002; Wells et al., 2000).

Collaborative care models are a well-established evidence-based approach for task shifting depression care to primary care. Although much of this work was developed and tested in HIC, there is increasing evidence that such programs can produce positive effects when implemented in LMIC, particularly regarding medication-based treatments for depression (Patel et al., 2009). Developed originally as an approach to manage chronic illnesses (e.g., diabetes), collaborative care is now a quality improvement model for integration of depression care into primary care settings, where mental health services can be more accessible and less stigmatized. Given that the burden of depression is high but often unrecognized, and that patients in East Asia often report greater somatic complaints (e.g., sleep problems, fatigue) rather than depressed affect, primary care settings are an ideal setting for provision of depression care.

Development of the Vietnam Multicomponent Collaborative Care for Depression Program

To help address this treatment gap, our research collaborative developed, implemented, and evaluated the Vietnam Multicomponent Collaborative Care for Depression Program (MCCD). The program was designed specifically for Vietnam but also structured so that it would be more broadly applicable for other LMIC. The program is based on a collaborative care, task-shifting approach to the treatment of depression, with mental health care for depression managed in community-based primary care settings by primary care providers (e.g., nurses, community health workers), with support from psychiatrists. The MCCD combines collaborative care models for the treatment of depression developed for low-resource communities in the United States (e.g., Partners in Care [PIC]; Wells et al., 2004) and in India (MANAS; Chatterjee et al., 2008). These programs were adapted for Vietnam by a team of mental health professionals in Vietnam and the United States who specialize in collaborative care for depression care. The Vietnam MCCD demonstration project was conducted from 2009 to 2012 in 12 sites in Danang and Khanh Hoa provinces, and 8 of these sites participated in the outcome trial.

Intervention Overview—The MCCD consists of eight components: routine screening, diagnostic assessment, psychoeducation, antidepressant medication, adherence management, behavior activation therapy (Ngo, Lam, Dang, & Weiss, 2010), follow-up, and family support. CHS nurses function as care managers overseeing treatment, providing routine screening, psychoeducation, BA, and care coordination; GPs are responsible for diagnosis and medication assessment and treatment. Community health workers provide the community education and follow-up. All interventions are conducted in individual (as opposed to group) sessions. CHS providers are supervised weekly by a visiting psychiatrist.

The MCCD involves a stepped-care model for management of mild to moderate depression at the CHS with more severe depression or individuals with risk indicators (e.g., suicidal ideation, substance abuse) seen by psychiatrist at CHS or referred to the psychiatric hospital. Patients considered to have mild depression (Patient Health Questionnaire [PHQ] 5 10–15, no risk indicators) are offered the first-level intervention, which includes psychoeducation and BA at the CHS. Patients with moderate and severe depression (PHQ >. 15, no risk indicators) in addition are offered the choice of antidepressant medication at the CHS. Patients with risk indicators or those not responding to medication after 4 weeks are treated by psychiatrist at the CHS or referred to the psychiatric hospital.

Identification of Depression—Community screening using PHQ-2 identified high-risk individuals and referred them for assessment at the CHS, which implemented routine screening for depression using the PHQ-9 (PHQ-9 score ≥ 10) and follow-up evaluation by a CHS GP using a Vietnamese version of the depression module of the MINI International Neuropsychiatric Diagnostic Interview (Lecrubier et al., 1997), also assessing for psychosocial stressors.

Psychoeducation—A motivational interviewing–informed 45-min psychoeducation session assesses patients' perspectives about their problems and their readiness for change and provides information about depression (e.g., its relatively high prevalence) to decrease stigma and educate patients about benefits and availability of depression treatment. During this session, patients complete a checklist regarding common barriers to care (e.g., transportation, work issues), and barriers are discussed and problem-solved.

Medication Management—Because of their limited formal psychotropic medication training, CHS GPs and nurses use a simplified algorithm for depression medication prescription. The algorithm involves two serotonin reuptake inhibitors (fluoxetine and amitriptyline) selected because of their low cost in LMIC and their differing effects on anxiety and sleep.

