

Mental Health Care and Support

FHI Vietnam Program



Clients doing yoga.

Courtesy of John Palen

Ceiling fans whirl quietly in the softly sunlit room while a small group of women and men sit cross-legged in a circle on a woven mat, breathing in and breathing out with their eyes closed. A gentle voice recites a rhythmic poem (“Duong Sinh TuNa”) in Vietnamese:

Breath, Meditate, Relax, Exercise

Bathe, Toilet, Eat, Think Positively, Are All Daily Habits

A Good Foundation Builds a Healthy Home

Healthy Minds, Clearer Thinking, Helps Recovery

Listening to this poem, people continue to practice deep relaxation breathing while also gently stretching and massaging their legs and arms. This poem promotes a connection to one’s body allowing people the quiet space to reflect on and cultivate their own internal strengths. Addressing the mental health (MH) needs of people living with HIV (PLWH) leads to increased coping mechanisms and capabilities. FHI’s integrated MH activities aim to support PLWH in a holistic manner, thus promoting positive living. As one client stated, “The most helpful service is [antiretroviral therapy (ART)], second is Duong Sinh TuNa, third is psychosocial support.”

Making Mental Health a Priority

The HIV epidemic in Vietnam is primarily driven by injection drug use, with the first person with HIV diagnosed in 1990. Prevalence in the general population is 0.29 percent with an estimated 254,000 PLWH in 2010 (UNAIDS 2010). Vietnam’s HIV epidemic remains concentrated among key groups including injecting drug users (IDUs), female sex

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This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector I, Task Order I.
USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

Disclaimer: The author’s views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

workers, and men who have sex with men. Of the total PLWH reported, 85 percent are men, 50 to 60 percent are IDUs, and 70 percent are under 30 years of age (FHI 2004; UNAIDS/World Health Organization [WHO] 2009).

With the advent of ART on a global scale, many PLWH can and do lead a normal and active life for many years. However, many suffer from underdiagnosed and undertreated MH conditions and, despite the growing evidence of MH needs of PLWH, MH and behavioral disorders are often overlooked in care, support, and treatment programs. Undetected and untreated MH problems include depression, anxiety, cognitive disorders, personality disorders, and co-occurring conditions such as substance-related disorders which have

been shown to have a profound effect on ART adherence, clinic attendance, immunological status, symptom severity and morbidity, mortality, and quality of life; they also influence HIV progression in general (Gutmann and Fullem 2009).

This case study presents two innovative pilot programs developed by FHI Vietnam with USAID funding to address the MH needs of PLWH. The first integrated MH services into a methadone maintenance treatment (MMT) program and the second embedded MH services in an HIV outpatient care and treatment clinic (OPC) at a district general hospital. The overarching approach linking the two programs is one of integration, building on what exists. Examining both programs in depth offers valuable lessons for program planners seeking to integrate MH services for PLWH. The

HYPOTHETICAL INDEX CASE

To understand MH services, this hypothetical index case is based on a “typical” client.

In the FHI program in Vietnam, the scenario consists of a male IDU diagnosed as living with HIV who is married to a spouse who is also living with HIV. Both are on ART. He lives with their two children (both negative) and in-laws, and has a common network of needle sharing partners. He does not live in an area with an MMT program, but does receive services from the OPC, which provides treatment, care, and strong MH identification and referral services.

This man, a former IDU, and his wife both receive monthly community- and home-based care (CHBC) visits. During a recent visit, the CHBC workers asked him, “How are you feeling lately? Is there anything making you sad?” and “Is there anything making you worried? How worried?” The client said yes to sadness and self-ranked as a 2; on worry, he self-ranked as an 8 (ranking is 1/mild to 10/extreme). The client spoke to the CHBC worker about his strong worry about not being able to fall asleep without using heroin. As he is in an area where there is no MMT program and heroin is widely available, this was a high issue of concern to him. He flagged this worry as an 8 out of 10 and his wife said it concerned her as well. The CHBC worker then asked, “Would you like to talk to someone about your problems? We have an excellent counseling service at the clinic. They are lovely and can help a lot. Would you like to make a referral or ask the counselor to come to your home?” The man said yes, and was referred for further MH screening with the MH counselor at the OPC.

At the first visit, he indicated that he had stopped using heroin but is finding it very hard to fall asleep at night. He also reiterated that he has a strong network of other users, so it is easy to access drugs if he wanted to. He spoke with the counselor about creating a plan to stop using at night. He created a plan that included giving all funds to his wife and asking her to not give funds to him. The man then requested the counselor to come to his home to discuss the plan with his wife. The counselor did so, and also spoke with the CHBC worker to reinforce the family’s and individuals’ strengths to actualize the man’s plan every night. This plan is working, and the man is reporting lower levels of anxiety and better sleep at night; his wife and family are also reporting less anxiety and worry.

WHO's definition of MH provides a scaffolding for each program, as MH is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community" (WHO 2010). This definition resonated with one IDU living with HIV in the MMT program in Vietnam who described his motivation for participating in the MH services as, "We were so desperate to live, but now that we are living we want to live our lives in the best way possible."

Implementation: Making it Happen

The MMT and the OPC mental health integration pilot programs are each unique and distinct in their treatment goals and design; however, both share a common focus to improve the quality of life among clients to maximize the treatment outcome and program benefit accordant with individual needs. Key strategies are 1) routine screening for depression and anxiety for all patients during intake assessment and routine review using consistent tools; 2) referring those who have severe conditions to psychiatry specialists; and 3) providing additional counseling, intervention techniques, and support for mild or moderate levels of depression and anxiety cases. Intervention activities performed at the clinics, including highlighting individual strengths and identifying and reinforcing the natural coping mechanisms, are key tenets of MH services.

