

Community integration services for children with mental health disorders: Evidence from social assistance facilities in Vietnam



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Abstract Families of children experiencing mental health conditions require not only therapeutic care but also supportive social environments characterized by empathy, understanding, and non-discrimination. Despite recent policy advancements in Viet Nam, community integration services for this population remain underexplored in empirical research, particularly with respect to their structural implementation and effectiveness. Guided by an ecological systems framework, this study examines the development, delivery models, and perceived effectiveness of community integration services for children with mental health conditions. A mixed-methods design was employed, combining a structured survey of 100 families and 100 service providers with 20 in-depth interviews conducted with family members, frontline professionals, and leaders of seven public and non-public social assistance facilities in Hanoi and Ho Chi Minh City. Quantitative data were analyzed descriptively and comparatively, while qualitative data were examined using thematic analysis to identify institutional and systemic factors shaping service implementation. The findings indicate that rehabilitation and special education services are the most institutionalized components of community integration support, whereas stigma-reduction communication and vocational guidance remain inconsistently implemented. Service delivery is predominantly facility-centered, with part-time models prevailing across institutions. Although satisfaction levels among families and providers are generally positive, structural constraints—including governance fragmentation, workforce specialization gaps, and persistent community stigma—limit service consistency and scalability. The study contributes to the literature by situating Viet Nam’s emerging service system within broader international mental health reform frameworks and demonstrating how multi-level structural factors mediate the implementation of community integration services. Strengthening coordinated governance, professional workforce development, and community-based engagement mechanisms will be critical for advancing inclusive and sustainable support systems for children experiencing mental health conditions.

Keywords: psychosocial support, social work practice, rehabilitation programs, service delivery models, vulnerable children

1. Introduction

According to estimates by the World Health Organization (WHO), more than 13% of children and adolescents aged 10–19 worldwide are currently living with mental health conditions. Data from the United Kingdom’s mental health services indicate that in 2023, one in every twelve children and adolescents experienced mental health disorders and were referred to mental health centers (WHO, 2020). Childhood and adolescence are characterized by rapid physical, cognitive, and emotional development. Consequently, children during these developmental periods are particularly vulnerable to external environmental influences that may contribute to mental health disorders (UNICEF, 2020–2021).

In Viet Nam, a comprehensive study titled “*A comprehensive study on school-related factors affecting mental health and holistic development of male and female adolescents in Viet Nam*”, published by UNICEF Viet Nam in collaboration with the Ministry of Education and Training, reported that approximately 20% of adolescents experience mental health disorders, while only 8.4% have access to support or counseling services (UNICEF, 2023). Beyond clinical symptoms, children experiencing mental health conditions also face multiple social challenges. Specifically, they may experience significant difficulties in daily life, learning, and routine functioning (Luo et al., 2020). UNICEF (2023) further highlights that one of the most difficult issues for children and their families is stigma-related barriers, including teasing, social exclusion, discrimination, and limited opportunities for community participation. These experiences not only provoke negative psychological responses but also reduce the effectiveness of care and support programs. For these reasons, the development of comprehensive support services in general, and community integration services for children with mental health disorders in particular, is crucial for children’s development and for strengthening the effectiveness of social programs and policies in Vietnam.



Despite increasing policy attention to child mental health and the expansion of social assistance services in Viet Nam, empirical evidence on the structure, delivery models, and effectiveness of community integration services remains limited. Existing studies primarily describe policy frameworks or prevalence patterns but rarely examine how services are implemented at the facility level or how institutional, workforce, and community factors jointly influence outcomes. Furthermore, few studies in the Vietnamese context apply an integrated theoretical perspective—such as ecological or systems frameworks—to analyze the multi-level determinants of service effectiveness. The lack of methodological transparency in prior research, particularly regarding measurement reliability, sampling procedures, and analytical strategies, also constrains the comparability and generalizability of findings. To address these gaps, this study provides mixed-method empirical evidence from social assistance facilities in two major Vietnamese cities. It systematically examines service types, delivery models, satisfaction outcomes, and institutional constraints, while situating findings within an ecological systems framework to better understand multi-level influences on community integration.

1.1. Theoretical framework

This study is informed by ecological systems theory (Bronfenbrenner, 1979) and service systems perspectives in social work. Ecological theory conceptualizes child development as occurring within nested systems, including the microsystem (family), mesosystem (interactions between family and institutions), exosystem (community and service environments), and macrosystem (policy and socio-cultural context).