Behavior Activation—The Vietnam MCCD five-session behavior activation (BA) therapy module (Ngo et al., 2011) was adapted by the first and second author from the BA module of the 12-session cognitive behavioral therapy (CBT) program used in the We Care, Community Partners in Care (CPIC), and REACH NOLA projects (Miranda et al., 2003; Ngo, Centanni, Wong, Wennerstrom, & Miranda, 2011). The MCCD BA program includes BA combined with problem-solving skills training, which was judged by the Vietnamese members of the team to be the most culturally appropriate, feasible, and potentially

efficacious psychological/behavioral intervention for rural Vietnam. Sessions focus on (a) the relation between activities, mood, and functioning; (b) increasing pleasurable activities; (c) overcoming obstacles to healthy activities (i.e., problem solving); (d) maintaining healthy activities; and (e) setting goals. The primary cultural adaptation made for Vietnamese society was modifying the stated purpose for increasing pleasurable activities, which typically is given as to reduce depression. This was, however, seen as self-centered in Vietnam, so the purpose of increasing pleasurable activities was given as to improve family and work functioning, which was more acceptable within collectivistic, functionally oriented societies such as Vietnam and likely many other LMIC.

Feasibility, Acceptability, and Effectiveness of the MCCD in Vietnam

Feasibility and acceptability are critical components of all health-related programs. To understand the feasibility and acceptability of the MCCD program in Vietnam, as part of our demonstration project (of which the outcome trial was a subcomponent), we tracked percentages of patients who accepted treatment and who completed treatment. The demonstration project was conducted for 2 years across 12 sites, which included four research (MCCD) and four comparison sites (guideline medication only) in the outcome trial, as well as four nonresearch implementation sites that also implemented the MCCD program but did not participate in the outcome study. Across these sites, nearly 40,000 people were screened for depression in the community using the PHQ-2, with 4,380 screening positive (PHQ ≥ 3) and referred to the CHS for further evaluation. Further evaluation included the routine screening with PHQ-9 and diagnostic evaluation using a structured diagnostic tool adapted from the MINI Depression module for positive PHQ-9 screens by primary care providers. Diagnoses were checked by supervising psychiatrists. More than half (2,541) of those who screened positive on the PHQ-2 followed up on the referral for assessment at the CHS, and 914 were formally diagnosed with a depressive disorder. Based on the PHQ-9, 50% had mild depression, 35% had moderate depression, and 14% had severe depression. Treatment acceptability was high, with 92% of patients recommended for treatment accepting, as were treatment completion rates, with 73% of patients completing treatment (Chatterjee & Nguyen, 2012). This treatment completion rate is higher than that of most other collaborative care depression programs around the world. In the MANAS program in India, for instance, 61% of patients completed treatment (Patel et al., 2003). Overall, these statistics suggest that the program was feasible, in that a substantial volume of individuals were screened, assessed, treated, and completed treatment. They also suggest that the program is acceptable in this context with this population, with more than 90% of patients offered treatment accepting.

As a component of the demonstration project, we conducted an outcome evaluation of the Vietnam MCCD program. The four research CHS sites (which received the full MCCD program including BA as well as guideline medication) were compared to the four comparison CHS (which received guideline medication only). This comparison allowed for assessment of the incremental effects of a complex, multifaceted, behavioral intervention—BA—delivered by non-specialists. Analyses indicated that at 3- and 6-month post baseline, both groups had significantly decreased in depression and anxiety and significantly

increased adaptive functioning, with the MCCD group showing significantly greater improvement.

Implementation Challenges

Based on these experiences and data, the MCCD program appears acceptable, feasible, and effective with our population of rural Vietnamese. Nonetheless, we faced a number of challenges in the project, particularly in the early phases.