Integrating Mental Health into Methadone Maintenance Treatment (MMT)

Background and Prioritization of Mental Health Services: FHI's HIV program in Vietnam, and for IDUs in particular, has a relatively long

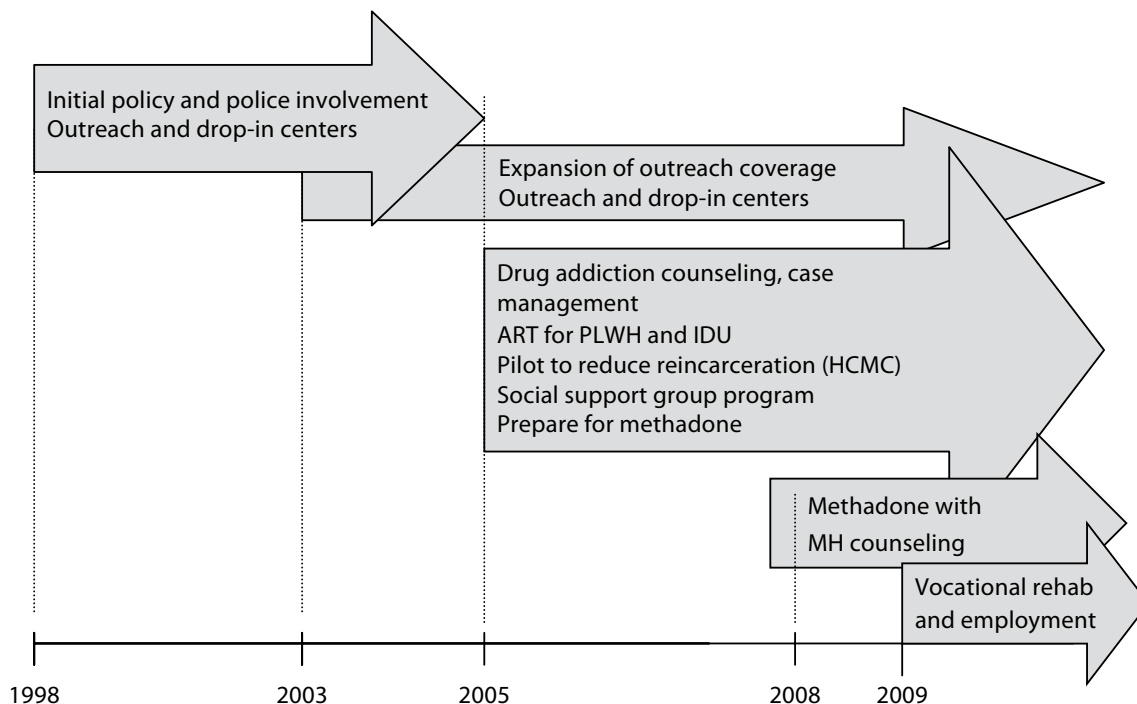
history and is supported by both USAID and the Centers for Disease Control and Prevention (CDC). Beginning in 2000, the program focused on HIV prevention and drug-use harm reduction with FHI operating outreach and drop-in centers (Figure 1).

In January 2008, FHI, in collaboration with Ministry of Health (MOH) and provincial health services, established the first piloted MMT program with an integrated MH component in six facilities in Hai Phong and Ho Chi Minh City with support from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Prior to 2008, the program did not include methadone or a specific targeted MH component. The Vietnam MOH's support for this program marks a shift away from compulsory drug treatment programs, which are often found to be ineffective, and toward a harm reduction approach. The harm reduction approach is holistic and community-based, focusing on treating heroin addiction as a disease, and focusing on the biological, psychological, and sociological responses to reduce the potential to relapse. Increasing access to and frequency of MH services, such as counseling and psychosocial support, helps recovering heroin users manage their addiction and reintegrate more fully into their families and communities.

MH needs emerged from baseline qualitative research. Evidence gathered from PLWH documented high levels of depression, anxiety, and low morale, especially among spouses of IDUs and IDUs living with HIV who had a history of recent drug use. Results from the data collected also pointed to lower quality of life, reduced physical well-being, and diminished social support, which can all affect immune function, ART adherence, and retention in care.

Key Stakeholders: Working closely with the government since 1998, FHI has strong relationships with many key stakeholders. FHI is an advocate for MH, creating awareness and sensitizing policymakers and providers on the

Figure 1. Evolution of the Drug Use Program in FHI Vietnam.



need for a comprehensive approach to HIV care and treatment, particularly among high risk groups such as IDUs. As MH is housed in different ministerial areas, key stakeholders in Vietnam at the policy level include the National Institute of Mental Health (NIMH), the MOH, and the Ministry of Labor, Invalids and Social Affairs (MOLISA). Technical MH expertise was also key to obtain, and FHI worked with the University of Melbourne for harm reduction training, including MH screening and treatment. Additionally, strong communication with PLWH ensured their needs were responded to throughout the process. Future plans include learning from other pilots (see subsequent discussion on OPC) and cultivating a deeper relationship with the Research and Training Center for Community Development (RTCCD) and the staff at the TuNa Clinic to strengthen in-country technical expertise on MH treatment. Major international partners such as USAID, CDC, WHO, and U.N. agencies also played a significant role in supporting both pilot projects.

Why were the Specific Interventions Selected and Integrated into Methadone Maintenance Treatment Programs? MH

services were selected to focus on increasing the quality of life of opioid drug users enrolled in MMT. As data identified low scores in quality of life indicators, interventions were selected to strengthen MH services using a harm reduction model, in particular looking at prevention and treatment under the three paradigms of addiction: 1) behavioral: methadone replacement; 2) psychological: MH assessment, counseling, relapse prevention counseling; and 3) sociological: peer support, family support, linkages to training, and employment. As lack of employment was associated with higher rates of depression and anxiety for both men and women IDUs, a recent innovation was to link clients to vocational training and job placement services. Employment was found to predict improvement in self-esteem and mental well-being, while also providing a sense of purpose and new social networks.

BOX 1. MENTAL HEALTH SERVICES IN MMT CLINICS

- MH and psychosocial assessment at intake and on a monthly basis at the clinic
- Individual and group counseling
- Matrix support groups
- Monthly family meetings
- Peer support
- MH case management, linkages, and referral services.

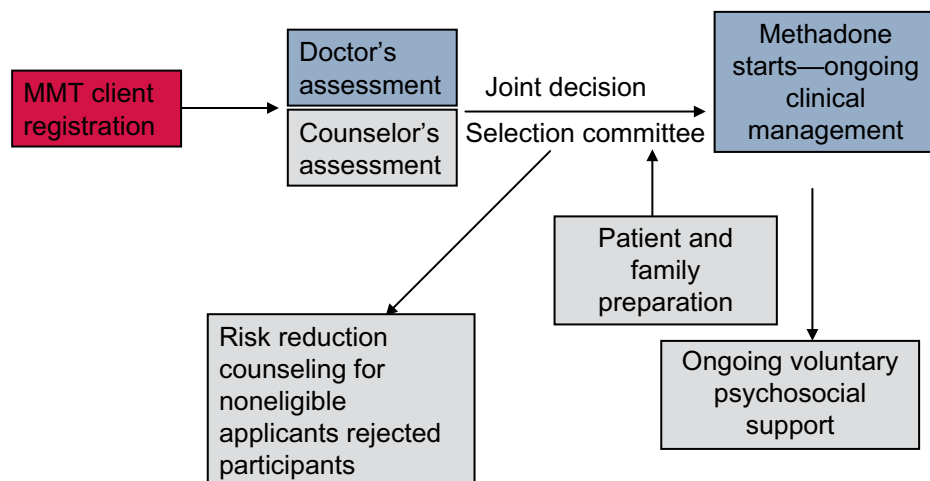
Services, Sites, and Staffing: For each of the six MMT clinics, 13 staff provide services, including a full-time and part-time doctor, two or three pharmacists, two counselors, nurses, receptionists, and peer support staff. Counselors and peer support staff provide a range of MH services, listed in the Box 1.