Community integration services for children with mental health disorders operate across these multiple levels. At the microsystem level, family capacity and caregiving skills influence children's participation and behavioral outcomes. At the mesosystem level, coordination between social assistance facilities and families shapes continuity of care. At the exosystem level, institutional resources, staffing, and infrastructure affect service accessibility and quality. At the macrosystem level, policy frameworks, funding mechanisms, and stigma influence the broader service environment. By applying an ecological systems perspective, this study moves beyond descriptive service mapping to analyze how multi-level structural factors shape service implementation and perceived effectiveness. This framework also facilitates comparison with international evidence on community-based mental health systems in low- and middle-income countries.

2. Materials and Methods

2.1. Study design

This study employed a mixed-method design integrating quantitative surveys, qualitative in-depth interviews, and document analysis. The mixed-method approach enhances methodological triangulation by combining numerical assessment of service patterns with contextualized interpretation of institutional and experiential factors.

2.2. Quantitative survey

To generate statistical evidence on the current status of community integration services for children with mental health disorders, a structured questionnaire survey was conducted.

2.2.1. Instrument development

The questionnaire was developed based on a review of national policy documents, prior studies on community-based mental health services, and consultation with three experts in social work and mental health. The instrument consisted of four sections:

- Child and family characteristics
- Types of services received
- Modes of service delivery
- Satisfaction and perceived effectiveness

Satisfaction was operationalized using a five-point Likert scale ranging from 1 (very dissatisfied) to 5 (very satisfied). Items assessed accessibility, service quality, communication effectiveness, and perceived child improvement.

2.2.2. Validity and reliability

Content validity was established through expert review prior to data collection. Three specialists in social work and child mental health evaluated the questionnaire for conceptual clarity, relevance, and alignment with the study objectives. Minor revisions were made to improve wording and item specificity. The instrument was pilot-tested with a small group of respondents to assess clarity, comprehensibility, and response consistency. Feedback from the pilot phase informed minor adjustments to ensure that items were clearly understood and appropriately reflected service experiences. Given the exploratory nature of the study, the emphasis was placed on conceptual coherence and descriptive adequacy rather than scale standardization.

2.2.3. Sampling procedure

A total of 200 questionnaires were administered: 100 to families or legal guardians of children with mental health disorders and 100 to service providers working at seven public and non-public social assistance facilities. Facilities were selected using purposive sampling to ensure representation of both public and non-public institutions in Hanoi and Ho Chi Minh City. Within each facility, respondents were selected using simple random sampling based on official service lists. Inclusion criteria required that children had received services for at least three months prior to the survey.

2.3. Qualitative in-depth interviews

Twenty in-depth interviews were conducted to explore institutional constraints, service implementation challenges, and stakeholder perspectives. Interview participants included policy makers in the mental health sector, facility leaders, direct service providers, and family members or legal guardians. Participants were selected using purposive sampling to ensure diversity in institutional roles and professional experience.

2.3.1. Interview procedure and analysis

Semi-structured interview guides were developed based on ecological systems theory and service delivery frameworks. Interviews were audio-recorded with consent and transcribed verbatim. Qualitative data were analyzed using thematic analysis following Braun and Clarke’s (2006) six-step procedure: familiarization, initial coding, theme development, theme review, definition, and reporting. Coding was conducted manually and iteratively to enhance analytical rigor.

2.4. Document analysis

Policy documents, legal regulations, and institutional guidelines related to children with mental health disorders were systematically reviewed. In addition, anonymized case files were examined to understand service trajectories and implementation practices. Document analysis followed a structured review framework focusing on policy objectives, implementation mechanisms, and institutional responsibilities.

2.5. Data analysis

Quantitative data were analyzed using descriptive statistics, including frequencies and percentages, to summarize service types, delivery models, and satisfaction levels. Comparative analysis was conducted to examine differences between public and non-public facilities. Qualitative findings were integrated with quantitative results to enhance interpretative depth and triangulation.

3. Results

3.1. Types of Community Integration Services

Tuaf (2023) examined 27 community-based psychosocial programs for adolescents with mental health disorders that incorporated recreational and social activities to promote community integration. These programs included stigma-reduction communication, rehabilitation services, vocational guidance and skills training, and special education (Tuaf, 2023). Drawing on in-depth interviews with seven leaders of social assistance facilities, the present study found considerable variation in the types of services implemented across facilities. As presented in Figure 1, rehabilitation and special education services are the most commonly provided forms of community integration support, whereas stigma-reduction communication and vocational guidance services are implemented less consistently. This distribution suggests that institutional priorities remain concentrated on therapeutic and educational stabilization rather than broader community integration mechanisms.