Engagement/Retention—In the initial project developmental phase, prior to initiating the research outcome evaluation, we faced significant challenges in identifying and engaging patients. Initially, all patients coming to participating CHS were screened for depression as part of the CHS' routine admissions evaluation. However, this approach underdetected depression, identifying only about 2% of patients as having possible depression, which is quite low for a primary care clinic, which has been estimated to be between 5%–9% (O'Connor et al., 2009). Also during this initial phase, treatment acceptance rates were low and dropout high. As in most LMIC, patients entering into primary care were neither seeking mental health care nor were they even experienced with the concept of depression. They thus found it odd to be asked questions about their emotions and other cognitive/affective symptoms of depression such as hopelessness, did not understand the relevance of these questions, and consequently often appeared disinclined to report depression symptoms regardless of whether they were experiencing them. Qualitative interviews with providers and patients after the first 6 months of the project indicated that low awareness and understanding of depression, lack of knowledge about the availability and efficacy of services, stigma about depression, and financial barriers were common reasons for poor patient engagement. Because the CHS was a new location for mental health services, even when patients were interested in depression treatment, there was little trust in the CHS. In fact, several patients in the initial project phase refused treatment at the CHS but followed-up with referrals to the provincial psychiatric hospital (Ngo et al., 2011).

To address this barrier, we engaged in a community-wide mental health information, education, and communication campaign. Partnerships were developed with community organizations, such as the Women's Union and Farmers Union, to strategize and develop the most effective mediums for dissemination of depression information. Education packages, including leaflets, posters, education brochures, and others, with information about depression prevalence, depression as a treatable illness, and the availability of services in the CHS were distributed throughout the community via door-to-door visits and community meetings held by our partnering community organizations. Posters explaining depression and its treatment as well as flipcharts about depression and stress management were distributed to health service settings for use with patients. Interviews with former patients regarding their perspectives and experiences with depression and its treatment were aired on local television. Public announcements through loud speakers, a common method for health campaigns in Vietnam, were also made to raise awareness and destigmatize depression care in communes where services were being offered. These efforts culminated in a highly publicized parade on Mental Health Day 2011, which was followed by televised coverage, newspaper articles, and radio interviews about depression and available services. These

education and engagement efforts not only raised awareness about depression and availability treatment but also generated significant local community "buy in" and political support for the program as well as national media attention. By the end of Year 2, positive screening and treatment acceptance had increased and treatment dropouts decreased significantly, and word-of-mouth referrals to the CHS for depression care had started creating patient-initiated demand for depression care services.

Limited Healthcare Human Resources—As with most LMIC, Vietnam faces significant shortages in healthcare human resources, in particular regarding mental health but also across all health domains. As a consequence, providers including those at CHS frequently are overburdened because the system is understaffed. Health system budgets and funding are centralized at the provincial and national levels, and CHS have fixed staffing so even if a project can fund additional staff, they cannot be hired. Not surprisingly then, initial implementation of the MCCD was met with some resistance by CHS providers who already felt overwhelmed and are not enthusiastic about one more program being placed on their shoulders. This was compounded by the fact that depression care requires longer sessions (45 min vs. 15 min for usual health visits), greater coordination, more frequent patient contact, and the like than typical healthcare visits. The provincial psychiatric hospitals providing supervision and project management also were overburdened and face chronic staffing shortages. Even if the hospitals had permission from the government for new positions, all psychiatrists in the hospital district already were working at the hospital, as mandated by the government. Psychologists and social workers are even in shorter supply in Vietnam. This lack of potential to increase staff at the hospital meant that the taking on of additional responsibilities for the project could not be compensated by reduction of other responsibilities at the psychiatric hospital. Finally, positions in the government health system are low-pay, so most specialists and doctors have after-hours private practices, which limit their ability to participate in projects after work hours.