Standardized psychosocial and MH screening assessments are conducted at intake and repeated on a monthly basis as part of a comprehensive assessment of all clients enrolled in MMT. All MMT clients receive counseling, ranging from one to three sessions per quarter, as a part of the maintenance program. In addition, clients participate in a “matrix support group” consisting of a group led by peer support staff covering various topics related to treatment adherence, relapse prevention, positive thinking/living, and social/family issues. Clients with significant depression or anxiety are referred to the clinic doctor for further assessment, treatment, or referral for more specialized MH care.

The flow of services is outlined in Figure 2. In the three clinics in Ho Chi Minh City, clients can register at MMT clinics and enroll in methadone treatment. In the three Hai Phong clinics, IDUs are referred through their commune board for entry into MMT. All potential clients undergo a thorough assessment and selection process for eligibility and suitability for MMT, including a psychosocial and MH assessment and screening for depression and anxiety using the Kessler Psychological Distress Scale, which is consistently used in all clinics. To be eligible for services, individuals must be opioid-dependent, 18 years of age, not in trouble with the law, have a stable residence in the city of the clinic, and when relevant, provide evidence of failing to stay abstinent. As this is still in the pilot stage, the needs far outweigh the openings for methadone treatment; on average, only 49 percent of applicants are accepted into the MMT program. If accepted, both the client and family participate in a preparation phase before entering MMT. Those who are not eligible are referred back to their communes for additional drug rehabilitation services.

Each of the MMT clinics were designed to provide services to 250 clients per clinic, but as of June 2010, numbers greatly exceed 250 due to the high demand and perceived success of those in treatment. Currently among the three clinics operating in Hai Phong, 31 percent of the 996 clients receiving methadone are living with HIV. Of these, only five are female clients. A total of 62 clients are also on ART. As noted previously, all MMT clients receive MH counseling that ranges from one to three sessions per quarter in the maintenance phase and participate

Figure 2. Client Flow of Services FHI Vietnam.



in various support group activities. In Ho Chi Minh City, MMT services are in the same facility as ART, but in Hai Phong, they operate at separate sites.

Initial Results and Evaluation: As this is a pilot intervention, FHI consistently collects regular qualitative and quantitative data to measure effectiveness. Initial results show that the MMT programs in Ho Chi Minh City and Hai Phong exceeded their initial targets (1,500 people), providing services for 1,735 heroin-dependent clients in three districts in each city. After a nine-month period, clients showed a high rate of retention with 97 percent remaining in methadone treatment. One client proudly said that his wife and daughter accompany him to the clinic each day for his methadone dose to ensure he takes it. There was also a significant increase in reported quality of life, rises in employment rates, and improved

physical health and mental well-being. Clients reported significant positive behavior changes: only 12.5 percent were found to have traces of drugs in their system, only 3 percent were engaged in criminal activities (compared to 40 percent before treatment), condom use with sex workers was 90 percent, and condom use with regular sexual partners increased from 37 to 44 percent. Clients' quality of life also improved as measured by employment rates increasing from 41 to 53 percent, with physical health scores increased from 68 to 79 (out of 100); their MH scores increased from 56 to 72 (out of 100). The pilot program's success is stimulating the government to expand the program to other provinces, with the goal of providing MMT with an integrated MH component to 80,000 drug users by 2015 (UNAIDS 2010).

MH is such an integral part of MMT that both clients and staff do not think of the specific MH services as separate. Clients reported reduced levels of depression after 9 months of treatment and MH services at the methadone clinic. Prior to treatment, patients reporting a high risk of depression was reduced from 80 to 5 percent after nine months of treatment. Clients and their families offer striking testimonials on the holistic benefits of the program: "After starting the methadone program, I was able

"After starting the methadone program, I was able to get married and earn more money in my job."

—Male client living with HIV

“With the help of the program, my family trusts me more and I can hold down a job. My self-esteem has increased and I can overcome barriers.”

—Male client living with HIV referring to MH services available at the MMT clinic

to get married and earn more money in my job” and “My life is more normal now.”

Integrating Mental Health into HIV Outpatient Care and Treatment Clinic (OPC)

Background and Prioritization of Mental Health Services: In 2005, the Government of Vietnam, with support from FHI, began to transition their CHBC efforts into a comprehensive HIV care and treatment program. While psychosocial support was always part of this program, more intensive MH services began in June 2009 after baseline studies indicated PLWH experienced high rates of depressive and anxiety symptoms. Fifty-three percent of women and 37 percent of men met criteria for depression and 32 percent of women and 22 percent of men reported anxiety symptoms (Green et al. 2010). In June 2009, FHI integrated a structured MH component as a pilot to enhance palliative care and treatment services. The program worked with PLWH in the Van Don OPC in Quang Ninh Province with support from PEPFAR. Van Don District Hospital was chosen as the pilot site as it serves a rural population with a high number of IDUs living with HIV; additionally, the availability of a comparison site at Cam Pha District hospital was necessary for evaluation purposes.



Courtesy of Melissa Sharer

Methadone maintenance treatment client.

Since services began in 2005, FHI recognized the psychosocial needs of PLWH, and the initial program included an emphasis on emotional support via peers, PLWH support groups, and CHBC teams. However, findings from a 2009 cohort study among PLWH on ART found reduced levels in quality of life, both emotionally and socially, and this data was reinforced in qualitative focus groups with PLWH. The clear unmet need for MH care stimulated the June 2009 pilot to increase MH services for PLWH registered at the Van Don Clinic.