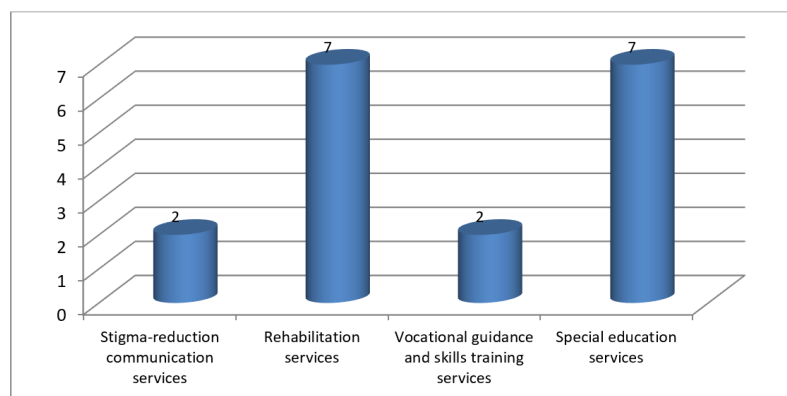


Figure 1 Types of community integration services.

3.1.1. Stigma-reduction communication services

For social protection facilities or mental health care institutions, the primary focus is in-facility care for children experiencing mental health conditions, a workload that is already extensive and time-intensive. Although social work centers formally include community support functions, such activities are not regularly implemented in practice. Social work centers tend to participate only during holidays, public events, or as part of programs and projects, and these activities are typically short-term. In some cases, communication activities are implemented within individual social work practice or case management when staff determine that communication is necessary to support a child's community reintegration. However, these efforts mainly target close social circles (e.g., friends or neighbors) rather than broader community audiences. Focus group discussions in Ho Chi Minh City illustrated this pattern: stigma-reduction communication activities are rarely conducted and are often recognized only through reading reports or professional exchanges among staff involved in individual interventions. When longer-term communication activities are implemented, they are typically driven by project requirements and partnerships. A focus group in Hanoi noted that certain social work centers received UNICEF support to implement pilot projects for child abuse and violence prevention through counseling, case management, and community communication activities. Such efforts were possible due to formal agreements, local authority approval, and dedicated funding, which enabled consistent implementation. In non-public facilities, stigma-reduction communication is generally not implemented, as most activities occur within the facility. Participation in external communication activities often depends on personal professional networks, such as being invited to speak at schools by highly specialized professionals.

From an analytical perspective, these patterns indicate that stigma-reduction communication remains peripheral to routine institutional practice. Its implementation is largely contingent upon external funding, partnerships, or individual initiative rather than being structurally embedded within service models. This suggests that community-level stigma continues to be addressed reactively rather than through systematic, sustained engagement strategies.

3.1.2. Vocational guidance and skills training services

Although mental problems are often categorized within disability frameworks, mental health conditions represent a distinct category. For children, vocational guidance and skills training are not always perceived as immediate needs by either families or care facilities. As one service provider explained, many adolescents aged 16–17 may still function developmentally like children aged 5–7; consequently, facilities primarily focus on basic rehabilitation and daily living skills and provide vocational information and training only upon parental request. As a result, only the Thuy An Rehabilitation Center for Children with Disabilities (Ba Vi) reported implementing vocational training in a systematic way, including training, production, and product sales. A facility leader described early implementation challenges: children had difficulty learning and sometimes displayed disruptive behaviors. Staff emphasized that patience and a clear understanding of vocational training as both a pathway to community integration and an effective rehabilitation approach were essential. However, challenges remain regarding market access and product competitiveness; products are often sold only at charity events rather than being accepted in mainstream markets. The center has considered shifting toward simpler products that may be easier to sell. The leader also emphasized the need for stronger government support to create opportunities for children with capacity and demand to receive vocational training and secure stable employment. While many children and families do not currently prioritize vocational services, a life-course perspective suggests that needs change with age. Younger children's needs often center on rehabilitation, physical health, nutrition, and education; older children increasingly require social interaction and community participation, for which vocational guidance and training can serve as a key transitional mechanism.