Thus, provider resistance to the program initially was abundant. In response, our program emphasized the importance of this initiative (developing collaborative care for depression in rural Vietnam) and helped the providers develop a sense of pride in being "agents of change" for the system, their patients, and their country. We appealed to their social and personal values, such as helping the community, having meaningful work, and others, providing opportunities for growth and leadership. We frequently solicited input from the providers, showing respect for their expertise, and most importantly used their feedback in real and visible ways to improve the system. Following the suggestion of community health workers, for example, we disseminated depression education materials door-to-door to raise awareness about depression care. The community health workers also suggested that the program be promoted through community meetings with local organizations and took the lead on these efforts. During the midterm and final program evaluations, providers stated how they participated because they felt inspired by the project, saw the positive impact on their patients, and appreciated what they learned in the program (Chatterjee & Nguyen, 2012; Ngo et al., 2011).

Limited Supervision Infrastructure—The supportive, collaborative, clinical improvement–focused supervision model, which is a key element of the Vietnam MCCD, was unfamiliar to our Vietnamese psychiatrist supervisors. It was, in fact, generally contrary to standard supervision in the Vietnamese health system, which tends to be hierarchical and punitive, focused on ensuring that subordinates do the tasks to which they have been assigned, monitoring of patient contacts, and others. As with most if not all manualized cognitive-behavioral interventions, MCCD supervision focuses on open discussion about mistakes and uncertainties and requires an open, trusting professional relationship. To resolve these conflicting perspectives, in addition to training supervisors in the technical aspects of the MCCD supervision process, we focused on the goals of collaborative supervision (i.e., to improve patient care) as well as on helping supervisors understand that collaborating with organizational subordinates did not undermine their authority within the institution and actually enhanced their efficacy when working with subordinates. In addition, to guide the implementation and support the supervision process, we developed implementation adherence tools and supervision support procedures. These included review of one audio-recorded BA session per provider per week for the first two cases or until competency and fidelity were demonstrated. Ongoing client progress was monitored with the PHQ-9 every 2 weeks and used in supervision, and the psychiatrist supervisors were themselves supervised by directors of the psychiatric hospital on a weekly basis, who were in turn supervised by the international clinical psychologist members of the team.

As a consequence, psychiatrists ultimately developed solid competency in the supervision model, became more knowledgeable in the use of fidelity and patient data to guide practice through supervision, and are now providing trainings and dissemination of the program to other groups, including the National Psychiatric Hospital and Hue Psychiatric Hospital. As their competence increased, reliance on international experts decreased and by the end of Year 2 was no longer needed.

Limited Mental Health Expertise and Experience—Depression care is relatively new for Vietnam because historically, most psychiatric services have been focused on schizophrenia, bipolar disorder, mental retardation, and epilepsy. And using evidence-based psychological treatments was essentially unheard of in Vietnam at the beginning of the project, so even the Vietnamese MCCD specialists needed extensive training. In addition, the MCCD required providers to assume professional roles counter to their traditional roles within society and the healthcare system. In Vietnam, relations between patients and medical personnel are hierarchical and directive, which runs counter to the more collaborative nature of most behavioral and psychological interventions. Correspondingly, Vietnamese patients expect health providers to be directive and even authoritarian. In fact, patients initially expressed discomfort with providers interacting in a collaborative style because they felt this indicated that the providers were lacking self-confidence and competence in what they were doing, because the providers were asking for and discussing the patient’s thoughts about health issues.

To address providers’ limited mental health expertise, workshops on collaborative care for depression, focusing on the Vietnam MCCD (screening, assessment, psychoeducation, BA, guideline in antidepressant care), were conducted. Training was explicitly designed to be

intensive to systematically build capacity across all levels of the system from specialists at the provincial psychiatric hospitals, to physicians and nurses at the CHS, to the village health collaborators. Under the guidance of the international experts on the team, the Vietnamese psychiatrists themselves first implemented BA at their hospitals to gain experience before becoming BA supervisors and ultimately trainers themselves. Trainings were provided on-site, with intensive (1–2 hours) weekly supervision, including the hospital directors, provided over the internet by the international clinical experts. To solidify the BA model, supervision included reviews of case conceptualization, feedback on adherence to the model, as well as support for clinical implementation.