Key Stakeholders: FHI prioritized working closely with the Vietnam Administration of Medical Services, the Vietnam Administration of HIV/AIDS Control, and relevant Ministries such as MOLISA and MOH to provide comprehensive care and treatment for PLWH. These relationships provided strong levels of trust when FHI began planning to expand its MH focus. The most critical element in establishing the pilot program was the active involvement of PLWH in all stages of program development and implementation. Research and practical experience indicates that people with HIV want to talk with another person living with HIV in order to develop rapport and empathy. The Vietnam National Network of PLWH, including the Bright Futures Group for People with Disabilities, provides

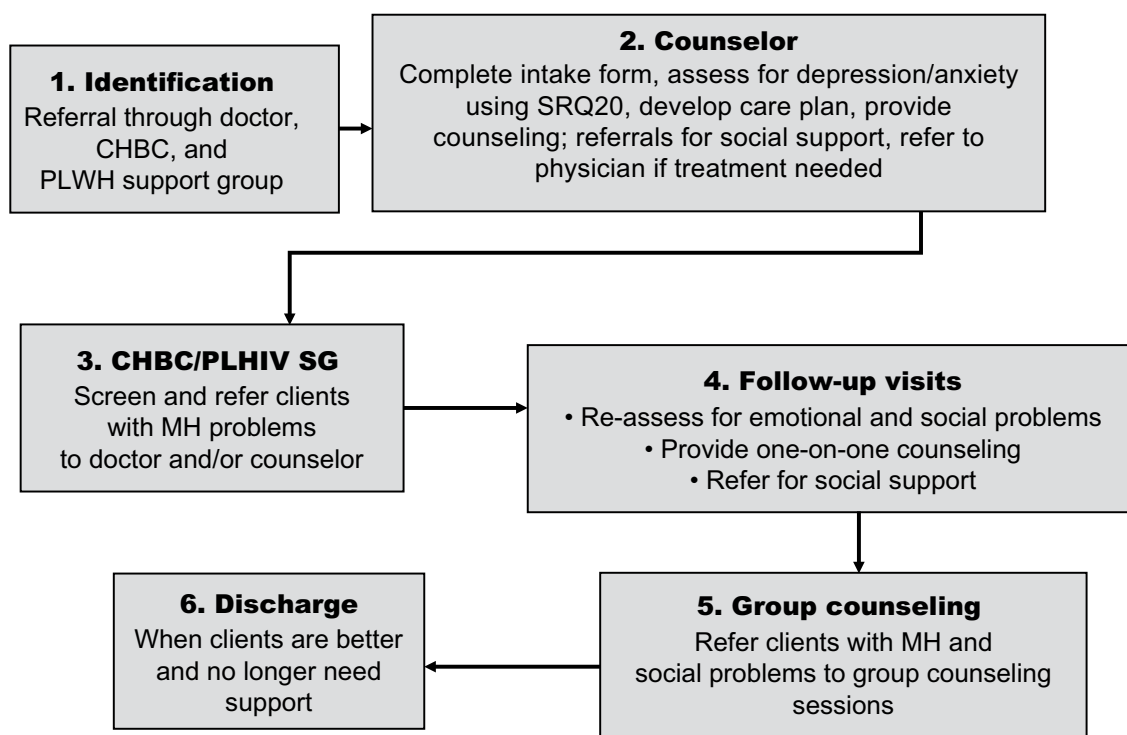
service linkages and information on the needs of PLWH, especially as the demographics change to include more women and children. Additionally, MH specialist support (psychiatric and psychological) provided by the RTCCD and the staff at the TuNa Clinic played a critical role to strengthen the level of in-country technical expertise on MH treatment.

Why were the Specific Interventions Selected and Integrated into the Existing Care and Treatment Program? Services that started in 2009 included additional means to refer PLWH for MH services. Now, referrals come from a variety of sources (self, doctor, CHBC, and/or PLWH support groups). FHI created a detailed standard operating procedures (SOPs) manual to outline steps to implement MH services in the clinic, including job descriptions for each of the key staff. Referral from both OPC and CHBC staff (see process in Figure 3) occur via two flag questions: “How are you feeling lately? Is there anything making you sad? How sad?” and “Is there anything making you worried?”

How worried?” If a client says yes to either one, he or she is asked to rank his or her level on a scale of 1 (mild) to 10 (extreme). Clients with ratings of four or above are referred for further MH screening delivered by trained MH counselors. In line with best practices that promote self-determination of clients, staff ask, “Would you like to talk to someone about your problems? We have an excellent counseling service at the clinic. They are lovely and can help a lot. Would you like to make a referral or ask the counselor to come to your home?” One particular strength is the bidirectional communications between CHBC/community workers and OPC/facility workers, as the two groups frequently coordinate services and communicate. These communication links support the referral of clients between community and facility services, ensuring linkages between the two and reinforcing the Continuum of Care (CoC) model (see Appendix 2).

When clients are referred for MH services (see list of services in Box 2), they are systematically

Figure 3. MH Flow of Services.



BOX 2. MENTAL HEALTH SERVICES IN OPC

- One-on-one basic cognitive behavioral therapy
- Breathing techniques
- Meditation
- Self-massage
- Yoga
- Peer support groups
- Medical treatment for MH
- MH case management, linkage, and referral services.

assessed by the MH counselor who is guided by a clinical algorithm (see Appendix 1) and uses a series of standard assessment tools to determine degree of anxiety or depression to develop a treatment plan with the client. Initial assessment consists of an interview and completion of the Self-Report Questionnaire 20 (SRQ20) to screen for mental distress. Clients scoring eight or above are further evaluated using the Hopkins Symptom Checklist 25 (HSCL 25), which measures symptoms of anxiety and depression. If significant symptoms of anxiety or depression exist, further assessments follow, using the Patient Health Questionnaire (PHQ 9) to measure depression and the Beck Anxiety Inventory (BAI 21) for anxiety. After these assessments, the MH counselor works with the client to develop a care plan that reinforces a client's strengths and provides a template for causal analysis, counseling, and treatment. Case management links clients to social support and other needed services. Moderate and severe cases are referred to the OPC treatment doctor for further evaluation and potentially treatment.

The MH and social support interventions include one-on-one basic cognitive behavioral therapy, group counseling, use of breathing techniques, self-massage, meditation and yoga to manage stress and depression, and medical treatment for those with moderate/severe depression and anxiety. As a key step in promoting client self-ownership, the MH services use the “Duong Sinh TuNa” poem described earlier.

Sites and Staffing: The pilot program takes place at the Van Don OPC and consists of key program staff including the OPC chief doctor, one treatment doctor, two nurses including an antiretroviral adherence counselor, one pharmacist, one MH counselor, two peer MH counselors, an OPC PLWH case manager, and three CHBC teams who are trained to screen for anxiety and depression.