Analytically, the limited development of vocational services reflects both developmental considerations and structural constraints. Although facilities recognize the long-term value of vocational preparation, implementation barriers—such as behavioral complexity, market integration difficulties, and limited institutional incentives—restrict systematic expansion. This indicates that vocational training remains a transitional rather than foundational component of community integration.

3.1.3. Rehabilitation services

Given the nature of mental health care, rehabilitation and special education services are provided by most care facilities. Both public and non-public facilities reported delivering these services, although the intensity and scope vary. For rehabilitation services, 7 of 8 facilities reported implementation. However, when examined in greater depth, rehabilitation primarily focused on physical rehabilitation through structured exercises using equipment indoors or outdoors. Social rehabilitation activities mainly involved training children in personal hygiene and appropriate communication with parents and peers. Methods were relatively basic, relying on direct instruction and guidance. Internationally, social rehabilitation often involves a wider range of interactive approaches and greater engagement with external social environments. For example, older children may practice language interaction by answering phone calls; younger children may learn through televised images or videos for easier comprehension. Community-based interaction activities—such as performances, games, gardening, and outdoor group activities—are used to strengthen children's social interaction skills.

Analytically, rehabilitation services appear structurally embedded within institutional mandates; however, their operational focus remains largely therapeutic and facility-based. While stabilization and functional skill development are prioritized, broader community-oriented rehabilitation components are comparatively limited.

3.1.4. Special education services

Regarding special education, most facilities reported implementing this service because it is particularly important for children experiencing mental health conditions. In childhood, education is a central developmental activity. However, attending mainstream schools often involves significant difficulties for children with mental health disorders. Barriers may include difficulty participating in general curricula, challenges engaging in group activities and peer relationships, and experiences of exclusion, neglect, or teasing. Therefore, one key solution is to provide tailored learning through special education classes within care facilities. When children with similar needs are taught using individualized curricula suited to their developmental levels, learning outcomes and adaptation to educational environments tend to improve substantially. For children with milder conditions, inclusive education models have been piloted. For example, a lower secondary school in Cau Giay District has collaborated with the New Star Center to integrate children into mainstream classrooms to protect educational rights and provide a learning environment similar to that of other children. Each child receives support from a social worker rather than being left solely to homeroom teachers. This arrangement reduces discrimination and supports children’s adaptation in school settings. The costs for these social workers are covered by parents under contracts with the care facility. For children with more severe conditions or those from low-income families, participation in special education classes at care facilities is often unavoidable. Facilities generally meet this need; however, challenges persist, including the lack of standardized curricula, limited teaching materials, and difficulties recruiting teachers formally trained in special education—particularly in public facilities located outside urban centers. Staffing constraints and limited civil-service positions further affect job stability. These findings suggest that special education services are comparatively institutionalized and responsive to immediate developmental needs. Nevertheless, implementation remains primarily centered within facility settings, with limited systematic linkage to inclusive community education systems.

3.1.5. Comparative patterns by facility type

To move beyond purely descriptive reporting, patterns were examined across public and non-public facilities. Public institutions demonstrated relatively broader provision of rehabilitation and special education services, reflecting alignment with state-supported mandates and institutionalized program structures. In contrast, non-public facilities appeared comparatively more flexible in organizing supervised community activities. However, both facility types showed limited implementation of stigma-reduction communication and vocational guidance components. This pattern suggests that while core rehabilitative services are relatively established, integrative and community-oriented elements remain underdeveloped across institutional settings. Service capacity is therefore influenced not only by client needs but also by governance arrangements, funding structures, and organizational mandates.

3.2. Modes of Service Delivery

Modes of service delivery were examined across three models: (i) full-time at social assistance facilities, (ii) part-time (at facilities and home), and (iii) full-time at home. As presented in Figure 2, part-time service delivery represents the predominant model across both public and non-public facilities.