In addition, to increase the likelihood that both the patient and provider would feel comfortable in a more collaborative relationship, training and supervision were provided to the providers in general counseling skills and engagement techniques (e.g., motivational interviewing approaches). These included discussion of the rationale for provider–patient collaboration—for example, regarding emotional functioning, patients have more understanding of their situation than a provider has. Providers were taught to focus on enhancing patient's own motivation for change rather than imposing the provider's own reasons for change.

These strategies resulted in greater treatment engagement and lower dropout rates than typical mental health treatment in Vietnam. Yet they also dramatically altered the dynamics and relations between higher level specialists (psychiatrists), GPs, nurses, and community health workers. Across the levels of the system, the providers saw themselves as members of a team united by the common goal of helping their patient rather than as superior or subordinate members of a medical hierarchy.

Sustainability—As with other LMIC as well as HIC, mental health remains one of the lowest priorities in terms of government spending in health (WHO, 2011). This poses numerous challenges for initial development and implementation of mental health programs but in particular for sustaining programs. This is true even for mental health interventions demonstrated to be feasible, clinically efficacious, and cost-effective for the health system and society. In Vietnam and other developing countries, most new social and mental health programs developed and piloted are funded by foreign donors, including international philanthropic organizations such as Atlantic Philanthropies or United Nations Children's Fund, or by research funding agencies in the United States, and so forth. This support is intended to be short-term, designed to lay the foundation for the program but not provide ongoing funding, with the expectation that the local government will take ownership and provide long-term financial support. Without local governmental support in funding as well as policy (to support nationalization of the program, etc.), these efforts cannot be sustained. Leadership from politicians, administrators, and health and mental health professionals is crucial.

Because of our long experience in the country, we were aware of this issue from the beginning of the project and consequently focused on engaging leadership across health, mental health, and social service sectors as well as funding agencies and policy makers. Workshops and meetings with leadership focused on educating leaders about the need for

depression care, the efficacy of programs such as the Vietnam MCCD, their social impact, and helping to develop a plan for the long-term support of the program. As a function of these efforts, several other projects grew from this work. For example, the WHO Vietnam office adopted the MCCD depression care guidelines developed by our collaborator, the director of the Danang Psychiatric Hospital, and these are being implemented in Danang province; limited funding has so far precluded dissemination to other provinces. Our Vietnamese psychiatrist partners (Trung Lam and Thanh Dang) have become national leaders in mental health in Vietnam, including membership in the National Mental Health Planning Committee, and they are leading other mental health efforts that have grown out of this project. The original project manager and program initiator (Tam Nguyen) has established a Vietnam office for Basic Needs, an international community-based organization focused on community-based mental health support, and now serves on mental health advisory boards for the MOH and Ministry of Labor, Invalids, and Social Affairs (MOLISA), which are the two ministries that address mental health issues. The Vietnam Veterans of America foundation project manager (Mai Hien Nguyen) is now a member of the Consortium Mental Health Project, which supports key Vietnamese ministries (MOH and MOLISA) in development of a national community-based mental health framework.

Most centrally, the MCCD continues to be implemented in the settings in which it was established. The four-treatment CHS continue to implement the MCCD, although with a simplified, what is seen as more realistic, one- to two-session BA program as well as the psychoeducation, guideline medication, and so forth. The two psychiatric hospitals that provided supervision are implementing the full MCCD. The program has not yet expanded, however, beyond its initial base primarily because of a lack of funding from the government.

Conclusions and Recommendations

Developing evidence for community partners strengthens the mental health initiative

At the beginning of the project, we encountered a great deal of resistance to task-shifting depression care. Mental health policy leaders did not believe that nonspecialists could safely and effectively work outside the scope of their formal training to provide health treatments normally provided only by specialists. But the success stories from the patients and both specialist and nonspecialist providers and strong research evidence convinced even the strongest critics that the task-shifting component of our program was not only feasible/acceptable but also effective. In order for local and national stakeholders outside direct project implementation to be aware of this information, workshops, conferences, and site visits were frequently held to provide opportunities for exchange and firsthand experience with the project successes. By the end of the project, this resulted in increased commitment at all levels, including national-level support, and an expansion of mental health efforts from direct services to policy changes.