One of the key factors of success was the regular training, mentoring, and supportive supervision, available both on-site and remotely, for MH staff provided by the TuNa outpatient MH clinic staff. The training

“I still have problems but now am handling them differently.”

—OPC client, man living with HIV referring to the basic cognitive behavioral techniques learned in this program



Courtesy of Melissa Sharer

Mental health counselor with algorithms behind her.

is highly interactive and participatory including an initial five-day training session for all OPC staff that is designed to sensitize staff on what MH is and why it is important. MH staff then receive an additional five-day training session on how to assess, stage, and provide counseling for mild/moderate anxiety and depression using cognitive behavioral concepts and stress management techniques. In addition, the head psychiatrist from TuNa Clinic provides on-site mentoring on a monthly basis and phone-based support to strengthen assessment and counseling skills and help the team address more severe cases.

Initial Results and Evaluation: FHI collects regular data, and results are analyzed to show effectiveness using quantitative and qualitative measures. Initial results show 466 people living with HIV enrolled in the OPC. Among them, 398 are on ART with 361 receiving CHBC services (71 percent of clients are male, 92 percent of whom have reported a history of injection drug use). Preliminary results after six months show that 100 percent of PLWH have been screened for MH needs, and 37 percent (166/466) of clients have received at least one MH counseling session (103 clients returned for more than one session). Out of the total 166 clients who received MH services, 100 were women. More women than men are seeking MH services, reflecting baseline findings regarding burden of disease by sex. Sociocultural factors may also be at play, enabling more women to seek MH

care. Of these 166 clients, 114 have been trained in relaxation/breathing/yoga exercises. Sixty-five individuals are undergoing medical treatment, specifically amitriptyline, for depression in addition to counseling. The program's SOPs for MH include treatment guidelines and algorithms for treatment planning and case management.

As MH interventions are designed to reinforce positive behaviors and healthy norms in a culturally appropriate manner, services are highly acceptable by staff at the facility, at the community level, and among PLWH. A review of cases suggests presenting MH issues were predominantly associated with HIV status, clinical progression, gender and gender-based violence, addiction, family issues, and lack of employment.

What Worked Well

A number of key elements are thought to have contributed to the early success of the two pilot MH programs.

Integrating into Existing Services: In both pilots, FHI integrated MH services into an existing CoC system of treatment and care, linking people to key services at facilities and in the community. Building on what exists produces a cost-effective model that is integrated into systems with minimal funding inputs (OPC has three dedicated staff, training, supervision and referral pathways outlined; MMT has two dedicated staff, training, supervision

***“Before my bones felt very tired,
now with massage and exercise I
feel more relaxed, confident, and
don’t worry as much.”***

***–OPC client, woman living
with HIV, wife of IDU***

BUILDING FROM WHAT EXISTS

1. Work with and through government partners to institutionalize efforts
2. Maximize the use of local Vietnamese technical expertise
3. Provide clinical mentoring and supervision
4. Work with preservice institutions to continue education.

and referral pathways outlined) and maximum outputs, showing improved quality of life among PLWH.

Focusing on Strengths, Reinforcing Positive Behaviors:

Both programs use a strengths-based approach to provide holistic MH services, using structured diagnostic algorithms to assess levels of depression and anxiety, while also using cultural, familial, and personal strengths to create a functional approach to MH focusing on well-being, coping, and resilience. As self-efficacy is central to this approach, in the OPC the poem of “Duong Sinh TuNa” worked to reinforce the clients’ own abilities to live and practice healthier lives. The MMT and OPC used strengths-based approaches to promote the value of the individual and family, setting achievable goals, and working with clients and their families to create a workable plan to reach these goals. Those who need additional MH services are referred for medical treatment in the OPC or TuNa Clinic.

Creating an Enabling Environment: Technical, Financial, and Policy Support:

Careful planning and strategic efforts were made early on to garner support and commitment from key stakeholders and potential partners including the national and provincial government leaders, major donors, and PLWH. Data from existing programs were used to raise awareness and sensitize practitioners and lead policy development in responding to the MH needs of PLWH. Building relationships with well-established, highly credible organizations and institutions, such as the RTCCD/TuNa Clinic and NIMH, to provide training, clinical support, and advocacy was critical for maintaining quality of services and ultimately for long-term sustainability. Leveraging the momentum from existing services with psychosocial support components (i.e., the palliative care and IDU outreach programs) was also strategic and created the opportunity for integrating the pilot MH services within these existing programs. In sum, the enabling environment included technical, financial, and policy support mechanisms and most importantly engaged PLWH in all phases of the program development and implementation.

Staff Training and Mentoring: In addition to piloting the development of clinical services and training staff, the pilot MH

“I feel confident and more relaxed. I don’t worry as much anymore and I sleep better.”

—Male OPC client living with HIV

program in the OPC serves as a model for scaling up services to provide quality MH care to PLWH in other facilities. Interventions were developed at both the community and the facility level, with both CHBC staff and clinical provider staff being trained in assessment, referral, and linkages. Key is that not all interventions are pharmaceutical but do include peer counseling and other interventions that can be implemented in the community. Securing in-country technical expertise from the TuNa MH clinic staff allowed FHI to move forward in a sustainable and country-owned manner. TuNa Clinic's national role as a key MH organization in Vietnam helped to legitimize FHI's approach, build the epidemiological evidence on the burden of MH, and influence policy development in Vietnam.

Workforce Development and Capacity Building: Given MH services are still a relatively undeveloped area of health care in Vietnam, it was necessary to identify and train a cadre of counselors, clinicians, and community health care workers in the basic skills of assessing and responding to MH needs of PLWH in MMT and the OPC. In addition to structured training and ongoing mentoring or supportive supervision, the development and use of standard client assessment tools and the clear, structured guidelines for case management has increased the efficiency and effectiveness of patient care and provided a mechanism for monitoring quality of care for both the MMT and OPC program.

One of the key factors was the establishment of a distinct MH unit in the OPC with dedicated staff and facilities focusing primarily on MH. OPCs are designed to provide comprehensive, holistic care and therefore must attend to multiple needs of the client. A dedicated MH team ensured that clients living with HIV, referred by other OPC and CHBC staff, receive appropriate assessment and treatment services.

“A year ago when I began delivering MH assessment and counseling, I didn’t think I could do it, now I know I can and feel that I am good at my job. My clients have helped me increase my capacity to provide useful support.”