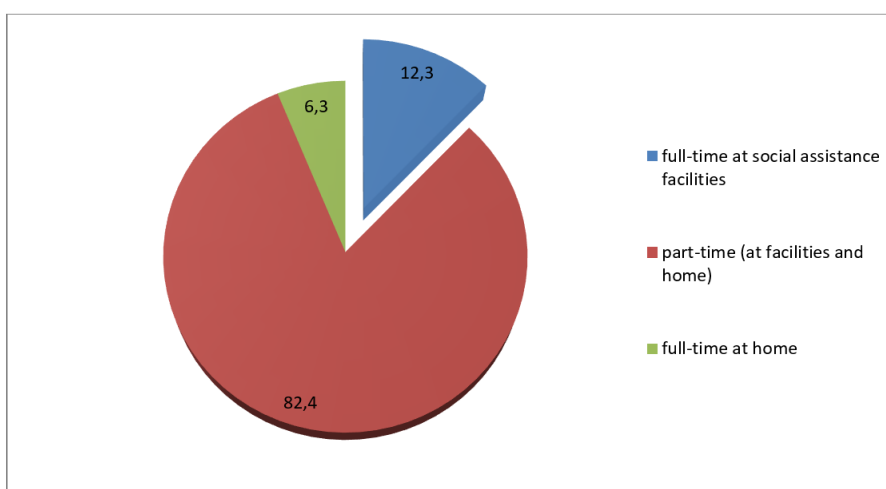


Figure 2 Modes of service delivery.



Although part-time delivery predominates in both institutional settings, differences emerge in the structural orientation of service provision. Public facilities are more closely aligned with formal eligibility criteria and policy-regulated residential arrangements, resulting in more structured full-time or institution-based care for specific beneficiary groups. In contrast, non-public facilities demonstrate comparatively greater flexibility in organizing hybrid or activity-based formats; however, these arrangements are often constrained by limited infrastructure and staffing capacity. Across both facility types, home-based full-time service provision remains marginal, reflecting broader workforce shortages and logistical barriers to community outreach. From a systems perspective, the predominance of facility-centered models is not merely a matter of parental preference but is structurally shaped by institutional mandates, funding allocation mechanisms, and professional specialization. The limited development of home-based and fully community-embedded models suggests an imbalance in the continuum of care, where stabilization and supervision are prioritized over outreach and integration.

In public facilities, full-time residential care is generally restricted to policy-supported cases, such as abandoned children or those without caregivers. However, many parents expressed a desire for full-time care for their children. This preference does not reflect parental abandonment; rather, parents reported that although they may have financial capacity, they lack caregiving skills and observe better improvements when children spend more time in professional care settings. A father (32 years old) reported that participation in special education classes at facilities was associated with noticeable behavioral improvements; the child was less disruptive and more engaged in daily activities, whereas weekends at home often involved more disruptive behavior. A mother (29 years old) shared that both parents work full-time and the father often travels; leaving the child with grandparents was difficult because they lacked caregiving skills. She expressed willingness to pay for several days of residential care if such options were available. These narratives illustrate a gap between institutional policy criteria and family-level demand, indicating that eligibility frameworks may not fully capture caregiving capacity constraints within households.

Many parents stated that they would prefer a hybrid model in which children receive weekday care at facilities while returning home on weekends. This model, similar to arrangements used in some primary schools, could theoretically support both structured rehabilitation and family bonding. However, facilities face constraints such as limited infrastructure and insufficient staffing for overnight care. Moreover, overnight care for children with mental health-related disturbances requires specialized professionals and sometimes medical staff, which many facilities cannot provide. One leader of a public social assistance facility emphasized that, unlike other client groups, overnight care involves more than basic supervision. Due to the complex mental health disturbances experienced by children, overnight care requires qualified professionals and, in some cases, medical involvement. The current workforce, however, is insufficient to meet these demands. This highlights how workforce capacity directly shapes feasible service models.

Home-based services remain limited due to staffing shortages and geographic distance between families and facilities. In addition, the workload of in-facility services is already high, restricting the expansion of outreach-based care. Existing home-based efforts are largely confined to case managers conducting home visits for assessment and intervention as required by case management processes. Community-based services such as early detection, integration support, and resource mobilization are implemented infrequently.

In non-public facilities, “community services” are often limited to supervised outings, such as visits to parks or structured recreational activities. More integrated community participation typically requires approval from local authorities, and non-public facilities may perceive administrative barriers or hesitate to undertake such initiatives. Similarly, in public facilities, community activities are often embedded within broader awareness campaigns rather than sustained integration strategies. Collectively, these findings indicate that service delivery remains predominantly facility-centered, with limited extension into community and home environments. Structural factors—workforce limitations, funding mechanisms, policy eligibility criteria, and administrative procedures—play a decisive role in shaping feasible service models.