Relationships are key to success

As we have hopefully articulated, the importance of establishing sustainable relationships is critical to achieve successful mental health program development and implementation in LMIC such as Vietnam. Strong relationships provide the foundation for the development of

trust, openness, and commitment without which a project cannot move forward successfully. Although intellectual understanding of a program and project is essential, often much must be taken on faith by both sides at least initially when working within a foreign country (Vietnam) or when working within a foreign professional perspective (Euro-American psychology). It is the quality and depth of the relationship that provides the trust for such faith. When we began working in Vietnam in 2001, at a meeting to discuss national mental health needs in Vietnam at the Central Psychiatric Hospital No. 1 near Hanoi, a staff member stated, “Foreign projects come, and foreign projects go. Nothing changes” (Dang & Weiss, 2007). Part of our ability to develop strong relationships with our Vietnamese colleagues comes from their awareness of our long-term commitment to Vietnam and mental health in Vietnam. There are times in most projects when one perspective must push and ask for things in an urgent manner for the sake of the project, and this becomes more feasible in the context of a good relationship. And ultimately, the extent to which professional relationships can extend into genuine personal relationships, the stronger these effects become.

Leadership also is key

It also is worth emphasizing that success achieved by projects such as the MCCD is highly dependent on dedicated leadership like that of our Vietnamese partners. Only local mental health leaders who are willing to make personal and professional sacrifices to champion such endeavors can provide the tireless leadership needed to shift the system and motivate providers, administrators, and policy makers to take action. True leadership involves having a vision of what the future can be, understanding the path necessary to arrive there, and the selfless commitment to sustain effort. Although leadership can be fostered, in projects such as the MCCD, it also is a matter of selection of partners through an evolutionary process of trial and error and learning and success.

It is necessary to obtain engagement of all levels of the healthcare system in advance to implement a multilevel healthcare program

The MCCD is a trans-system program that spans from the lowest level of the healthcare system in Vietnam (the CHS) to the highest care level (provincial hospitals). Our experience was that in order for the program to be appropriately and successfully implemented, all levels of the system needed to be strongly committed to the project—that success was dependent on the weakest link. Throughout the duration of the project, we employed a wide range of activities for strategic engagement, focused on ensuring that needs and concerns of the various levels were at least somewhat addressed to support engagement. Linkages with leading community organizations such as the Women’s Union, the Farmers Union, and the People’s Committee were developed early. These linkages were essential not only for direct program support (e.g., receiving permission to implement the program) but also for indirect yet essential support of the program (e.g., increasing community awareness and education about depression).

Linkages across service sectors are needed for sustainable health system integration

Given the fragmentation of the health and mental health services and the low levels of human resources, it was necessary that all services be willing and ready to fill gaps for one

another. For instance, CHS medical staff were unable to make home visits because of their overburdened schedules, so community health workers from social organizations such as Women's Union and Farmer's Union played a key role in conducting home visits for follow-up care. These community providers extended the care from the primary providers to reach patients where they were most comfortable, often in their homes. The flexibility of the mobile team of psychiatrists from the provincial psychiatric hospitals was critical, providing emergency clinical backup to fill in for the CHS GPs' lack of expertise, ameliorating the primary care providers' initial concerns about practicing outside their usual scope of practice.

Although mental health services in LMIC countries such as Vietnam are often heavily influenced by national economic functioning, ultimately the biggest challenges we faced were not directly economic in nature but rather social, cultural, and political. It was through the strength of the relationships among the team members and the commitment and dedication of all partners that these challenges were overcome and project success ultimately was achieved.