—MH Counselor, OPC

Continuous Learning and Innovation:

There is a strong commitment to monitoring and evaluation to both improve quality of care and promote evidence-based decision making. Not only was planning for both pilot programs based on data from previous studies and epidemiological surveys (e.g., Integrated Biological and Behavioral Surveillance), but future plans for scale-up are informed by the results. Data leads to program innovations, most recently with the inclusion of vocational training and employment services as a response to a major area of concern and source of depression and anxiety, especially for male IDUs. Programs need to cultivate an evaluative mindset in both programmers and practitioners who would value the use of data to guide decision making and innovation to improve the care and support of PLWH.

Challenges

Mental Health Needs of Women and Children: Although the HIV epidemic among high-risk populations across the country has begun to stabilize, the number of new infections caused by transmission from high-risk men to their spouses or regular sex partners is expected to rise. Given the estimated increase in numbers of women and

children needing HIV care and support, there will be a parallel increase in need for MH services for women and children. The National Plan of Action for Children affected by HIV/AIDS was approved in September 2009 and represents the first comprehensive approach to address the needs of children. It also recognizes the importance of psychosocial care for children and families affected by HIV.

Recent data have shown women attending the OPC are more likely to report symptoms of anxiety and depression, reflected in the higher percentage of women than men receiving counseling in the Van Don Clinic. More targeted efforts are needed to focus on the special needs that exist for women and children. Qualitative data from the OPC MH evaluation suggests gender-based violence is an important factor in the MH of women living with HIV. More in-depth analysis will provide a better understanding to guide programmatic direction.

Mental Health Needs of Men: Men living with HIV, including those with a history of injection drug use, have a number of support needs with a direct bearing on their MH. As females were more likely to seek MH care than males, the OPC program in particular would benefit from increasing its outreach to men and ensuring that services address the comprehensive needs of men. Continued access to MMT was one major concern to men, as it has been instrumental in allowing them to lead more normal lives and reducing risk of anxiety and depression. Employment status was also shown to be a significant factor in the MH of male clients and the introduction of vocational services in the pilot MMT program

was mentioned by both clients and counseling staff as critical in improving the MH of IDUs. Consistent with a CoC model, the linkage of MH services with other care and support services, including MMT and employment opportunities, supports a comprehensive approach to MH which enhances self-esteem, reduces risk of depression, and targets the specific concerns of men living with HIV.

Human Resources: The MOLISA in Vietnam recently developed a Framework on Social Work Profession Development 2010–2020, legitimizing and codifying the role of social workers in providing MH and case management services (at hospitals and clinics). Although these developments are promising, there remains a lack of adequately trained holistic MH providers to respond to the impact of HIV and drug use in Vietnam. The efforts in Vietnam are landmark events professionalizing social work, having many positive implications regarding the use of social workers in HIV programming, with particular focus on MH services.

Staff Care: FHI promotes the MH of staff caregivers both at the facility and community levels. As the strains on those caring for PLWH are vast and widespread, the program uses a similar approach to increase coping mechanisms of staff. The OPC staff regularly use the “Duong Sinh TuNa.” The quality of care the MH counselors provide and their ability to do so over a sustained period depends on their own well-being, which remains a challenge that FHI keeps forefront.

Recommendations

FHI staff and clients had the following recommendations on how to develop MH services in other countries for PLWH. Although they are divided into steps, please note all country’s actions will evolve differently and the below steps might overlap significantly in reality.

“The stress is high, but we are able to use ‘Duong Sinh Tuna’ as well to help us cope.”

—CHBC worker

Step One

- Think big but start small. Cost-effectiveness of programs should be addressed at the onset by adding MH services that require minimal financial input. Key costs may include one to three new staff and pre- and in-service training with regular mentoring.
- Build on what already exists. Talk to PLWH to find out the support they need and want and build from there. Professional input from in-country MH experts is important to define the range of services to best respond to MH needs including psychosocial support, cognitive behavioral interventions, and medical treatment of psychiatric symptoms.
- Use data to build support. MH services were integrated after research showed existing psychosocial support was not enough, therefore deeper and more targeted MH services were piloted and both OPC and MMT has shown promise, with minimum investment in staff and training. Data led to an enabling environment with key stakeholders, including the government, providers, community workers, and most importantly with the PLWH themselves. Prioritize a small number of trained MH staff and establish standard protocols resulting in an increase in the quality of life for many people, while also providing the data needed to support scale-up plans.
- Obtain commitment from relevant ministries and stakeholders to promote country ownership and sustainability.

Step Two

- Integrate MH into HIV services at the start, and work to ensure comprehensive HIV services, including MH, are integrated into the national health care system as standard policy.

- Draw on traditional methods of coping with sadness and anxiety that is culturally acceptable and compatible with other treatment modalities including cognitive behavioral therapy and pharmacologic treatment of anxiety and depression.
- Include and engage in-country experts in MH as trainers, mentors, and advocates of integrating MH services in existing facilities.

Step Three

- Advocate and use emerging data to build supportive policies that reinforce government policies and priorities (e.g., social work enabling in the context of Vietnam).
- One area to consider for further development is to increase the number of trained personnel to provide and manage psychopharmacologic treatment of MH disorders as part of the integrated MH services.
- Address the gender issues that play a role in access to MH care. Poverty, stigma, discrimination, lack of knowledge, and social role expectations may all act as potential barriers for men, women, and children living with HIV in seeking MH care and support. A more proactive approach may be needed with explicit policies to prioritize access for hard-to-reach groups to HIV prevention, treatment, care, and support interventions, including MH services.

Future Programming and Scale-Up

By the end of 2009, there were 36,008 adults and 1,987 children receiving ART in Vietnam. By 2012, an estimated 100,000 adults and 5,700 children will

be eligible for ART. As ART prolongs life, MH and quality of life for PLWH has become an increasingly important concern. One of the challenges facing current programming is the scale-up of MH services as part of the national strategy to meet the increasing need. Integration of MH services into HIV care and treatment appears to be the most strategic and possibly cost-effective way to address the MH needs of PLWH, but challenges remain in terms of human resources and coordination of services to target those in greatest need. The success of the pilot MMT program has led to the government's decision to expand MMT for 80,000 drug users by 2015. Similarly, there is government support for replicating the Van Don MH program in other OPCs.