3.3. Satisfaction with Community Integration Services

3.3.1. Family satisfaction

In this study, satisfaction was assessed based on feedback from families as service users, supplemented by assessments from service providers. As presented in Figure 3, the highest proportion of family respondents reported being “satisfied” (47.4%), while “dissatisfied” accounted for 6.2%, and no respondents reported being “completely dissatisfied.” The combined proportion of “satisfied” and “very satisfied” reached 63.9%, whereas the combined proportion of “neutral” and “dissatisfied” responses was 36.1%.

Overall, family satisfaction levels were concentrated in the “neutral” to “satisfied” range, suggesting generally positive perceptions of service effectiveness, although the relatively large proportion of neutral responses indicates areas for improvement.

When comparing facility types, families associated with public institutions tended to report more stable satisfaction patterns, likely reflecting structured and policy-supported rehabilitation and special education services. Families engaging with non-public facilities expressed appreciation for flexibility and individualized attention but also highlighted variability in service

continuity and scope. These differences suggest that satisfaction is influenced not only by service availability but also by institutional stability, predictability of support, and alignment between family expectations and service capacity.

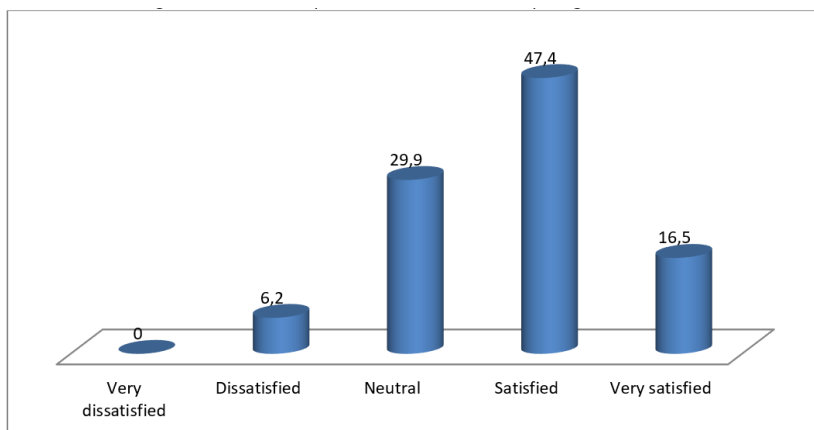


Figure 3 Level of family satisfaction with community integration services.

A mother (35 years old, Hanoi) reported high satisfaction because her child was cared for attentively, had opportunities to interact with peers, and participated in activities tailored to developmental needs. Families attributed satisfaction to reasonable service fees, supportive conditions, attentive staff, professional competence, relatively adequate facilities, and simplified administrative procedures. However, dissatisfaction and neutral responses were linked to concerns about staffing shortages, limited service diversity, and community-level stigma. Analytically, satisfaction appears to function as an indicator of both service quality and structural constraint. Positive evaluations reflect perceived benefits of structured rehabilitation and education, whereas neutral responses suggest expectations exceeding current institutional capacity.

3.3.2. Service provider satisfaction

Service providers’ satisfaction largely aligned with families’ perceptions. As presented in Figure 4, providers most frequently reported being “neutral” or “satisfied,” while 2.1% reported being “very dissatisfied.” Compared with family assessments, staff reported slightly higher dissatisfaction and somewhat lower overall satisfaction, suggesting greater awareness of structural limitations in service provision.

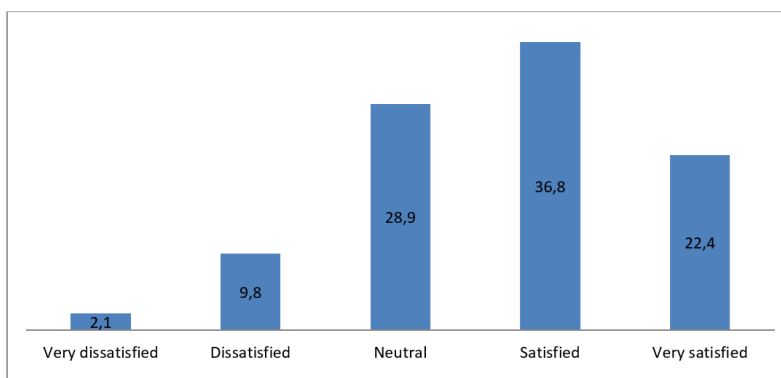


Figure 4 Level of satisfaction among community integration service providers.

At the same time, the proportion of staff reporting being “very satisfied” (22.4%) was substantial and comparable to those reporting neutral assessments (28.9%). Interviews indicated that highly satisfied staff often had received core and specialized training relevant to their roles. Training improved professional confidence, reduced stress, and enhanced perceived competence.