Acknowledgments

The preparation of this article was supported in part by the Implementation Research Institute (IRI), at the George Warren Brown School of Social Work, Washington University in St. Louis; through an award from the National Institute of Mental Health (R25 MH080916-01A2); and by the Department of Veterans Affairs, Health Services Research & Development Service, Quality Enhancement Research Initiative (QUERI).

References

Chatterjee S, Chowdhary N, Pednekar S, Cohen A, Andrew G, Andrew G, Patel V. Integrating evidence-based treatments for common mental disorders in routine primary care: Feasibility and acceptability of the MANAS intervention in Goa, India. World Psychiatry. 2008; 7:39–46. [PubMed: 18458786]

Chatterjee, S.; Nguyen, C. Final evaluation of the Vietnam Collaborative Care for Depression Program. Vietnam Veterans of America Foundation; New York, NY: 2012. Vietnam Veterans of America Foundation. Unpublished evaluation report

Central Intelligence Agency. World fact book—Vietnam. Author; Washington, DC: 2013.

Dang, LB.; Weiss, B. Research findings from the Vietnam Children's Mental Health Research Training Program. Educational Publishing House; Hanoi, Vietnam: 2007.

Fulton BD, Scheffler RM, Sparkes SP, Auh EY, Vujicic M, Soucat A. Health workforce skill mix and task shifting in low income countries: A review of recent evidence. Human Resource Health. 2011; 9(1):1.

Lecrubier Y, Sheehan DV, Weiller E, Amorim P, Bonora I, Sheehan KH, Dunbar GC. The Mini International Neuropsychiatric Interview (MINI). A short diagnostic structured interview: Reliability and validity according to the CIDI. European Psychiatry. 1997; 12(5):224–231.

Lewin, S.; Dick, J.; Pond, P.; Zwarenstein, M.; Aja, GN.; van Wyk, BE.; Patrick, M. Lay health workers in primary and community health care. Cochrane Database of Systematic Reviews. 2005. CD004015. http://dx.doi.org/10.1002/14651858.CD004015.pub2

Mathers CD, Loncar D. Projections of global mortality and burden of disease from 2002 to 2030. PLoS Medicine. 2006; 3:e442. [PubMed: 17132052]

Miranda J, Chung JY, Green BL, Krupnick J, Siddique J, Revicki DA, Belin T. Treating depression in predominantly low-income young minority women: A randomized controlled trial. JAMA: Journal of the American Medical Association. 2003; 290:57–65. http://dx.doi.org/10.1001/jama.290.1.57.

Mutamba B, van Ginnekan N, Paintain L, Wandiembe S, Schellenberg D. Roles and effectiveness of lay community health workers in the prevention of mental, neurological and substance use disorders in low and middle income countries: a systematic review. BMC Health Services Research. 2013; 13:412. http://dx.doi.org/10.1186/1472-6963-13-412. [PubMed: 24119375]

Ngo VK, Centanni A, Wong E, Wennerstrom A, Miranda J. Building capacity for cognitive behavioral therapy delivery in resource poor disaster impacted contexts. Ethnicity and Disease. 2011; 21:38–44.

Ngo, VK.; Lam, T.; Dang, T.; Weiss, B. Vietnamese version of the individual therapy manual for behavior activation: Activities and your mood. Danang Provincial Department of Health; Danang, Vietnam: 2010. [Treatment manual adapted from Miranda et al., Group cognitive behavioral therapy for depression: Activities and your mood]

Ngo, VK.; Nguyen, C.; Do, D.; Nguyen, C.; Truong, N.; Nguyen, T. Promoting community-based mental health period 2009-2011. A mid-term evaluation. Vietnam Veterans of America Foundation; New York, NY: 2011. Vietnam Veterans of America Foundation. Unpublished evaluation report

Niemi M, Malqvist M, Giang KB, Allebeck P, Falkenberg T. A narrative review of factors influencing detection and treatment of depression in Vietnam. International Journal of Mental Health Systems. 2013; 7:15. http://dx.doi.org/10.1186/1752-4458-7-15. [PubMed: 23647977]