The next steps in Vietnam include the following:

- Adapt model in Van Don for roll-out in other OPC sites. This will include modifying SOPs and expanding MH services to other OPC sites.
- Develop MH services for children, ensuring services reflect key developmental stages.
- Review services to incorporate more gender-sensitive programming and counseling to address both the constraints and strengths of men and women.
- Increased availability to treatment for depression and anxiety across MMT and drug use interventions.
- Further training in the MH needs of drug users will be provided to MH staff, OPC staff, drug use intervention staff, and MMT staff in other facilities.
- Continue to enhance a system of clinical supervision and mentoring to reinforce skills in MH assessment, treatment, and referral so

better outpatient therapy will be available for those who need it. ■

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Available at <http://www.anxietyclear.com/beck-anxiety-inventory.pdf> (accessed July 2010)

Hopkins Symptom Checklist
Available at http://www.hpvt-cambridge.org/Layer3.asp?page_id=10 (accessed July 2010)

Kessler Psychological Distress Scale
Available at http://www.nevdgp.org.au/files/programsupport/mentalhealth/K10_English%5B1%5D.pdf (accessed July 2010)

Patient Health Questionnaire
Available at <http://www.mhqp.org/guidelines/perinatalPDF/PHQ9DepressionScreeningTool.pdf> (accessed July 2010)

Self-Report Questionnaire
Available at http://whqlibdoc.who.int/hq/1994/WHO_MNH_PSF_94.8.pdf (accessed July 2010)

ACKNOWLEDGMENTS

AIDSTAR-One would like to thank the team at FHI Vietnam including Kimberly Green, Stephen Mills, Vu Ngoc Phinh, Vuong Thi Huong Thu, Dinh Thi Bich Hanh, and Rachel Burdon for their full support in the development of this case study. Likewise, the authors wish to thank the leadership of Vietnam Ministry of Health and the FHI staff for accompanying them on field visits and sharing their experiences and insights. Special thanks also to Dr. Tran Tuan and the staff at TuNa Clinic for sharing their experiences and research on this topic and taking the time to meet with the authors. Finally, thanks to USAID/Vietnam, in particular Le Thi Thu Hien, and the PEPFAR Care and Support Technical Working Group (Cochairs: John Palen, USAID and Jon Kaplan, CDC) for technical insight and financial support for this case study.

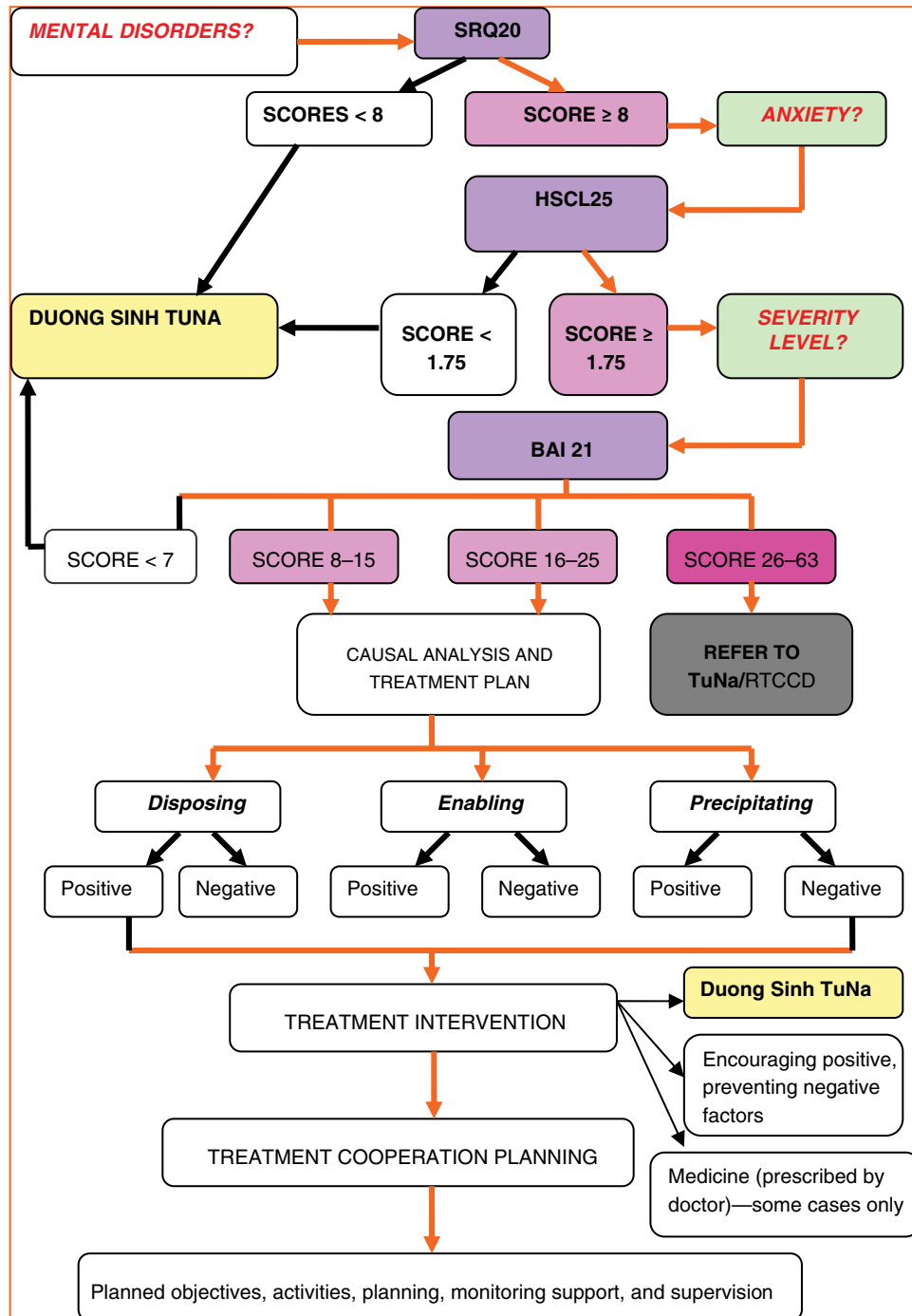
RECOMMENDED CITATION

Gutmann, Mary, and Melissa Sharer. 2010. *Mental Health Care and Support: FHI Vietnam Program. Case Study Series*. Arlington, VA: USAID AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