One provider (male, 38 years old) described transitioning from nursing to social work when the facility expanded its social work functions. Initially facing knowledge gaps and practical uncertainty, he reported significant improvement after participating in specialized training organized by the Department of Social Protection. Structured assessment tools and clearer intervention procedures strengthened his professional identity and job satisfaction. Interviews and focus group discussions suggested that staff whose formal education aligns with their assigned roles demonstrate stronger performance and confidence. However, many personnel currently work outside their original training fields. Recruitment limitations and staffing constraints thus influence professional satisfaction and service quality.



Overall, satisfaction among families and providers reflects positive perceptions of service effectiveness while simultaneously revealing systemic constraints related to workforce capacity, institutional governance, and resource allocation. These findings reinforce the interpretation that service outcomes are embedded within broader structural and organizational ecosystems.

4. Discussion

The findings of this study reveal a service system that is expanding yet structurally uneven. Rehabilitation and special education services are relatively institutionalized, whereas stigma-reduction communication and vocational guidance remain peripheral and inconsistently implemented. This pattern is consistent with international evidence from low- and middle-income countries (LMICs), where child and adolescent mental health systems frequently prioritize facility-based stabilization and educational continuity while community-based integration mechanisms remain underdeveloped (WHO, 2022; UNICEF, 2021).

Globally, the *World Mental Health Report* emphasizes that many countries remain in transitional phases, shifting from institutional or facility-centered care toward community-oriented and integrated models (WHO, 2022). Similar structural imbalances have been documented in emerging mental health systems, where workforce shortages, fragmented governance, and funding constraints limit the scalability of home-based and outreach-oriented services (Patel et al., 2018; WHO & UNICEF, 2022). In this respect, the Vietnamese case reflects a transitional service configuration situated between institutional care traditions and evolving community-based paradigms.

Interpreted through an ecological systems perspective (Bronfenbrenner, 1979), service effectiveness is shaped not solely by facility-level resources but by interacting constraints across multiple levels. At the microsystem level, family caregiving capacity strongly influences demand for structured or residential care. At the mesosystem level, coordination between families and facilities affects continuity of support. At the exosystem level, workforce capacity, infrastructure, and administrative procedures determine feasible service models. At the macrosystem level, policy eligibility rules, financing mechanisms, and persistent social stigma shape institutional priorities.

This multi-level explanation clarifies why rehabilitation and special education services are comparatively institutionalized, while stigma-reduction communication and vocational preparation remain underdeveloped. Community-level interventions require intersectoral collaboration, outreach capacity, and sustained funding mechanisms, which are structurally more complex than in-facility therapeutic programs.

The governance dimension is particularly salient. Although policies for children experiencing mental health conditions in Viet Nam have gradually improved (Nguyen, 2017; Tran & Doan, 2010), implementation and intersectoral coordination remain structurally constrained. Similar governance fragmentation has been identified in other LMIC contexts undergoing mental health system reform (WHO & UNICEF, 2022). Thus, the Vietnamese case reflects a broader implementation gap observed internationally, where policy advancement does not automatically translate into coordinated service delivery. Strengthening legal instruments and clarifying institutional responsibilities—issues raised in Vietnamese scholarship (Nguyen, 2017; Tran & Doan, 2010)—are aligned with global recommendations emphasizing whole-of-government approaches to child and adolescent mental health (WHO, 2022; UNICEF, 2021).

Workforce development emerges as a central determinant of service effectiveness. Satisfaction findings indicate that professional training significantly enhances provider confidence and performance. However, staffing instability and role misalignment remain persistent challenges. International evidence similarly highlights that workforce shortages and limited professional specialization undermine continuity and quality of child and adolescent mental health services (Luo et al., 2020; WHO, 2022). In the Vietnamese context, workforce constraints identified by Nguyen (2017) and Tran and Doan (2010) further illustrate how policy–practice gaps are mediated by human resource limitations. Incentive mechanisms, professional certification systems, and structured career pathways are therefore essential components of sustainable system development. UNICEF (2023) emphasizes that strengthening the professionalization of the social service workforce is critical for improving service quality and long-term system resilience.