O'Connor, EA.; Whitlock, EP.; Gaynes, B.; Beil, TL. Screening for depression in adults and older adults in primary care: An updated systematic review. Agency for Healthcare Research and Quality; Rockville, MD: 2009. (Evidence Synthesis No. 75. AHRQ Publication No. 10-05143-EF-1)

Patel V. The future of psychiatry in low- and middle-income countries. Psychological Medicine. 2009; 39:1759–1762. http://dx.doi.org/10.1017/S0033291709005224. [PubMed: 20162837]

Patel VH, Chisholm D, Rabe-Hesketh S, Dias-Sexena F, Andrew G, Mann A. The efficacy and cost-effectiveness of drug and psychological treatments for common mental disorders in general health in Goa, India: A randomised, controlled trial. The Lancet. 2003; 361:33, 39.

Patel VH, Kirkwood BR, Pednekar S, Araya R, King M, Chisholm D, Weiss H. Improving the outcomes of primary care attenders with common mental disorders in developing countries: A cluster randomized controlled trial of a collaborative stepped care intervention in Goa, India. Trials. 2008; 9:4. http://dx.doi.org/10.1186/1745-6215-9-4. [PubMed: 18221516]

Patel V, Simon G, Chowdhary N, Kaaya S, Araya R. Packages of care for depression in low- and middle-income countries. PLoS Medicine. 2009; 6:e1000159. [PubMed: 19806179]

Phan T, Steel Z, Silove D. An ethnographically derived measure of anxiety, depression and somatization: The Phan Vietnamese Psychiatric Scale. Transcultural Psychiatry. 2004; 41:200–232. http://dx.doi.org/10.1177/1363461504043565. [PubMed: 15446721]

Stern, LM. The Vietnamese Communist Party's agenda for reform: A study of the Eighth National Party Congress. McFarlane; Jefferson, NC: 1998.

Unutzer J, Katon W, Callahan CM, Williams JW Jr. Hunkeler E, Harpole L, Langston C. Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. Journal of the American Medical Association. 2002; 288:2836–2845. [PubMed: 12472325]

Vietnamese Ministry of Health. Five-year health sector development plan 2011-2015. Author; Hanoi, Vietnam: 2010.

Vuong DA, Van Ginneken E, Morris J, Ha ST, Busse R. Mental health in Vietnam: Burden of disease and availability of services. Asian Journal of Psychiatry. 2011; 4:65–70. http://dx.doi.org/10.1016/j.ajp.2011.01.005. [PubMed: 23050918]

Weiss B, Dang HM, Ngo V, Pollack A, Sang D, Lam TT, Do K. Development of clinical psychology and mental health resources in Vietnam. Psychological Studies. 2011; 56:185–191. http://dx.doi.org/10.1007/s12646-011-0078-x. [PubMed: 21785513]

Wells KB, Sherbourne C, Schoenbaum M, Duan N, Meredith L, Unützer J, Rubenstein LV. Impact of disseminating quality improvement programs for depression in managed primary care: A randomized controlled trial. Journal of the American Medical Association. 2000; 283:212–220. [PubMed: 10634337]

Wells KB, Sherbourne C, Schoenbaum M, Ettner S, Duan N, Miranda J, Rubenstein L. Five-year impact of quality improvement for depression: Results of a group-level randomized controlled trial. Archives of General Psychiatry. 2004; 61:378–386. [PubMed: 15066896]

World Bank. Gross national income per capita—2012. Author; Washington, DC: 2012.

World Health Organization. The World Health Report—2006: Working together for health. Author; Geneva, Switzerland: 2006.

World Health Organization. The global burden of disease: 2004 update. Author; Geneva, Switzerland: 2008.

World Health Organization. Mental health atlas: 2011. Author; Geneva, Switzerland: 2011.

World Health Organization. International statistics: Vietnam. 2013. Retrieved from http://www.who.int/countries/vnm/en/