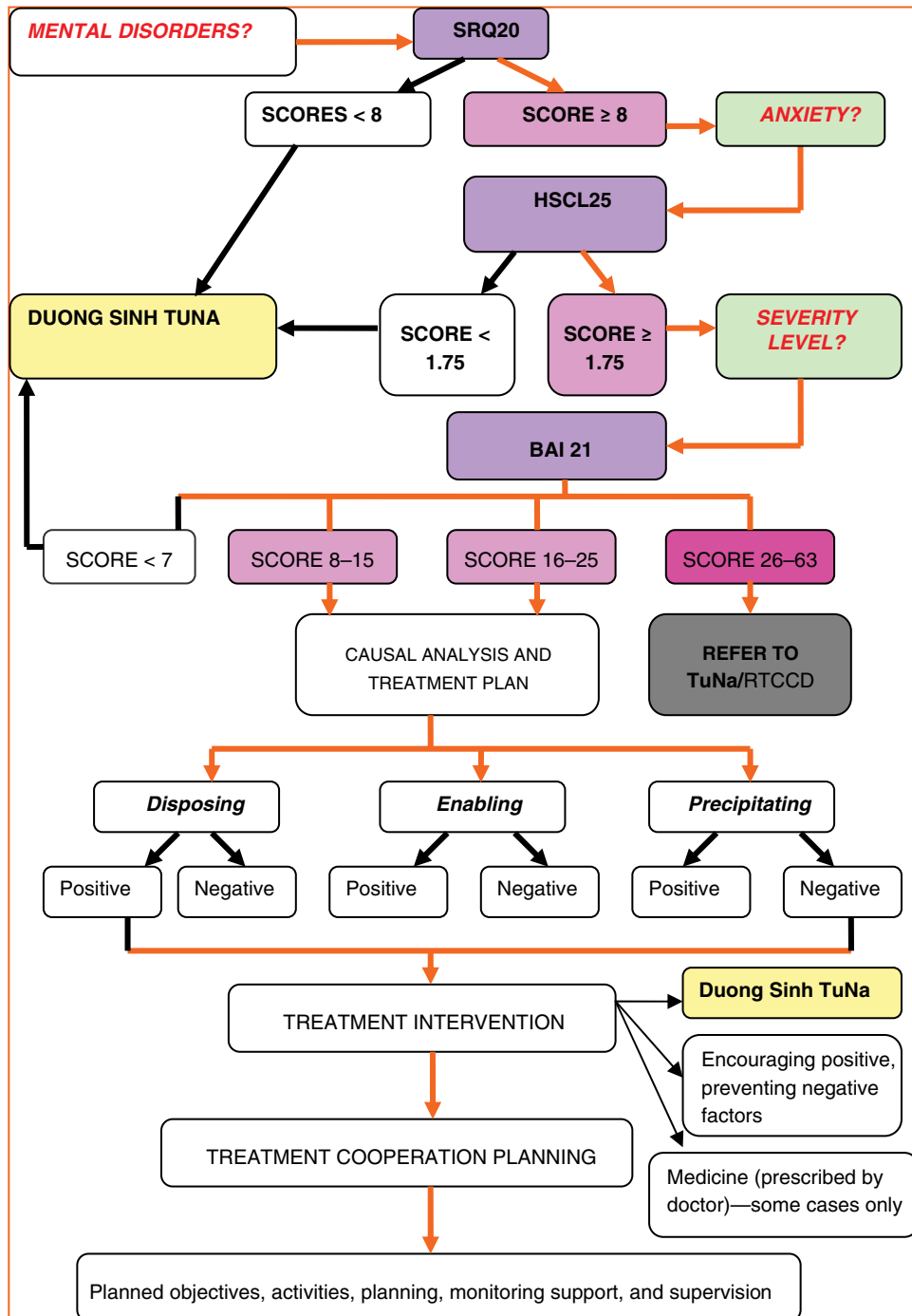
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APPENDIX I: ANXIETY AND DEPRESSION ALGORITHMS

ANXIETY DIAGNOSTIC ALGORITHM USED IN VAN DON OPC



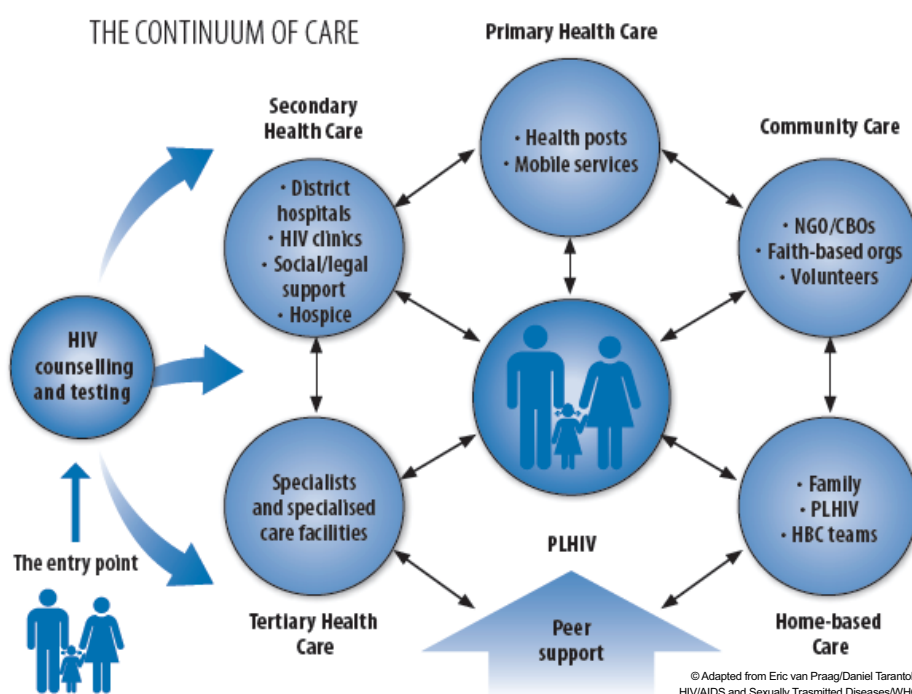
DEPRESSION DIAGNOSTIC ALGORITHM USED IN VAN DON OPC



APPENDIX 2: INTEGRATING MENTAL HEALTH WITHIN A CONTINUUM OF CARE MODEL

Recognizing that PLWH experience a range of emotional, social, physical, and spiritual needs that vary over the course of their illness, UNAIDS and WHO proposed a CoC model (UNAIDS 2000) to promote comprehensive and responsive care for PLWH and their families through a network of linked services at multiple levels of the health care system.

The CoC approach included psychosocial support for PLWH. These two pilot programs outlined in this case study followed a number of strategic steps outlined in the HIV Continuum of Care Toolkit (Green et al. 2007). These steps represent the essential building blocks to integrate MH programs and respond to local needs while also planning for national impact.





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