The uneven geographical distribution of services also reflects broader structural inequalities. Remote and underserved areas face more pronounced workforce shortages and limited institutional infrastructure. This pattern mirrors global disparities in access to child mental health services (WHO, 2022; UNICEF, 2021). In Viet Nam, scholars have similarly noted that policy implementation remains uneven across provinces due to fiscal capacity and administrative differences (Nguyen, 2017). Expanding non-public participation, as recommended in both international frameworks (WHO, 2020; WHO, 2022) and Vietnamese policy analyses (Tran & Doan, 2010), may enhance service coverage when accompanied by appropriate quality assurance mechanisms.

Cultural barriers and stigma remain significant constraints on meaningful community integration. Misconceptions about mental health contribute to avoidance and exclusion, reducing both service uptake and long-term outcomes (Corrigan & Watson, 2002; UNICEF, 2021). The present findings suggest that stigma-reduction communication in Viet Nam remains largely project-based and episodic. International guidance stresses that stigma reduction must be embedded within sustained community engagement strategies and supported by cross-sector collaboration (WHO & UNICEF, 2022). Thus, the limited

institutionalization of such activities reflects not only local constraints but also a common global challenge in transitioning from awareness campaigns to structurally embedded inclusion mechanisms.

Importantly, satisfaction levels among families and providers indicate that current services generate positive perceived outcomes despite structural constraints. However, neutral responses and provider-reported dissatisfaction signal awareness of systemic limitations. This dual pattern reflects a system that is functioning but not yet fully optimized. As emphasized in international reform frameworks, strengthening child mental health systems requires coordinated improvements across governance, workforce development, financing, and community engagement rather than isolated program expansion (WHO, 2022; Patel et al., 2018).

Overall, this study contributes to the literature by demonstrating how structural and governance factors mediate the implementation of community integration services within an emerging mental health system. By integrating Vietnamese policy analyses (Nguyen, 2017; Tran & Doan, 2010) within broader global reform frameworks (WHO, 2022; UNICEF, 2021), the study provides a contextualized yet internationally relevant account of service system transition. The Vietnamese case illustrates the complexities of moving from institutional stabilization toward integrated, community-based mental health care for children, thereby enriching comparative understanding of system reform in LMIC contexts.

5. Conclusions

This study has several limitations. The sample was limited to seven social assistance facilities and may not fully represent the diversity of service models across all regions of Viet Nam. In addition, quantitative findings relied primarily on self-reported satisfaction measures, which may be influenced by subjective perceptions. The cross-sectional design also limits assessment of long-term service outcomes. Future research could incorporate longitudinal approaches and broader regional samples to strengthen empirical evidence.

Community integration services for children experiencing mental health conditions in Viet Nam have expanded in recent years, particularly in rehabilitation and special education. Satisfaction levels reported by families and service providers suggest positive initial outcomes. However, service provision remains uneven across institutional contexts, and structural constraints persist in governance coordination, workforce specialization, and community inclusion mechanisms. The findings indicate that strengthening system coherence, professional workforce development, and community-based engagement will be critical for advancing service effectiveness. The transition from facility-centered stabilization toward integrated and community-oriented mental health systems requires coordinated reforms across policy, organizational, and professional domains. Through sustained institutional development and multi-level collaboration, community integration services can more effectively support children's social participation and long-term developmental well-being.

6. Declarations

6.1. Ethical Considerations

This study was conducted as part of a research project approved and commissioned by the Ministry of Labour, Invalids and Social Affairs (MOLISA), Viet Nam. The research proposal and data collection procedures were reviewed and authorized in accordance with national scientific research management regulations prior to implementation, and the project was officially accepted upon completion. The study complied with the ethical principles of the Declaration of Helsinki and the UNESCO Universal Declaration on Bioethics and Human Rights. As the research involved vulnerable populations, including children with mental health disorders, special safeguards were applied. Written informed consent was obtained from all adult participants and legal guardians before participation or access to case files. Participation was voluntary, and confidentiality and anonymity were strictly ensured. No clinical or experimental interventions were conducted, and no identifiable personal data are disclosed in this publication.

6.2. Use of artificial intelligence (AI)

The author declares that the generative artificial intelligence (AI) tool ChatGPT was used exclusively for language editing and grammatical refinement. The use of AI did not influence the scientific content, study design, data analysis, interpretation, results, or conclusions of the manuscript. Full responsibility for the content remains with the author.

6.3. Conflict of Interest

The author declares no conflicts of interest.

6.4. Funding

This research was conducted as part of a research project commissioned by the Ministry of Labour, Invalids and Social Affairs (MOLISA), Viet Nam.

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